ACCOUNTABILITY AND TRANSPARENCY FOR UGANDA'S HEALTH SECTOR
COVID-19 RESOURCES (2019-2021)

A Report with Reflections from Both National and District-Level Stakeholders

UGANDA DEBT NETWORK (UDN)

November 2021

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List of Abbreviations and Acronyms

ADDA:	Amuria District Development Agency
BoU:	Bank of Uganda
CABRI:	Collaborative Africa Budget Reform Initiative
CEHURD:	Center for Health, Human Rights and Development
CFO:	Chief Finance Officer
CSO:	Civil Society Organisation
COSO:	Committee of Sponsoring Organisation
DECODI:	Destiny Community Development Initiative
DHO:	District Health Officer
DTFs:	District Task Forces
EU:	European Union
FY:	Financial Year
GDP:	Gross Domestic Product
HMIS:	Health Management and Information System
HSDPII:	The Second Health Sector Development Plan
IASs:	International Accounting Standards
IBP:	International Budget Partnership
ICT:	Information and Communication Technology
ICU:	Intensive Care Unit
IDB:	Islamic Development Bank
IFMS:	Integrated Financial Management Systems
IFRSs:	International Financial Reporting Standards
IMF:	International Monetary Fund
IMT:	Incident Management Team
KCCA:	Kampala Capital City Authority
LC:	Local Council
LDCs:	Least Developed Countries
MDAs:	Ministries, Departments and Agencies
MoFPED:	Ministry of Finance, Planning and Economic Development
MoH:	Ministry of Health
MoLG:	Ministry of Local Government
MPs:	Members of Parliament
NDP III:	The Third National Development Plan (2021–2025)
NGOs:	Non-Governmental Organisations
NHPIII:	Third National Health Policy
NRH:	National Referral Hospital
NTF:	National Task Force
OAG:	Office of the Auditor General
OOP:	Out of Pocket Payments
OPM:	Office of the Prime Minister
PAC:	Public Accounts Committee
PAP:	Participatory Action Planning

PAR:	Participatory Action Research
PFM:	Public Finance Management Act
PPDA:	Public Procurement and Disposal of Public Assets
PTA:	Preferential Trade Area
RDC:	Resident District Commissioner
RRH:	Regional Referral Hospital
SMEs:	Small and Medium Enterprises
SOPs:	Standard Operating Procedures
TASO:	The AIDS Support Organisation
UBTS:	Uganda Blood Transfusion Services
UDN:	Uganda Debt Network
UHC:	Universal Health Coverage
UHF:	Uganda Healthcare Federation
UNHCO:	Uganda National Health Consumers' Organisation
USA:	United States of America
VFM:	Value for Money
VHTs:	Village Health Teams
WHO:	World Health Organisation

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EXECUTIVE SUMMARY

Uganda has not been immune to the global Covid-19 pandemic. The first case in Uganda was declared on 21 March 2020, by the Ministry of Health (MoH). Consequently, several measures were put in place to prevent its spread as well as handle those that had been infected. Covid-19 mitigation required a multi-sectoral approach to countervail its associated adverse health, social and economic impacts.

Uganda prepared a Covid-19 Preparedness and Response Plan, March 2020–June 2021, oriented on eight pillars that guided all actions undertaken to handle the pandemic. With the leadership of the Office of the Prime Minister, all ministries were coordinated and drawn together to support and steer all Covid-19-related interventions. A National Task Force was formed, and was composed of different stakeholders, including scientists, and at the district level, the task forces were led by the Resident District Commissioners (DRCs).

Despite the concerted effort by the Government of Uganda in collaboration with various stakeholders, Uganda endured two waves of Covid-19, with the most recent lasting from May to July 2021, characterised by several lockdowns.

Using the World Bank Accountability Framework of 2004, this study sought to review and assess the level of transparency and accountability in the management of public resources towards Covid-19 health service delivery in Uganda. Specifically, the study analyses the mobilisation strategies for Covid-19 resources, appropriateness in utilisation, as well as their reporting and accountability mechanisms. The results of the study aimed at generating evidence that would support citizens' participation and influence public finance management in Uganda. The study was undertaken at both national and district levels, i.e. in Kanungu, Rubirizi, Kapelebyong and Apac districts. In addition to the desk reviews, the study purposively engaged vital stakeholders to deeply understand the subject matter at the national and district levels. The findings therein are clustered as:

Mobilisation of Covid-19 Resources

Financial and in-kind resources were raised for Covid-19, amounting to UGX 4,361.53 billion. At the national level, loans, grants, donations and budget reallocation were the primary sources of Covid-19 resources. The significant contributors at this level included the World Bank, IMF, EU, the Islamic Development Bank, and governments of foreign countries. Generally, loans formed the most significant proportion of all mobilised Covid-19 resources. At the district level, Covid-19 resources came from the central government, local leaders (including churches), implementing partners such as Rhites E, Rhites-West, TASO, UNHCR, UNICEF, WHO, ACODEF, Reproductive Health Uganda and individual donors, who included Members of Parliament.

These resources were mobilised through district task forces headed by RDCs. Some of the notable challenges experienced during the mobilisation of these resources included: insufficient planning; insufficient resources to motivate health workers and their support teams; a small and unreliable contingency fund; and lack of budgets/targets for resources to be mobilised at the district level.

Overall, respondents applauded the initiative of engaging the population in soliciting support to improve their health status during the pandemic. However, this should not relegate the government's constitutional obligation of providing healthcare to its citizens as required by law.

Utilisation of Covid-19 Resources

The Covid-19 Preparedness and Response Plan March 2020-June 2021 stipulates the guidelines for utilising mobilised resources at the national and district levels. Expenditure was meant to be on specific pillars, i.e. Leadership, Stewardship, Coordination and Oversight of all Covid-19-related activities; Surveillance and Laboratory; Case Management; Strategic Information; Research and Innovation; Risk Communication and Social Mobilisation; Logistics; and Continuity of Essential Health Services. Respondents at district level highlighted several items on which the funds were spent including but not limited to paying allowances for the task force members and VHTs, providing material items to the vulnerable, community mobilisation, and Covid-19 awareness campaigns.

Reporting and Accountability for Covid-19 Resources

With the leadership of the district task forces, districts highlighted several approaches used to ensure accountability for all generated resources, including, but not limited to, the public declaration of all the support received, especially on media platforms such as radios, television and community social media. This portrayed transparency as a motivating factor for more donations, and increased public participation in the mobilisation teams. Issuing vouchers for all generated materials/funds and for those issued was one of the good practices identified. Delayed disbursement of risk allowance for identified cadres and discrimination of cadres entitled to this allowance were identified as the gaps that the government and districts need to address.

At the national level, the respondents highlighted gaps in accountability emanating from duplication of tasks, late involvement of the political leaders in the fight against Covid-19 (e.g. Members of Parliament), limited segregation of duties and failure to adhere to procurement regulations such as skipping the contracts committees.

Evidence from reviewed literature pointed to the following gaps: unaccounted for funds, e.g. UGX 1.317 billion out of the UGX 284 billion that was disbursed to 17 entities remained unaccounted for; 94 (68%) out of 135 entities that received donations in kind did not undertake valuations, and this is contrary to paragraph 15.5.1 of the Treasury Instructions; items valued at UGX. 55.8 billion which were distributed under the Office of the Prime Minister (OPM) lacked sufficient back-up evidence; and lastly, UGX.10.574 billion in five (5) entities was diverted and spent on items other than those for which the funds were disbursed.

Best Practices

Best Practices for better accountability and transparency for health resources requires but not limited to:

- Communication and visibility of resources generated, and their utilisation are key to further resource mobilisation. Communication is a key ingredient of transparency.
- Availability of a clear feedback mechanism across actors enhances quality service delivery; regular budget reviews are inevitable in every accountability cycle for health service financial management.
- Well-defined guidelines and targets enhance transparency and accountability in the use of health resources.
- The motivation of staff who handle pandemics under risky health conditions forms part of the core budget.
- Evidence-based criteria for the allocation of funds to districts is essential.

- Engaging communities in raising resources for health is an excellent avenue for expanding the resource envelope for the health sector.
- Segregation of duties is an essential tool for the prevention of misappropriation and defrauding of public resources, among others.

Key Recommendations

a) For Local Government

- 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) For 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 sectors.

Enactment of a comprehensive law by Parliament, in liaison with the Ministry of Health and the Ministry of Disaster Preparedness on pandemics or epidemics.

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 MoFPED should protect the contingency fund from political influence by ensuring its independent management and monitoring.

