UGANDA DEBT NETWORK (UDN)

Do Transparency and Accountability Matter in Pandemics?

Lessons from Covid-19 Resource Management and Utilisation in Uganda

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Executive Summary

Being a global pandemic, Covid-19 did not spare Uganda. It adversely affected the health, political and socio-economic sectors. Uganda contained the first wave that stretched from 21 March 2020 to early January 2021. Under the Covid-19 Preparedness and Response Plan (March 2020-June 2021), several interventions were implemented to contain the pandemic. Committees were instituted at national and local levels to guide Covid-19 management, including, but not limited to, the National Covid-9 Task Committee and the District Covid-19 Task Forces.

Covid-19 financing between March 2020 and June 2021 was majorly from loans (UGX 4,297.4 billion), grants (UGX 17.98 billion), cash donations (UGX 11.6 billion) and donations in kind (UGX 34.55 billion). Loans and aid were largely secured from international donor agencies such as the World Bank, the International Monetary Fund (IMF) and foreign governments. At district level, funds were sourced from the central government and specific individuals, including area leaders such as Members of Parliament. These funds were used to procure several items, including foodstuffs, medical equipment, and vehicles, especially pick-ups, among others.

Several accountability gaps were identified, such as limited segregation of duties during authorisation and reporting for the resource utilisation, failure to follow procurement standards and procedures, full payments to suppliers before delivery, a poorly managed contingency fund, inflated expenditures, inadequate supporting documents, and non-participation of contracts committees.

Some best practices need to be adopted, given the inadequate resources made available to the health sector. For instance, engaging the public to fund health campaigns though this intervention should not relegate the government's role to provide the needed health services to the citizens. This is, however, contingent upon transparent and inclusive engagement of citizens.

To local governments authorities, the brief recommends that: i) Strengthening citizens' engagement in decision-making, accountability, and health service delivery through Participatory Action Planning (PAP), ii) Local Government Public Accounts Committees to work with District Task Forces to monitor all resources allocated for management of pandemics, iii) Training of all district and subcounty accountants in public finance management including IFMS and PPDA by the Local Government Finance Commission, iv) Keeping district task forces active especially in fragile zones such as border districts to ignite their functionality during periods of emergency,

To the central government, the brief recommends: i) Establishment of a multisectoral engagement approach for resource mobilization and use during pandemics through coordinated efforts across all sectors by the Office of the Prime Minister, ii) Enactment of a comprehensive law by Parliament, in liaison with the Ministry of Health and the Ministry of Disaster Preparedness on pandemics or epidemics, iii) Institutional Capacity-Building by the Office of the Prime Minister to strengthen the systems and competence of all MDAs to enhance their resilience and agility during pandemics, iv) Operationalization of the national health insurance scheme by the Ministry of Health and Parliament among other recommendations.

To civil society and development partners, the brief recommends: i) Extension of technical, financial, and in-kind support to the health sector after engaging beneficiaries in situational analysis/needs assessment studies and ii) Regular monitoring and evaluation of the appropriateness in utilising funds extended to the public sector using village/society committees.

To the general population (citizens), the brief recommends: i) Contribution to the provision of better health services through donations where they are acceptable and Constant demand for accountability from the political leaders and service providers to ensure Value For Money and improve service delivery.

Introduction

Uganda's bid to roll out Universal Health Coverage (UHC) is included in the Third National Health Policy (NHPIII), the Second Health Sector Development Plan (HSDPII 2020/21-2024/25), the Third National Development Plan (2021-2025), the Roadmap to UHC and Uganda's Vision 2040. In the face of several shortcomings, especially limited finances, the health sector has not yet achieved this goal. It has for several years been hamstrung by inadequate funding, especially from the government (15.7%), leaving about 41.7% and 42.6% of the sector's budget financed by development partners and the private sector, respectively (MOH, 2016). With the outbreak of the Covid-19 pandemic in March 2020, Uganda's bid to achieve UHC was nearly brought to an abrupt halt.