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 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/needs assessment studies.

Regular monitoring and evaluation of the appropriateness in utilising funds extended to the public sector using village/ society committees.

d) For the General Population (Citizens)

Contribution to the provision of better health services through donations where they are acceptable.

Constant demand for accountability from the political leaders and service providers to ensure Value for Money and improve service delivery.

Overall, effective handling of Covid-19 is hinged on the country's institutions that can effectively absorb the shocks that come with the adverse effects of the pandemic. A whole society approach (linked to a whole government approach) is key to ensure that all resources are used effectively by actors.

1.0 INTRODUCTION AND BACKGROUND

Uganda's commitment to achieve Universal Health Coverage (UHC) is explicitly found in the key government documents, including 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 Vision 2040. However, the UHC commitment has not yielded the required considerable investment in health infrastructure as well as human resources for health. The given resource challenges are even worse for Uganda, and are exacerbated by the Covid-19 pandemic, lending credence to questions about the available resources to meet healthcare needs. The health sector has for several years been characterised by inadequate funding, especially from the government (15.7%), leaving about 41.7% and 42.6% of the sector's budget to be financed by development partners and the private sector, respectively (MOH, 2016). The low health budgetary allocation and its unpredictability have been cited as a key hindrance to proper planning (Ssempala, 2020), thus contributing to the high Out of-Pocket (OOP) households bear for health services, recently estimated at 41.4% of the total health expenditures in FY 2018/19 (Kwesiga et al., 2020).

In March 2020, the Government of Uganda undertook deliberate Covid-19 response measures to invest heavily in the health sector to manage the situation. It declared a series of interventions aimed at controlling the spread of Covid-19 and its negative effects. These included, but was not limited to, a nation-wide lockdown, temporary closure of schools and places of worship, banning of international travel, and the provision of food relief to the vulnerable, among others. The protracted lockdown measures, however, affected Uganda's Gross Domestic Product (GDP) growth, which reduced from 6.8% in FY 2018/19 to 3.3% in FY 2020/21 (Bank of Uganda [BoU], June 2021). Tax revenues, too, reduced as a result of the poor economic conditions faced in FY2019/20. This, however, occurred amidst increased government expenditures, especially on the health sector, Small and Medium Enterprises (SMEs) and the vulnerable. As a result, the fiscal deficit in FY19/20 widened to 7.1 % of GDP and the public debt ratio increased by almost 6 percentage points to 41.1 % (IMF, 2021).

Across the globe, the health sector is presumably vulnerable to financial mismanagement and corruption, given its inherent characteristics such as asymmetric information (Koller, Clarke, & Vian, 2020). Vian (2020) notes that the key facilitating factors for corruption and mismanagement of healthcare resources include:

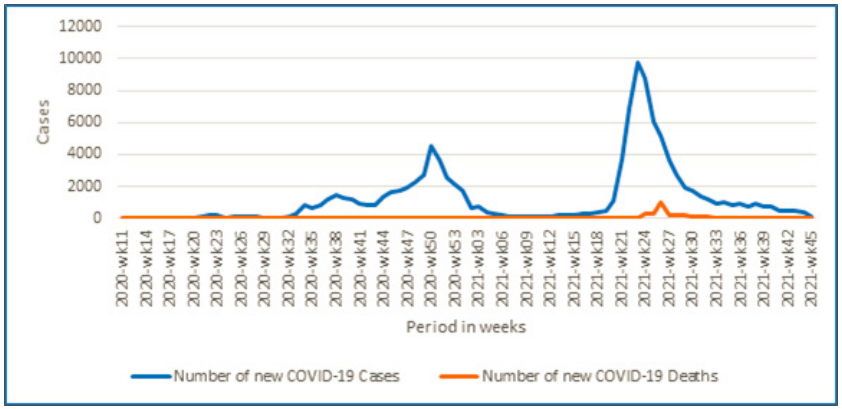
1. asymmetry of information that characterises the patient-provider relationship;
2. the uncertainty that surrounds the illness experience;
3. the multiplicity of actors and services involved in illness care; and
4. the challenges of ensuring accountability in complex health systems.

The fact that governments across the world during the Covid-19 period introduced emergency procurement regimes that could facilitate quick procurements and approval of funds, among others, posed a more significant potential for fraud, mismanagement, and general inefficiencies than usual (Serebro, 2020). The implication is that management of resources during pandemics requires robust flexible approaches that can ensure Value for Money (VFM) and the provision of quality services, including healthcare to the population.

1.1 Context of the Study

Uganda was affected by the outbreak of Covid-19 pandemic. Both economic and health systems were adversely affected as a result of the measures adopted to prevent the spread of the disease. The increased number of infections, especially during the second wave (May to July 2021), was reported to have overwhelmed the health sector (MOH, 2020d). As shown in Figure 1, the covid-19 cases and deaths eased, suggesting levels of efficacy of the containment measures.

Figure 1: Trend of Covid-19 cases in Uganda (1st and 2nd waves- 10/03/2020-19/11/2021



Source: MoH, Covid-19 Response Hub

The low numbers of Covid-19 cases during the first wave were greatly attributed to the country's preventive measures, which included intensive sensitization of the citizens about Covid-19, a mandatory quarantine, or isolation for affected individuals, testing of all travelers from Covid-19 affected countries, and a national lockdown, among other interventions. To fully implement the highlighted interventions and many others, mobilisation of resources was necessary to invest in the health sector. Therefore, a deliberate move was undertaken by the government using the Covid-19 Preparedness and Response Plan (March 2020-June 2021) to raise both financial and in-kind resources (OAG, 2020). Financial resources were raised through grants, loans, donations (cash and in-kind), reallocation and supplementary budgets approved by Parliament.

However, reports from government oversight bodies such as the Office of the Auditor General, Parliament and Civil Society Organizations' (CSOs) indicated accountability gaps in the use of Covid-19 funds. This is in relation to other literature that demonstrates that healthcare resources are more prone to corruption and mismanagement (Vian, 2020). To bridge this

gap, strategies aimed at ensuring social accountability and transparency are thus inevitable (National Academies of Sciences and Medicine, 2018). Against that backdrop, Uganda Debt Network (UDN) commissioned a study to review and assess the level of transparency and accountable management of public resources for Covid-19 health service delivery in Uganda.

Specifically, this study analyses the mobilisation strategies for Covid-19 resources as well as the appropriateness of the utilisation, reporting and accountability mechanisms for these resources.

The results of the study are aimed at generating evidence that will support citizens' participation and influence public finance management in Uganda. The study was undertaken at both national and district levels and covered the districts of Kanungu, Rubirizi, Kapelebyong and Apac.

1.2 Objectives of the Study

The study was guided by the following specific objectives:

To generate evidence for citizens' actions on transparent and accountable management of Covid-19 public resources in Uganda.

To strengthen community monitoring capacities, linkages and advocacy actions for transparent and accountable health service delivery in the districts of Kanungu, Rubirizi, Kapelebyong and Apac.

To identify best practices, opportunities and challenges in enhancing transparency and accountability in performance monitoring during pandemics in Uganda.

1.3 Scope of the Study

The study covered selected resources that fell under grants, loans and supplementary budgets by Parliament, the private sector/ corporate and individual contributions (donations) in cash and in kind. At district level, the study was conducted in Rubirizi, Kapelebyong, Kanungu and Apac. This data was analyzed at both national and district levels.

2.0 METHODS

2.1 Study Population

The study was conducted at national and district level covering Kapelebyong, Kanungu, Rubirizi and Apac districts. Political, technical, health facility managers and Covid-19 task committee members were interviewed. These were selected purposively, given their roles in the Covid-19 prevention, resource mobilisation as well as accountability for the raised resources. At district level, the key informants included, DHOs, CFOs, District Planners, HMIS focal persons, health facility in-charges, representatives of implementing partners (IPs) such as Rhites E, district council members, and beneficiaries, among others. At national level, different parliamentary committee members were interviewed; the MOH officials and a few CSOs that represented the views /voices of the citizens, e.g. Uganda National Health Consumers' Organisation (UNHCO), Uganda Healthcare Federation (UHF) and the Center for Health, Human Rights and Development (CEHURD). Table 1 below summarizes the key respondents interviewed at the district and national levels.

The majority of the district-level respondents, as presented in Table 1, were part of the task forces, followed by district service respondents. The least category of respondents were health facility managers and beneficiaries/citizens. At the national level, the majority were chairpersons of the selected parliamentary committees critical to Covid-19, e.g. the Health Committee, the Committee on National Economy and PAC. Other respondents included representatives from civil society organizations', especially those critical to health issues such as the Uganda National Health Consumers' Organization (UNHCO), Center for Human Rights and development (CEHURD).

2.2 Categories of Respondents

Table 1: Categories of respondents at national and district levels

Category of respondents	Number	Percentage
District level		
District leaders	8	
Health facility managers	5	
Covid-19 task force	8	
Beneficiaries	3	
Sub-total	**24**	**75.0**
National level		
Technical officials (MoH, OAG)	2	
Chairpersons Parliamentary Committees	3	
Civil Society Representatives	3	
Sub-total	**8**	**25.0**
Total Respondents	**32**	**100.0**

Source: Primary data from KIIs at national and district levels

2.3 Other Data Sources

Specific information was collected from literature through a rigorous desk review, especially for national-level Covid-19 resource mobilisation, utilisation and accountability. Information obtained from the literature was triangulated with key informants' insights on the topic. Our key informants were drawn from the Parliament of Uganda, the Ministry of Health, Departments, Agencies and CSOs, given their role in Covid-19 prevention, mobilisation of funds for it and their subsequent utilisation.

2.4 Data Collection Exercise

Data was collected between October 2021 and January 2022. The research team included the Lead Consultant and trained enumerators. Data collection involved a review of documents and interviewing of purposively selected respondents at both national and district levels. Figure 2 presents some of the moments when data collectors were interacting with different respondents.

Figure 2: Data collectors interacting with respondents in the field

Mr. Christopher Ayella (at extreme left), District Technical Officer, RHITES-E, explaining the role of IPs in supporting Covid-19 resource mobilisation to the UDN team, Kapelebyong district

Mr. Sam Birungi, Clerk to Council, Kanungu district (in blue), intersecting with the UDN team about Covid-19 situation in the district and how the political leadership supported its prevention in the district

Dr. Hadus Masereka, Senior Medical Officer (Kanungu HCIV), sharing with the UDN team about the Covid-19 situation in Kanungu district and some of the challenges the facility encountered while handling the pandemic.

Ms. Angella Akurut, Deputy CAO, Kapelebyong district (on right), briefing the UDN team about the district's general Covid-19 resource mobilisation strategies.

Source: Primary data, October 2021

2.5 Data Processing and Analysis

The data collected from both literature and key informants at district and national levels was analyzed descriptively. The study adopted a data abstraction approach during data analysis. Data was reduced to a simplified representation of the study population considering a set of essential characteristics of the findings. A stakeholder validation meeting was organized in which preliminary results were presented for validation and stakeholders' ownership. Stakeholders' suggestions were incorporated into the draft study report after the validation workshop.

2.6 Limitations of the Study

The study was confined to four districts of Uganda, i.e. Apac, Kapelebyong, Rubirizi and Kanungu. Therefore, the insights presented mainly reflect the conditions in those districts.

The respondents at the national level were too busy to allocate time for interviews. This affected the response rate that we had planned. However, key individuals across institutions, ministries and CSOs were prioritised for the study, e.g. chairpersons of the different parliamentary committees and leaders of institutions, among others. Virtual interviews were conducted for those who could not allocate time for physical meetings.

3.0. FRAMEWORK FOR THE STUDY

The study was guided by the World Bank Framework for Accountability and Transparency, given its application and relevance to the subject (World Bank, 2003). The framework has been widely adopted in many accountability studies, such as, among others, those by Posani and Aiyar (2009), which focuses on the evolution, practice and emerging questions in public accountability in India, and by Baez Camargo (2011), which centres on accountability for better healthcare provision, which provides a framework and guidelines to define, understand and assess accountability in health systems. Similar to this study by UDN, these studies provide for the key actors in the accountability and transparency process, their roles and relationships and how resources can be used effectively to meet the needs of the citizens. The World Development Report (2016) on the evolution of the World Bank's thinking on governance also points out the short and long routes of accountability presupposed by the framework and how the different actors co-exist in the accountability mechanism (Lateef, 2016). These, and several others, are in harmony with the objectives of this study as guided by the same framework.

3.1 Description of the Accountability and Transparency Framework Adopted for the Study

The framework elaborates different actors involved in the accountability process, including the state (politicians and policymakers), providers (frontline and organizations') and citizens (poor and non-poor).

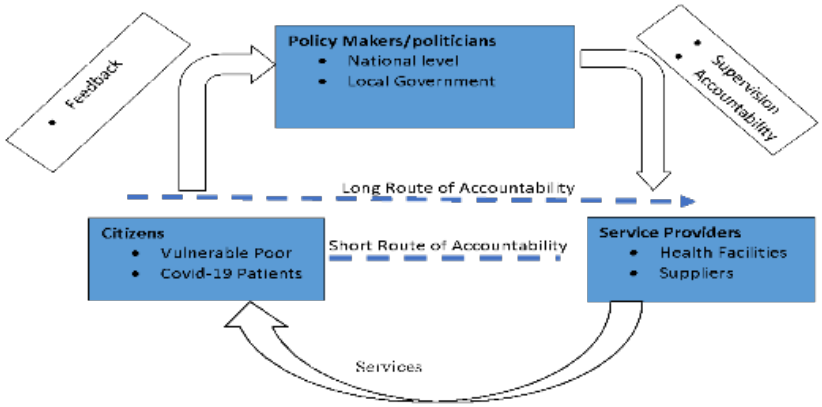
It portrays the routes to accountability for public resources, where the government (state) provides services to its citizens through designated service providers. These routes are divided into two, i.e. ***short and long routes.*** The framework suggests that from the three actors, poor people (citizens), who include patients in clinics (health centres), students in schools and other categories of citizens (clients), should be part of the decision-making and implementation processes. Involvement of the citizens in decision-making, especially with the service providers, constitutes the "short route" to accountability. However, where citizens acquire services through the state/politicians who link them to service providers, this constitutes a "long route" to accountability. According to this framework, "long routes" are characterised by many gaps and insufficiencies, thus affecting accountability processes. Given the weaknesses in the long

route of accountability, such as bureaucracy, strengthening the "short route" can improve service quality. One of the key strategies is increasing the clients' power over service providers through citizens' engagement/feedback (civic education).

In the context of this study, citizens are assumed to have a direct connectivity with the health service providers such as doctors, nurses and clinical officers, village health teams (VHTs), and other medical professionals and support teams. Political leaders at both national and local levels, i.e. Members of Parliament (MPs), Ministers and Accounting Officers, are obliged to procure and provide services from the service providers on behalf of the citizens and undertake an oversight role (supervision) of the service providers. In Uganda's health system, there is no clear approach through which citizens directly seek accountability from healthcare providers and managers. This implies the "short route" process to accountability is compromised.

Citizens seek accountability through policymakers, who in turn exert pressure on service providers. This constitutes a "long route" to accountability. However, the government addresses the challenges associated with the "long route" by enforcing accountability policies such as the Public Finance Management Act of Uganda (PFM Act, 2015), through guidance from the Permanent Secretary, Secretary to the Treasury, Public Procurement and Disposal of Public Assets (PPDA Act, 2003), International Accounting Standards (IASs), International Financial Reporting Standards (IFRSs), and Integrated Financial Management Systems (IFMS), among others. Despite the existence of such policies, it is likely that there was limited compliance with them since Covid-19 was an unprecedented pandemic, which was handled as an emergency (OAG, 2020). This might have influenced the accountability and transparency processes for Covid-19 resources in Uganda. Figure 3 below summarizes the logical connectivity between the three actors in the accountability and transparency process for Covid-19 resources.

Figure 3: Accountability and Transparency Framework



Source: Adopted with modifications from World Development Report 2004

United States Donation of 647,080 COVID-19 Vaccines for Uganda, (September 6, 2021)

4.0 RESULTS/FINDINGS

4.1 Resource Mobilisation for Covid-19 and Its Prevention Strategies

National- and district-level stakeholders identified sources of funds for Covid-19. These included donations, grants, loans, and support from the government through MOH, MoFPED, and local governments. District Covid-19 resources included cash and in-kind support.

i) Cash/funds transfers to districts

All districts received Covid-19 funds from the central government. Key informants, specifically CFOs and CAOs, confirmed this reality. However, it was noted that funds received were heterogeneous, with some districts being given more resources than others. A summary of the funds received by the districts sampled during the study is shown in Table 2.