Given its indiscriminate multi-sectoral nature, Covid-19 has hit Uganda's health, political, social, and economic sectors hard. Infections were overwhelming and worrying, especially during the second wave (MOH, 2021). In response, the Covid -19 Preparedness and Response Plan (March 2020–June 2021) was initiated to raise both financial and in-kind resources (Office of the Attorney General [OAG], 2020). Financial resources were raised through grants, loans, donations (cash and in-kind), reallocations and supplementary budgets approved by Parliament. However, oversight bodies such as the Office of the Auditor General, Parliament, and civil society organisations (CSOs) identified accountability gaps in the management of Covid-19 funds. This is what motivated Uganda Debt Network (UDN) to commission a study to review and assess the level of transparency and accountability in the management of public resources targeted at Covid-19 health service delivery in Uganda. The policy brief summarises the key findings and recommendations drawn from this study.

Uganda's strategies to prevent the spread of Covid-19

The Ministry of Health, in cooperation with the Office of the President, the Office of the Prime Minister (OPM) and international agencies, adopted universal measures and strategies to address the pandemic. The Covid-19 Preparedness and Response Plan (March 2020–June 2021) was formulated. Some of the measures included: closure of Entebbe international Airport effective 16 March 2020; closing ground-crossing points for passengers except for cargo drivers; temporary closure of schools and a ban on public gatherings; freezing public and private transport; and outlawing all mass gathering events, including at places of worship. There were two major nationwide lockdowns declared on 24 March 2020 and 18 June 2021, respectively, with the second stretching for 42 days. This enabled the Ministry of Health to register success in the containment of Covid-19 illnesses. These were enforced and backed by quarantines, the establishment/gazetting of isolation centres, night curfews and sensitisation of citizens to Covid-19 spread and prevention, including the popular *Tonsemberera* (Don't come near me) campaign.

Quarantines enabled health workers to monitor exposed persons for symptoms and ensure early detection of cases to prevent additional exposures or the spread of infections. This necessitated different health systems investments, such as human resources and financial resources, among others. Quarantine facilities and human resources included toilet and hygiene items, beds, information sharing, reliable ventilations, medical staff, and psychosocial counsellors, among others.

All Covid-19 prevention measures were spearheaded by the National Task Force (NTF), the Incident Management Team (IMT), the District Task Forces (DTFs) and their sub-committees. Their role was to develop and enforce Standard Operating Procedures (SOPs) in collaboration with security agencies, develop public awareness messages as well as guide the President and Cabinet on the way forward. Other tasks included ensuring capacity-building for the health workforce and reorganising service delivery to ensure the continuity of essential health care services.

Experiences and best practices were benchmarked from the most affected countries such as Italy, Spain, and the USA. However, at the time of the Covid-19 outbreak, Uganda had less than one hospital bed per 1,000 patients. There were only 137 fully equipped intensive care unit (ICU) beds in public hospitals nation-wide, including only 102 (74%) of the beds in Mulago National Referral Hospital (NRH) and the rest in other Regional Referral Hospitals (RRHs). This demonstrated a gap in the health sector that needed to be bridged for the effective

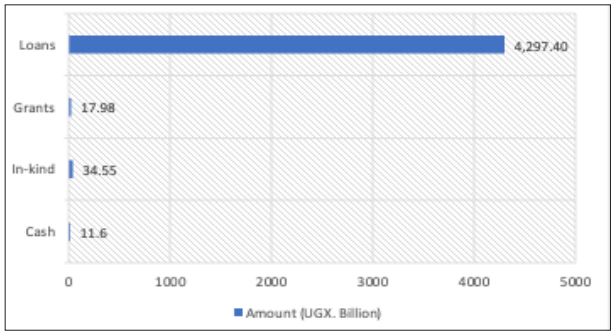
management of Covid-19.

On 10 March 2021, Uganda launched its first efforts in Covid-19 vaccination at Mulago National Referral Hospital. Over 864,000 doses of Astra Zeneca had been secured by 5 March 2021. By 9 December 2021, a total of 7,813,170 vaccine doses had been administered. This represents a share of 2.73% of the population fully vaccinated and 11.1% who had received at least the first dose of Covid-19 vaccine.