Table 2: Central government financial transfers to districts

#	District	Covid-19 funds received in FY 2019/20	Covid-19 funds received in FY 2020/21
1	Apac	Not identified	265,600,000
2	Kapelebyong	180,530,229[1]	347,943,000[2]
3	Rubirizi	165,530,000	0
4	Kanungu	185,503,299[3]	20,000,000

Source: Primary data from districts (Apac, Kapelebyong Rubirizi, Kanungu)

Table 2 above shows that Rubirizi did not receive Covid-19 funds for FY 2020/21 from the central government.[1] The total amount of Covid-19 funds mobilized internally at district level majorly depended on the willingness and number of donors/individual that contributed to the resource mobilisation drive/ initiative.

ii) Cash/funds mobilised at national level

At national level, the major sources cited by respondents included grants, loans, and reallocation of the already approved budget by Parliament.

The largest portion of Covid-19 response funds (over 90%) were obtained from international donor agencies who extended substantial amounts of money to Uganda to fight the pandemic. (Key informant from Office of the Auditor General)

A respondent from the Parliamentary Committee on National Economy reaffirmed this finding, noting that the largest proportion of Covid-19 funds came from grants and loans.

Covid-19 funds were to a larger extent from external grants and loans. I sit on the Parliamentary Committee of the National Economy and our role is to scrutinize and approve government loans. (Hon. Migadde, Vice-Chairperson, Committee on National Economy)

Evidence from the Auditor General's Report (2020) revealed that a total of UGX 4,361.53 billion was raised to fight Covid-19 in Uganda, as shown in Table 3 below.

1 *Rubirizi district received these funds in FY2021/2022 as per the district key informant*

Table 3: Summary of Covid-19 resources mobilized at national level

Source of funding	Amount (UGX billion)
Cash	11.6
In-kind	34.55
Grants	17.98
Loans	4,297.4
Total	**4,361.53**

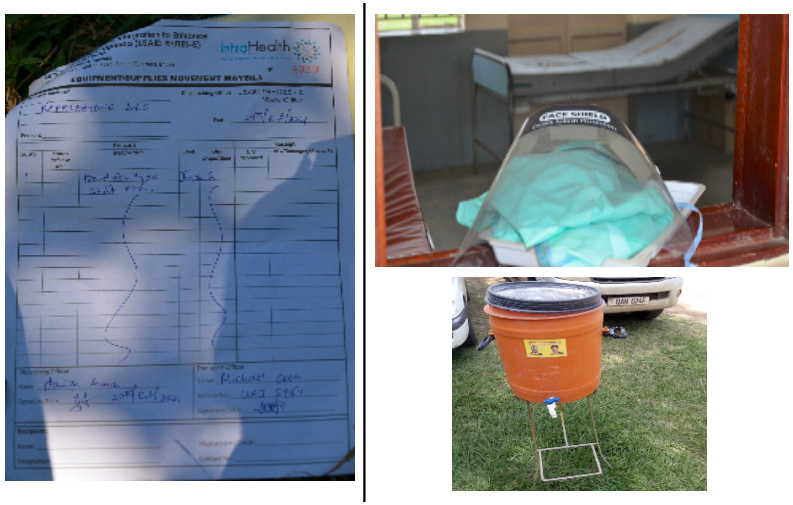
Source: Office of the Auditor General, 2020

iii) In-kind support

Other resources were in the form of material support such as mattresses for patients and contacts in quarantine/isolation centres, medical supplies, hand sanitizers, personal protective equipment, motor vehicles, especially ambulances and pick-ups, bottled drinking water and other in-kind items. These were received from the central government, individual donors, politicians, private companies and civil society.

Internal donations such as fuel, airtime, Jik, alcohol (mobilized), fumigators, teardrop banners, liquid soap, hand spray, clinical thermometers, surgical gloves, face masks, plastic sprayers, radio talk shows, public drivers and pieces of public health rules were provided by TASO, DECODI, Child Fund, ADDA, Uganda Sanitation Fund and Uganda Cares. (Deputy CAO, Kapelebyong – key informant)

Figure 4: Some of the Covid-19 items donated at district level



Source: Primary data, 2020

District task forces devised innovative ways of mobilized support from communities. These included directly contacting prospective organizations'/individuals for support as well as drives on mass media encouraging members to contribute.

We mobilized funds from our community; the district could write letters to people as well as organizations' in the district asking them to support resource mobilisation drive. (Key informant at district level, Rubirizi)

We received support from implementing partners who supported WASH, mobilisation and capacity building. (Key informant, Apac district)

This was the same in Apac district, where local NGOs and implementing partners supported the resource mobilisation drives.

Most of the funds came from government and other partners. …. We got over 165 million shillings from the central government, and support from Rhites, North Lango, Plan Uganda, Apac Anti-Corruption, and TASO. (Key informant, Apac district)

Sporadic Covid-19 relief contributions/donations were to a larger extent made by politicians, especially in the first wave. Contributions from politicians surpassed those from private individuals.

The first Covid-19 wave happened during campaigns for general elections. Many politicians came and donated to our district. In this hospital, some politicians could come and directly donate beds and assistance items to patients. (Beneficiary, Kanungu district)

Different reports, however, provide varying figures for the total amount of Covid-19 resources mobilized in Uganda. For instance, UGX 4,361.53 billion (Approximately USD 1.234 billion) is reported by the Auditor General (See Table 3). In contrast, Global Integrity reported USD 1.180 billion (see Annex 1).

Overall, Covid-19 resources were raised in the form of cash and in-kind donations. The major sources of donations were international donor agencies such as the World Bank, IMF, EU, PTA Bank, Islamic Development Bank (IDB), Stanbic Bank and foreign governments such as the Chinese government, among others. Cash donations largely came from local individual contributors, CSOs and private companies. Loans constituted the greatest proportion of the centrally mobilized resources.[2] At district level, most of the resources were in-kind.

In incidents of pandemics, therefore, the availability of well-planned, coordinated, and multi-stakeholder mobilisation strategies can induce communities to contribute towards the provision of healthcare services that are currently underfunded. Further, engaging the population together with their political leadership is a good strategy and precursor to establishing a national health insurance scheme where communities can willingly contribute to their healthcare and subsequently expand the healthcare resource envelope for the country.

4.2 Use of Covid-19 Resources

a) Expenditure planning

At district and national levels, the use of Covid-19 resources was mostly guided by Task Force Committees chaired by RDCs and the Prime Minister respectively. At district level, the respondents noted that the use of locally raised Covid-19 resources was at the discretion of the district task force (DTF) members. Funds at national level were ring-fenced for specific activities across the eight pillars stipulated in the Covid-19 Preparedness and Response Plan. However, the respondents noted duplication of resources arising from this arrangement.

Funds from the central government were specifically meant for holding task force meetings, conducting Covid-19 risk assessments, supporting the training of laboratory technicians, collection of samples for submission to the laboratories for testing, supporting surveillance, supervision and monitoring, supporting home-based care and counselling, community sensitization and facilitation of VHTs, among others.

2 *See Annex 1*

Findings from the districts revealed that some of the activities funded by the central government also attracted in-kind support from district donors, thereby leading to duplication in procurements.

Some of the donated items would come with strings attached, as a committee transferring such donations to buy other items (not funded by central government) wouldn't be possible… because our local donors funded specific items, for example buying fuel, sanitizers etc. (HMIS focal person – key informant)

Despite variations in the amounts mobilized, there was a similarity in activities on which Covid-19 funds were spent across districts. This was premised on the universal guidelines and guidance provided by MoH, MoFPED and the Ministry of Local Government on the use of Covid-19 resources.

There were guidelines we were following from the Ministry of Health…… Just know this was an emergency that relied on orders from the MoH. (District task force key informant, Kanungu district)

Funds were mainly used to support efforts to sensitize the population about Covid-19, to provide relief items to the vulnerable, and to procure WASH facilities, construction of oxygen plants and procurement of oxygen cylinders among others. In some districts, funds were used to renovate/build isolation centres for Covid-19 patients (see Figure 5 below).

Figure 5: Some of the items onwhich the Covid-19 funds were spent

A Covid-19 isolation Centre constructed at Rugazi Health IV, Rubirizi district (Source: Pictorial from Primary data)

Some of the hand-washing facilities found at Kapelebyong HC IV

National-level literature revealed that the central government expenditures were mainly hinged on the approved the Covid-19 Preparedness and Response Plan March 2020-2021 streamlined across eight pillars. From Table 4 below, the budgeted (planned) expenditure surpassed the committed (allocated) funding across pillars indicating a deficit (underfunding) in resources available for covid-19 prevention and management.

Table 4: Expenditure allocations across pillars

Item/Pillar	Budget		Committed	Gap	% Gap
	USD	UGX	USD	USD	
Leadership, Stewardship, Coordination and Oversight	85,483,978	316,290,717,031	24,072,355	61,411,623	72
Human Resource	19,033,298	70,423,203,385	10,117,240	8,916,058	47
Health Infrastructure	78,250,569	289,527,106,895	29,353,299	48,897,270	62
Continuity of Essential Health Services	7,649,869	28,304,515,600	1,581,288	6,068,581	79
Surveillance and Laboratory	22,190,888	82,106,655,954	13,673,652	8,517,336	38
Case Management	29,668,867	109,774,808,792	9,851,712	19,817,156	67
Logistics and Operations	21,656,063	80,127,433,576	13,459,739	8,196,324	38
Strategic Information, Research & Innovation	3,928,390	14,535,044,450	1,544,288	2,384,102	61
Supply Chain Management	252,969,767	935,988,138,417	77,388,293	175,581,475	69
Risk Communication and Social Mobilisation	15,963,524	59,073,109,400	6,089,004	9,874,520	62
Community Engagement and Social Protection	62,691,406	231,958,203,140	19,122,928	43,568,478	69
ICT	1,049,021	3,881,379,296	971,184	77,837	7
Total	600,535,742	2,221,990,315,936	207,224,981	393,310,761	65

Source: Budget Allocation (March 2020-July 2021) MOH, Covid-19 Preparedness and Response Plan March 2020-June 2021 Budget gap: USD 393,310,761.***

Overall, the existence of well-defined guidelines on the use of resources enhances transparency and accountability. Resources are exposed to misappropriation if no clear guidelines are provided on their utilisation and reporting. In most cases, these guidelines are provided by the politicians/policymakers to suppliers and suppliers (service providers) to the citizens. Politicians/policymakers usually enforce guidelines through oversight and supervisory roles. Whereas respondents noted that the Ministry of Local Government and MoFPED provided guidelines on how the Covid-19 funds should be used, gaps were highlighted therein. These included the late provision of guidelines on the funds, especially first disbursements to the districts, and stringent guidelines that could not allow reallocation of resources according to the district Covid-19 priorities. Uncoordinated guidelines were cited as a constraint on accountability for Covid-19 resources, thus undermining the proper utilisation of resources and citizens' trust in the whole process.

b) Sectoral allocation of Covid-19 resources

At district level, Covid-19 resources were allocated at the discretion of the DTF members. At national level, specific sectors were prioritised. This was based on the multi-sectoral approach the government adopted to prevent and manage Covid-19 and its adverse effects. Through use of the 'whole country' (multisectoral) approach, different Ministries, Departments, and Agencies (MDAs), NGOs, and private sector actors were all engaged (MOH, 2020). Resources to support this effort were approved by the Parliament of Uganda as a supplementary budget worth UGX 285 billion in FY2019/20. The distribution of this amount across ministries and agencies are summarized in Table 5 below.

Table 5: Supplementary Budget Sectoral allocation for Covid-19 resources (period?)

Sector	Amount requested for by the Central Government (UGX)	Amounts approved by Parliament (UGX)	Variation in Resources
Health	82,562,065,127	104,188,234,110	26.19% (Favourable)
Security	81,498,000,000	77,497,505,890	4.91% (Adverse)
Local Government	36,199,000,000	36,199,660,000	0.00182% (Favourable)
Disaster Preparedness	59,400,000,000	59,400,000,000	0% (Favourable)
Kampala Capital City Authority (KCCA)	30,181,535,267	2,000,000,000	93.37% (Adverse)
Ministry of ICT	14,720,000,000	6,000,000,000	59.34% (Adverse)
Total	**304,560,600,394**	**285,285,400,000**	**6.33% (Adverse)**

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

Generally, the overall allocation of Covid-19 resources was guided by the national guidelines from the MOH, MoFPED and district task forces. Consequently, these guidelines were the yardsticks for all resource allocations. This, however, necessitated sensitization of the task forces on Covid-19 resource utilisation to permit appropriate allocation. It is from the effective resource utilisation that sustainable impact can be harnessed to facilitate better healthcare service delivery during pandemics.

c) **Use of domestically mobilized resources**

Monetary and in-kind resources were mobilized at district and national levels. District task forces, with the leadership of the RDCs, controlled domestically generated resources as well as their respective distribution/allocation. From the district-level interviews, it was established that resources such as cash, foodstuffs and vehicles, among others, were mobilized. Mainly, the mobilized resources were distributed to the vulnerable and health workers in the communities. In the case of politicians, the respondents noted that they ring-fenced most of their donations for their electorates/constituencies. This approach was reported to have affected the fair distribution of the mobilized resources. The same instance was reported at national level, especially regarding the criteria used for the procurement of vehicles (Covid-19 pick-ups).

> Who guided/advised MOH to buy vehicles: ....why were pick-up vehicles procured instead of ambulances?... (Executive Director, Uganda National Health Consumers' Organisation)

The respondents noted gaps in the use of Covid-19 resources. They cited discrimination in the of resources across health facilities.

> …you, see, private sector raised huge resources for Covid-19, but the government used them to support only public facilities…., where is the point of inclusiveness in this? (Ms. Grace Kiwanuka, Executive Director, Uganda Healthcare Federation)

However, it was noted that the prevention of Covid-19 needed a multi-sectoral approach since its effects spread across all sectors. This, therefore, necessitated the allocation of resources to other sectors beyond health.

> Covid-19 affected all sectors of the country…The population think that all resources were extended to the Ministry of Health alone. In fact, there are sectors which received more funds than us [MoH]. (Key informant from MOH)

The resources raised were used to procure essential medical items that were inadequate during the early stages of the pandemic. These included the installation of oxygen plants in various hospitals, and the procurement of beds and type B ambulances, among other items.

Figure 6: Some of the Covid-19 medical items and facilities

Thirty-three type B ambulances procured by MOH to handle emergencies.
Source: https://bit.ly/3B3QByM

Some of the beds and mattress that were procured by MOH.
Source: https://bit.ly/3gt4lti

Some of the ICU beds that were distributed to various hospitals.
Source: https://bit.ly/3sgUuMJ

Oxygen plants procured for Covid-19 management facilities.
Source: https://bit.ly/3rwqsFi

Overall, domestically generated covid-19 resources were used to extend assistance to the vulnerable and health workers. However, most of the in-kind support especially from politicians was ringfenced, tied to specific usage and population, undermining the jurisdiction of district task forces to fairly distribute resources according to priority needs.

4.3 Transparency and Accountability for Covid-19 Resources

Accountability mechanisms are best understood as the demarcated approaches to ensuring the proper use of resources. Thus, public institutions, including the health facilities, health departments and ministries, can justify their budgetary and expenditure decisions through accountability.

For sectors such as 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.[3]

a) The role of district and national Covid-19 task forces in the use of Covid-19 resources

The respondents noted that the district Covid-19 task forces guided the utilisation of the raised resources. This role was also extended to lower-level local government leaders at sub-county level and health facility managers that received and managed the Covid-19 resources.

Yes, we have a Covid-19 task force for which I am a member. It is the task force that has been playing the oversight role on the utilisation of the funds directly allocated for Covid-19 response. (District task force key informant)

b) Declaration of the resources raised to the public

Almost all the respondents across the districts and at national level acknowledged the adoption of this approach in their areas. The task force committees regularly notified the population about the resources raised. At national level, the president regularly declared names and specific amounts of donations received from various donors (see Figure 7). This was not different from the district level where leaders read out the lists of people and organizations' that supported resource mobilisation.