Sources of funding for Covid-19 response in Uganda

As per the Auditor General's report for Financial Year 2019/2020, the major sources of Covid-19 response funds were grants (UGX 17.98 billion), loans (UGX 4,297.4 billion), cash donations (UGX 11.6 billion) and donations in kind (UGX 34.55 billion). Loans and aid were largely secured from international donor agencies such as the World Bank, the International Monetary Fund (IMF), the European Union (EU), the PTA Bank, the Islamic Development Bank (IDB), Stanbic Bank and foreign governments such as the Chinese government, among others. Donations largely came from individual local contributors, CSOs and private companies. On the contrary, Global Integrity reported support amounting to US$1,180,025,824. This support was in terms of cash and materials.

Figure 1: Graph showing the major sources of Covid-19 response funds in Uganda

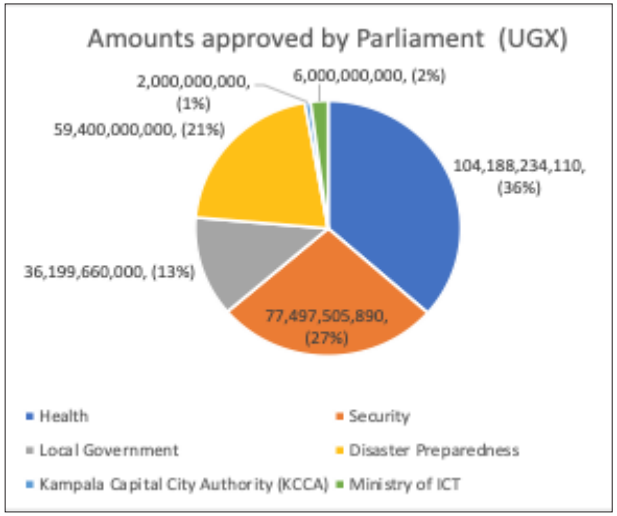


Source: Office of the Auditor General (2020)

Covid-19 funds management and accountability by Ministry of Health

Utilisation of Covid-19 resources

From the Covid-19 Preparedness and Response Plan March 2020- 2021, a multi-sectoral approach to budget allocation and expenditure was adopted. The sectors involved included Ministries, Departments and Agencies (MDAs), partners, non-governmental organisations (NGOs), private sector entities and other stakeholders, and these contributed to the efforts of preventing and contracting the spread of Covid-19 (MOH, 2020). Parliament approved a supplementary budget worth UGX 284 billion for the Ministries of Health, Security, Local Government and ICT, the Office of the Prime Minister (Disaster Preparedness) and Kampala City Council Authority (KCCA). The breakdown of the resource allocation is shown in Figure 2 below:



Source: Parliament of Uganda, Addendum 2 of Supplementary Expenditure Schedule No.2 2019/2020, with modification by the author

The Ministry of Health allocated the Covid-19 resources across the eight pillars, including Leadership, Stewardship, Health Infrastructure, Case Management, Supply Chain Management, Community Engagement and Social Protection. The least financed pillar was Strategic Information, Research and Innovation and ICT. The Ministry of Health spent the Covid-19 funds specifically on the procurement of ambulances, procurement of specialised medical equipment, including ICU machines, securing accommodation for the quarantine of returnees from abroad and of suspects, acquisition of

blood collection materials for Uganda Blood Transfusion Services (UBTS) , procurement of testing kits, provision of mobile health services, especially at border points, procurement and distribution of personal protective equipment, procurement of non-medical masks, provision of pillar allowances for staff, operationalisation of testing laboratory points at borders and procurement of spray pumps (MoFPED, 2020).[1] Generally, there was an average funding gap of USD 393,310,761 (65%) for the eight Covid- 19 pillars.