Lists are available for the Covid-19 support resources received and how they were distributed… these lists are even shared on the community WhatsApp group called Ekyato we created. (Key informant, Rubirizi district)

3 *https://www.internationalbudget.org/open-budget-survey/call-open-budgets*

Figure 7: List of the some of the Covid-19-related donations

National Response Fund to COVID-19 list of donations

23	Mandela Group Of Companies	362,000,000	In Kind
24	Fountain Publisher	354,874,500	In-Kind
25	Uganda Virus Research Institute	345,000,000	In Kind
26	Mobile Telephone Network (MTN)	330,000,000	In Kind
27	The Indian Association of Uganda	310,337,200	In Kind
28	Spouts Of Water Limited	292,500,000	In-Kind
29	Citi Bank Uganda Ltd	270,155,000	In-Kind
30	Coca Cola Beverages Africa	258,559,000	In Kind
31	UNRA Staff Contribution	245,534,000	In Kind
32	Toyota Uganda	245,000,000	In Kind
33	Bul-Bidco Jinja	240,000,000	In-Kind
34	Brookside Ltd / Fresh Diary	238,636,364	In-Kind
35	General Machinery Group	220,400,000	In Kind
36	Nile Fishing Company Limited	210,000,000	In-Kind
37	United Nations Population Fund(UNFPA)	210,000,000	In-Kind
38	Mulwana Group Of Companies	209,000,000	In Kind
39	Airtel Uganda	200,000,000	In-Kind
40	Government Of India	200,000,000	In Kind
41	Hoima Sugar Ltd.	200,000,000	In-Kind
42	People's Republic Of China	200,000,000	In Kind
43	Giant Uganda Co Ltd & Sino Uganda Modern Economic Development Special Zone	190,000,000	In-Kind
44	Roko Construction Ltd	190,000,000	In Kind
45	The Grain Council Of Uganda	190,000,000	In Kind
46	Africell Uganda	187,000,000	In Kind
47	Kwagalana Group	160,000,000	In Kind
48	Top Bet Ltd	160,000,000	In Kind
49	Microhagem Scientific And Medical Supplies LTD	155,000,000	In-Kind
50	Crown Beverages	154,099,000	In Kind
51	Korean Foundation For International Health Care (KOFIH	152,000,000	In-Kind
52	Arinaitwe Brain Mr.	150,000,000	In-Kind
53	Heal the Planet and Prudential Insurance	150,000,000	In-Kind
54	Sudhir Group Of Companies	148,000,000	In Kind
55	TATA Uganda Ltd	143,000,000	In Kind
56	Ruparellia Foundation	140,912,500	In-Kind
57	National Aviation Services	133,000,000	In Kind
58	Overseas Pakistanis Global Foundation Africa	125,800,000	In Kind
59	Ug National Association of Building and Civil Engineering Contractors	125,690,000	In-Kind
84	Uganda Fish Processors & Exporters Association (UEPEA)	100,000,000	In-Kind
85	Uganda Flower Exporters Association & Fresh Handling Ltd	100,000,000	In-Kind
86	Shree Kutch Satsang (Swaminaratan Temple)	99,200,000	In-Kind
87	Centenary Bank	97,100,780	In-Kind
88	Medical Access Uganda Limited	95,220,000	In-Kind
89	Food Machinery	95,000,000	In-Kind
90	NSSF	95,000,000	In-Kind
91	Dott Services	94,600,000	In Kind
92	National Medical Stores(NMS)	93,752,000	In-Kind
93	L1 Group Of Companies	91,427,500	In-Kind
94	Indian Business Forum	89,000,000	In Kind
95	H.H. The Omukama Of Tooro	88,880,000	In-Kind
96	African Queen No.1 Distributor LTD & Partner Companies	88,000,000	In-Kind
97	Sarai Group Of Companies	88,000,000	In-Kind
98	Kyoga Dynamics Ltd	87,400,000	In-Kind
99	Ramco International Uganda Limited	82,450,000	In-Kind
100	Riham (Motor Vehicle)	82,000,000	In Kind
101	The Bible Society Of Uganda	80,210,000	In-Kind
102	China Huangpai Food Machines (U) Ltd	80,000,000	In-Kind
103	Kiboko Enterprises Limited	80,000,000	In-Kind
104	Lions Clubs Of Uganda	80,000,000	In-Kind
105	Living Goods	80,000,000	In-Kind
106	Mbuga S.K	80,000,000	In-Kind
107	Oryx Energies	80,000,000	In-Kind
108	Silver Springs Hotel-Raghbir Sandhu	80,000,000	In Kind
109	The Vice Chancellor And Makerere University Staff	80,000,000	In-Kind
110	Ugandan Somali Community	80,000,000	In-Kind
111	African Skies Ltd	77,520,000	In-Kind
112	The Mehta Group Management Ltd	77,000,000	In-Kind
113	Kawacom (U) Ltd	76,000,000	In Kind
114	Tweed Properties	76,000,000	In Kind
115	Kabale Referral Regional Hospital	75,300,000	In Kind
116	Watoto Church	74,500,000	In-Kind
117	Lake Bounty Group	74,000,000	In Kind
118	Ministry of Health (Transfer of Stock for storage)	72,855,000	In-Kind
119	Airtel Staff contribution	72,280,000	In Kind
120	Bidco Uganda Ltd	70,000,000	In Kind
121	Keisokugiken Co. Ltd	70,000,000	In Kind
122	Yoshino Trading Ltd	70,000,000	In Kind
146	Vivo Energy Uganda	52,000,000	In-Kind
147	BRAC Uganda	50,880,000	In-Kind
148	Bukoola Chemical Industries Ltd	50,000,000	In-Kind
149	Honan Road & Bridge Contractor Group Co. Ltd	50,000,000	In-Kind
150	Malaysia Furnishings	50,000,000	In Kind
151	Mega Standard Super Market Ltd	50,000,000	In-Kind
152	Mr. Matovu Aloysius	50,000,000	In-Kind
153	Simba Automotives Ltd	50,000,000	In-Kind
154	Zhong Ding & Zhong Kai Electricals	50,000,000	In-Kind
155	Champion Bet	49,181,818	In-Kind
156	Askar Security Services	47,000,000	In-Kind
157	Mantra Motorbike East Africa LTD	46,500,000	In-Kind
158	Chairman Masaka Business Community	46,000,000	In-Kind
159	Uganda Development Corporation (UDC)	46,000,000	In-Kind
160	Kalpataru Power Transmission Ltd	45,600,000	In Kind
161	Teju Soroti Fruits Factory	45,000,000	In-Kind
162	Uganda Insurers Association	45,000,000	In-Kind
163	Kaliro Sugar	43,100,000	In-Kind
164	Water & Sanitation sector Partner's Contribution	43,000,000	In-Kind
165	Baps Charities	41,500,000	In-Kind
166	Tieng Adhola Cultural Institution, TACI	41,300,000	In-Kind
167	WHO through Ovidian (U) Ltd	40,500,000	In-Kind
168	World Health Organisation WHO	40,500,000	In-Kind
169	Mr. Juma Kalema	40,005,000	In-Kind
170	ADH Group Ug Ltd	40,000,000	In-Kind
171	KK Group Companies Ltd	40,000,000	In-Kind
172	Ugachick	40,000,000	In-Kind
173	Japan International Cooperation	39,780,000	In-Kind
174	Canaanze Construction Company Ltd	38,000,000	In-Kind
175	Presidential Initiative On Banana	38,000,000	In-Kind
176	Innovative Research & Development(INRAD Corp)	36,440,000	In-Kind
177	Euro Chik	36,000,000	In-Kind
178	Uganda Episcopal Conference	35,000,000	In-Kind
179	Good Brothers International LTD	33,750,000	In-Kind
180	Generation Seven (G7)	32,000,000	In-Kind
181	Islamic University in Uganda (IUIU)	31,700,000	In-Kind

Source: New Vision extract 29 June 2020 (https://www.newvision.co.ug/articledetails/692)

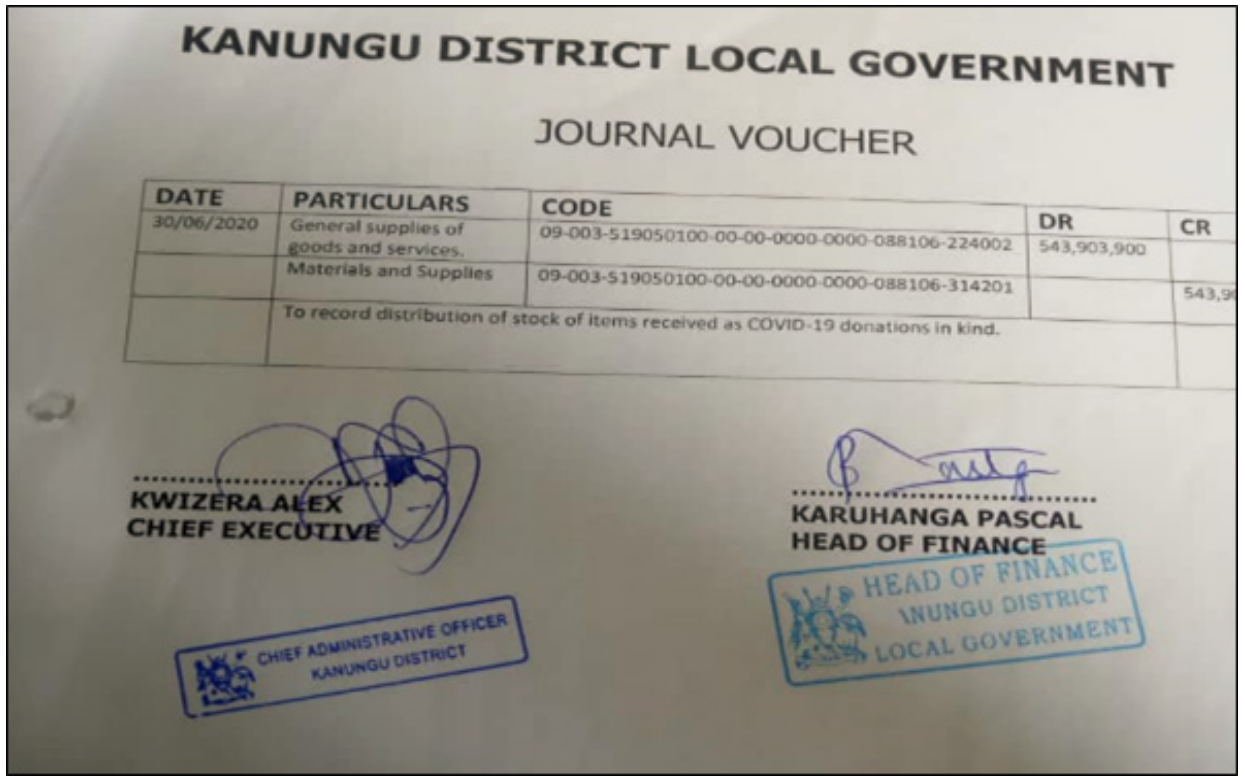
> The RDC and Task Force Committee would go on radio and inform the citizens about donations and funds received for the Covid-19 fight. For asset verification, this has not been much applied on Covid-19 assets. (Key informant, Kanungu district)

c) Transparency in transactions

Use of vouchers for all funds given out was highlighted as one of the mechanisms for ensuring transparency. Other approaches included announcing the donations given out to a given group of people. However, it was noted that some donations would be given directly to beneficiaries and the donors would report or sometimes not report to the task forces.

> We could give vouchers for all donations we received or given out, but there were instances where politicians could give directly to their electorates and inform us afterwards. (District key informant)

Figure 8: Sample of a supporting document at district level



KANUNGU DISTRICT LOCAL GOVERNMENT

JOURNAL VOUCHER

DATE	PARTICULARS	CODE	DR	CR
30/06/2020	General supplies of goods and services.	09-003-519050100-00-00-0000-0000-088106-224002	543,903,900	
	Materials and Supplies	09-003-519050100-00-00-0000-0000-088106-314201		543,9
	To record distribution of stock of items received as COVID-19 donations in kind.			

KWIZERA ALEX
CHIEF EXECUTIVE

CHIEF ADMINISTRATIVE OFFICER
KANUNGU DISTRICT

KARUHANGA PASCAL
HEAD OF FINANCE

HEAD OF FINANCE
KANUNGU DISTRICT
LOCAL GOVERNMENT

Voucher issued upon distribution of Covid-19 resources by Kanungu district

d) Adherence to Integrated Financial Management Systems (IFMS)

The respondents acknowledged the use of IFMS while making expenditures. Other platforms highlighted included the use of the e-payment system via mobile money to make payments to health workers and VHTs. However, there were challenges, especially where Covid-19 contacts were registered in other people's names erroneously or intentionally. The respondents noted that funds to cater for transaction costs (send charges) were not catered for in the budget, which significantly reduced the available funds for paying health workers.

> We used a digital system of payment (e system). Though it is good for accountability, it has a cost, MTN/Airtel charges. In fact, some of our people missed because of this. (DHO – Key informant)

4.3.1 Transparency and accountability issues/gaps

a) Non-segregation of duties

The findings highlighted low levels of segregation of duties in managing Covid-19 resources.

At district level, some of the respondents complained of receiving direct orders from their superiors. This weakened their authority in ensuring proper segregation of duties, especially during expenditure and procurements.

> At times we could get direct orders from our top managers to undertake an unplanned transaction without clear explanation. This distorted independence in our work. (District leader – key informant)

This was not exceptional at national level. It was noted that in some of the transactions which needed clear procurement approval and reporting the contracts committee were skipped. As a key informant in the Office of the Auditor General commented, …. skipping the contracts committee during major procurements was a fundamental irregularity.

The failure to observe maximum segregation of duties exposed the Covid-19 resources to fraudulent tendencies. Effective financial management and procurement practices require adherence to the PFM Act and the PPDA Acts during all government transactions, and failure to do this creates loopholes that may lead to intentional financial misstatements.

b) Lack of supporting documents for expenditures

Anomalies were identified in Covid-19-related transactions at district level. In some instances, signatories of bank accounts were absent, leading to delays in executing transactions and reporting. Some of the transactions were not adequately supported.

> The district authorities tasked sub-counties to account for the resources given to them from which the accountabilities had not yet been submitted. (District task force – key informant)

The absence of a comprehensive law on how pandemics are handled exposed the Covid-19 resources to the risk of misappropriation and fraud.

> As a country, we need a comprehensive law on managing pandemics. The current Disaster Preparedness and Management Policy is not enough to manage this situation. (Hon. Medard Lubega Ssegona, Chair, Public Accounts Committee, Parliament of Uganda)

Such lack of supporting documents creates a mismatch with the guidelines of the World Bank Framework (2004) which proposes supervision and accountability for public services to realise efficient and effective service delivery to the clients (citizens).

The failure to provide adequate supporting documents for transactions promotes poor financial management and non-compliance with the PFM Act and signifies weaknesses in financial control systems. This exposes public funds to unsupported haphazard expenditure that is not free from financial errors and fraud.

c) Weaknesses in budget reviews

Across almost all the districts, budget reviews for Covid-19 resources were conducted on a quarterly basis. However, the respondents lacked adequate information about budgetary variances between the targeted Covid-19 resources and what was actually received or mobilized.

> Every quarter, the budget review meetings are held to review and streamline the district activities. (Chief Finance Officer, Rubirizi)

At national level, a respondent noted a gap in the accessibility to sufficient budgetary information on Covid-19 resources.

> I had no access to Covid-19 budgetary information. (An MP who sits on the National Health Committee – Key informant)

Proper budgetary processes and accounting practices require that budgetary reviews spell out the variances between planned and actual expenditure and any cash or bank balances available. Failure to analyze such budgetary variance may lead to expenditure beyond the itemized budget limits.

Figure 9: Summary of accountability gaps and irregularities in Covid-19 resources management

Gap 1:

National level: It is worth noting that the same supplier M/s Silver Backs installed oxygen plants in 13 RRHs in 2017 at the same amount that the GoU spent on only two oxygen plants today (FY 2019/20). A contract was signed between M/s Silverbacks and Naguru Hospital to install 13 oxygen plants at the sum of USD 1,800,347 in May 2016 (this translated into UGX 6.0 billion at the then exchange rate of Ugx 3,370).

District level: There was no evidence of quotations and market price surveys prior to Covid-19-related procurements. No lists of pre-qualified suppliers were identified at district level to justify cases of single sourcing.

Gap 2:

National level: Several activities outside the budget line on equipment were implemented and paid by the MoH. These included: Procurement of emergency tools for the MoH Service Bay, printing of pull-up banners and teardrops for the National Fitness Day and purchase of a flag and a bull bar for the Minister of General Duties. These payments were made to individuals and moreover outside the budget lines.

District level: Despite quarterly budget reviews, there were no data on budgetary variance analyses for itemized Covid-19 budgets.

Gap 3:

National level: Accommodation hired to quarantine abroad returnees and Covid-19 suspects: The MoH accommodated over 2,500 Covid-19 suspects and returnees in various institutions by August 2020. The unit cost of full accommodation varied from USh. 60,000 to USh. 250,000. Although there was a guideline that travelers' from abroad should cater for their accommodation costs, the MoH incurred costs for several people. The selection criteria regarding the beneficiaries of these services remained unclear.

District level: There was limited segregation of duties. Authorization of transactions and other modalities were entrusted to the District Task Forces.

Gap 4:

National level: Lack of receipts and unclear accountability with expenditures on coordination activities lacking supporting documents in relation to number of days and cadres of health workers paid for Gulu RRH.

District level: Like at national level, there were incidents of unsupported Covid-19-related expenditure in districts.

Gap 5:

National level: The contract for the establishment of fabricated health facilities was signed as lump sum and was expected to start 14 days upon contract signature on 16th June 2020 and end by 16th September 2020. However, by 15th September 2020, the contractor had fabricated only 50% of the mobile facilities required. He could not install any for lack of land at the designated places. Confirmation of land availability was not done prior to contract signature leading to resource overruns. Equipment and human resource to run these facilities was also not planned. An explicit plan for both items could not be traced by time of monitoring done on 15th September 2020. The failure to undertake preliminary checks prior to signing contracts resulted in delays in delivery and under-planning for resources.