However, the resources received did not adequately support the Covid-19 priorities in some districts, such as Rubirizi, where its only public health centre IV facility had three oxygen cylinders, which were insufficient to handle Covid-19 patients. In other cases, a lot of strings were attached Covid-19 support in terms of expenditure patterns and budgetary items, making it difficult to address the priority needs. Some districts experienced challenges where councillors who were not part of the Covid-19 task forces demanded allowances, something which hampered proper allocation, disbursement, and expenditure.

Accountability

For the Ministry of Health, accountability and transparency are manifested in the quality of the services, the accounting procedures as indicated in the Public Financial Management Framework (PFM), adherence to international financial reporting standards, citizens' participation, and the overall responsiveness to the needs of the population.

1 https://covid19.gou.go.ug/uploads/document_repository/authors/minstry_of_finance,planning_and_economic_development/document/COVID-19_Interventions_Report.pdf

The Ministry of Health spent its Covid-19 resources on quarantine centres, where expenditure involved items such as individual residents' logistics like bedding, food, water, medical care and room utensils. All quarantine and isolation centres had managers accountable to the populations under their jurisdictions. They worked with other medical teams, i.e. clinicians, nurses, psychosocial workers and counsellors, all of whom were remunerated. Institutional logistics included power, water, security, cleaning services, ambulances, fuel, information, education and communication, coordination meetings, advocacy and social mobilisation on radio and television. Financial reporting was majorly done using integrated financial management systems (IFMSs), except for some districts which had inexperienced accountants.

Shocks and Irregularities in transparency and accountability for Covid-19 funds by Ministry of Health

Several anomalies were identified during the management and accountability for Covid-19 resources in Uganda. These included limited segregation of duties during authorisation and reporting for the resource utilisation, failure to follow procurement standards and procedures, full payments to suppliers before delivery, inflated expenditures, inadequate supporting documents, non-participation of contracts committees, unplanned expenditure, and haphazard re-allocation of resources. Some of the accountability reports were duplicated to provide false evidence of unexplained expenditure.

Conclusion

Uganda has a global record for managing epidemics. This is drawn from her experience with Ebola, cholera, Marburg, Crimean Congo haemorrhagic fever, yellow fever, Rift Valley fever, avian influenza, and measles, among others. Using several approaches, including the implementation of the Public Health Emergency Operations Centre (PHEOC) and the National Task Force (NTF) for public health emergencies to plan, such health hazards were successfully contained. With Covid-19, the country leveraged the previous efforts to implement a plan that preceded registering relatively lower cases and deaths compared to developed countries such as Spain, Italy, and USA, among others. Necessary resources were raised both from internal and external sources to fund Covid-19 interventions. However, irregularities were exhibited in the process. Despite Covid-19 being an emergency, adherence to several financial management provisions, such as the Public Finance Management Act, the Public Procurement and Disposal of Public Assets Act and the International Financial Reporting Standards were necessary to ensure proper utilisation of resources and value for money. The loopholes manifested in the process, therefore, constituted early warnings and lessons for Uganda's health system and other ministries to streamline, coordinate efforts and strengthen their institutional capacity to manage pandemics as well as other unprecedented natural disasters.

Key Priority Policy Recommendations

a. For Local Government/District Authorities

- Local Government Authorities should strengthen citizens' engagement in decision-making, accountability, and health service delivery through Participatory Action Planning (PAP).
- Local Government Public Accounts Committees should work with District Task Forces to monitor all resources allocated for management of pandemics
- Local Government Finance Commission should train all district and subcounty accountants in public finance management including IFMS and PPDA.
- District task forces should be kept active especially in fragile zones such as border districts to ignite their functionality during periods of emergency

b. Parliament and MDAs

- The Office of the Prime Minister should establish a multisectoral engagement approach for resource mobilization and use during pandemics through coordinated efforts across all sectoral.
- Enactment of a comprehensive law by Parliament, in liaison with the Ministry of Health and the Ministry of Disaster Preparedness on pandemics or epidemics. A law to guide the country on management of emergencies, their accountability and reporting mechanisms should be enacted to prevent haphazard expenditure and improve management of the contingency fund.
- Institutional Capacity-Building by the Office of the Prime Minister to strengthen the systems and competence of all MDAs to enhance their resilience and agility during pandemics.
- The Ministry of Health and Parliament should devote efforts to operationalise the national health insurance scheme.
- The MoH should engage civil society and the private health sector institutions in management structures for pandemics using a well-designed framework.
- The MoH should motivate all staff involved in the management of pandemics by setting an indicative allowance rewarding scale for all staff engaged in the prevention and treatment of pandemics.
- MoH together with Parliament and other line ministries should enact a national health security policy to advocate for and finance a national one health platform for multi sectoral coordination, planning before, during and after pandemics.
- Improving coordination of activities between MoH, local government, health facilities and district task forces to enhance participatory monitoring of activities and citizen-oriented health service delivery.
- Improving segregation of duties in MoH to promote accountability and transparency. There is need to define the roles of resource managers and cost centers to reduce non-segregation of approval and authorization procedures during pandemics and
- Parliament should define limits for health innovation seed grants

c. For Civil Society and Development Partners

- Extension of technical, financial, and in-kind support to the health sector after engaging beneficiaries in situational analysis and
- Regular monitoring and evaluation of the appropriateness in utilising funds extended to the public sector.

d. For the General Population (Citizens)

- Contribution to the provision of better health services through donations.
- Constant demand for accountability from the political leaders and service providers.

References

Baez Camargo, C. (2011). Accountability for better healthcare provision: A framework and guidelines to define, understand and assess accountability in health systems. Available at https://baselgovernance.org/sites/default/files/2019-06/biog_working_paper_10.pdf

Bank of Uganda (BoU). (June 2021). ***State of the economy report***. BoU.

Cao, B., Wang, Y., Wen, D., Liu, W., Wang, J., Fan, G., . . . Wei, M. (2020). A trial of lopinavir–ritonavir in adults hospitalized with severe Covid-19. ***New England Journal of Medicine.***

MOFPED. (2020) Covid-19 Interventions Report FY2019/20.Budget Monitoring and Accountability Unit (BMAU) https://bit.ly/366ZQ5L

MOH. (2016). Health Financing Startegy FY 2015/16- 2024/25.

MOH. (2020a). Coronavirus Disease-2019 (Covid-19) Preparedness and Response Plan March 2020 – June 2021.

MOH. (2020b). The effect of Covid-19 pandemic on the continuity of essential health services delivery, access and uptake in Uganda.

MOH. (2020c). Guidelines on Quarantine of Individuals in the Context of Containment of Coronavirus Disease (Covid-19) in Uganda.

MOH. (2020d). Updates on the Covid-19 response in Uganda.

National Academies of Sciences, Engineering and Medicine. (2018). ***Crossing the global quality chasm: Improving healthcare worldwide.***

MOH. (2021) Reporting Template For All Covid Related Procurements, FY 2020/21. https://bit.ly/34R8EMd

Ndejjo, R., Naggayi, G., Tibiita, R., Mugahi, R., & Kibira, S. P. (2021). Experiences of persons in COVID-19 institutional quarantine in Uganda: A qualitative study. ***BMC Public Health,*** *21*(1), 1-11.

Office of the Attorney General (OAG). (2020). ***Annual performance report for financial year 2019/2020***. OAG.

Posani, B., & Aiyar, Y. (2009). State of accountability: Evolution, practice and emerging questions. ***AI Working Paper (pp. 2).***

Parliament of Uganda (2021). ***Report of the Parliamentary Task Force on the National Covid-19 Response, Addendum 2, of the Supplementary Expenditure Schedule No. 2 for Financial Year 2019/2020.***

Vian, T. (2020). Anti-corruption, transparency and accountability in health: Concepts, frameworks, and approaches. *Global Health Action, 13*(sup1), 1694744.

World Bank (2003). ***World Development Report 2004: Making services work for poor people.*** World Bank.

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