District level: Bank account signatories were noted to be absent in instances where district task forces needed urgent transactions. This led to delays in transactions and affected health service delivery during the pandemic, given its unprecedented nature.

Source: MoFPED, 2020, Primary data, 2021.

4.4 Best Practices, Opportunities and Challenges Identified

Although Covid-19 was unprecedented, lessons and best practices emerged across districts for adoption in order to transform Uganda's public finance management practices. They included the use of IFMS for managing resources, the declaration/communication of mobilized Covid-19 resources which enhanced trust in the political leadership, community sensitization through the use of mass media such as radio and television, an increase in people's acceptability of the new interventions, the availability of proper accountability reports which enhanced accountability and citizens' action on public resources. All these practices enhance accountability not only for Covid-19 resources, but for all public resources. The emergence of Covid-19 thus provided an opportunity to check Uganda's health system and its readiness to provide the needed health services to the population. Covid-19 demonstrated the need to handle health priorities in a multi-sectoral manner as opposed to 'silo planning' since an emergency in one sector such as health can easily spill over into other sectors of the country.

Overall, Covid-19 was handled as an emergency. Mobilisation, use and accountability for its resources were dealt with in that context. However, key best practices were identified across the districts that can be adopted for future management of pandemics in Uganda.

A man receives a dose of the COVID-19 vaccine during mass vaccination in Kampala, Uganda, on Oct. 16, 2021

5. 0 KEY STUDY CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusion

Covid-19 was and remains a global pandemic that hit almost all countries across the world and did not spare Uganda. Experienced at a time when Uganda was battling unprecedented natural disasters such as floods and locusts, the health sector was left with only the option of managing Covid-19 as an emergency. Despite the existence of a contingency fund approved by Parliament, supplementary budgetary requirements and reallocation were exorbitantly high, given the multi-sectoral nature of Covid-19 that called for huge expenditure. Donations, grants, loans, and individual contributions were cited as the major sources of Covid-19 response resources. Administering standard operating procedures (SOPs) enforcement as well as preventive measures such as curfew and lockdowns, managing patients and health facilities in quarantine centres and citizens' planned massive sensitization called for tremendous budgetary adjustments. However, these were not exempt from professional public financial management practices, procurement standards, monitoring, reporting, accountability, and efficient health services delivery. The findings presented in this study are solely aimed at identifying and analyzing the controls, procedures, gaps, and best practices adopted by Uganda's Ministry of Health in mobilisation, utilisation, reporting and accountability for both financial and in-kind Covid-19 resources.

Communication of mobilized resources to the public using radio and talk shows, Integrated Financial Management Systems (IFMS) and direct interventions by implementing partners (IPs) were among the best practices identified in this study. Several loopholes/gaps in accountability, management, control, and reporting practices for Covid-19 resources were identified. These included: limited segregation of duties, confining several accounting cycle procedures on single individuals, thus worsening the risk of fraud and material misstatements; duplication of budget items and transactions for supplies; failure to determine the value of Covid-19 innovations, especially local medicines that were allocated seed grants; inexperienced financial staff at district level; limited traceability and apportionment of some budget items such as fuel; unsupported expenditure; ineligible expenditure such as on local government councils that were not directly part of the district Covid-19 task forces; cases of other diseases mistakenly identified as Covid-19; demotivated health workers; full payments for undelivered supplies; politicization of the contingency fund; severity of strings attached to some donations; and cases of top government health monitoring officials who were ignorant about Covid-19 budgetary allocations and expenditure on health services.

To strengthen the resilience of the health sector, flexible and effective institutions need to be built, backed by a comprehensive law on handling emergencies like Covid-19.

5.2 Recommendations from the Study

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). For any interventions planned by the government, especially amidst pandemics like Covid-19, citizens ought to be involved not only for acceptability of their implementation but also to save lives.

- 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. Staff should be trained and retrained especially in the finance management functions, to acquaint them with the current public sector reporting standards and practices to ease financial reporting and strengthen accountability.
- District task forces should be kept active especially in fragile zones such as border districts to ignite their functionality during periods of emergency. These should be periodically monitored with clear indicators to ignite their functionality during periods of emergency

a) 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. The law should be comprehensive enough to control the behaviour of different actors regarding raising, utilizing, and accounting for funds including prohibition of excessive use of cash.
- 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. Emphasis should be put on governance and internal control systems during pandemics. This should be one of the national disaster/pandemic preparedness plan components.
- The MoFPED should protect the contingency fund from political influence by ensuring its independent management and monitoring. Politically influenced management of the contingency fund reduces the available reserves to address emergencies. There should be clearly stipulated thresholds and approval procedures on the withdrawals from the fund to prevent unnecessary expenditure and misappropriation.
- The Ministry of Health and Parliament should devote efforts to operationalise the national health insurance scheme. Amidst financial challenges at national and household levels, the scheme can act as a substantive mitigation strategy to shield households from catastrophic health expenditures.
- The MoH should engage civil society and the private health sector institutions in management structures for pandemics using a well-designed framework. CSOs play a significant role in bridging the gap between citizens and the government. Public Private Partnership (PPP) should be a key approach in health sector resource mobilization and management during pandemics and beyond.
- 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. Motivation should be inclusive for all cadres involved in management of pandemics (including health and non-medical staff).

- 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. The coordination should start with stakeholders at grass-roots level such as local leaders, opinion leaders, VHTs etc 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. Conducting spot checks and interim audits across all government MDAs to lower the probability of unsupported expenditure. Tendencies towards fraud and misappropriation of health finances will be minimised.
- Parliament should define limits for health innovation seed grants: With the several scientists inventing vaccines, medicine and medical supplies, the government should set clear budget ceilings for innovation grants before they are approved since their value is difficult to determine and the probability of exaggerating the value (overvaluation) is high.
- 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. This will provide for district and sub county one health committees' response for health security to replace the tasks forces with mandate to strengthen coordination, surveillance, capacity building, risk community communication, reporting on pandemic emergences and response.

b) For Civil Society and Development Partners

Extension of technical, financial, and in-kind support to the health sector after engaging beneficiaries in situational analysis. Local and international development partners should streamline and remodel their interventions approach to concentrate on beneficiaries. They should reduce bureaucratic tendencies, undertake Participatory Action Research (PAR) and solicit feedback from Covid-19 vulnerable groups to permit tailor-made financial support.

Regular monitoring and evaluation of the appropriateness in utilising funds extended to the public sector. Village committees should be engaged in fund management during pandemics. Ineligible expenditure and fraud will ultimately be addressed.

c) For the General Population (Citizens)

Contribution to the provision of better health services through donations. In addition to the government and development partners' support, citizens ought to contribute to providing their healthcare services. In circumstances where donations are acceptable, citizens should contribute to the cause.

Constant demand for accountability from the political leaders and service providers. The short run route to accountability requires proactive citizens who are concerned about the activities of political leaders and suppliers. Citizens ought to always demand accountability from their leaders. This will contribute to the provision of quality services and strengthen accountability frameworks.

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APPENDICES

Annex 1: List of Respondents' Institutions

#	Institution/Committee (National Level)
1	Center for Health, Human Rights and Development
2	Uganda Healthcare Federation
3	Office of the Auditor General
4	Public Accounts Committee
5	Ministry of Health
6	National Economy Committee
7	National Health Committee
8	Uganda National Health Consumers' Organisation
	Districts Visited
1	Apac
2	Kanungu
3	Kapelebyong
4	Rubirizi

Annex 2 : Categories of Covid-19 Resources and Their Respective Sources

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
IMF	Fight against Covid-19	Covid-19 financial assistance and debt service relief	Multilateral	491,500,000	Rapid Credit Facility (RCF)	Cash
Save The Children UK	Covid-19 Education in Emergencies Response	This project will ensure that education continues to take place in an emergency setting as part of Save the Children' s wider Covid-19 response.	Bilateral	121,896	Covid-19 Response	Cash
Central Emergency Response Fund	Health Covid-19	Accelerated response to Covid-19 outbreak in Uganda		499,984	Covid-19 Response	Cash
Mastercard Foundation	2020 Covid-19 Response: Prevention, Recovery and Resilience in Uganda	Provide support to community health workers, including provision of mental health services. Prepare secondary school students for exams during lockdown. Support recovery of impacted MSMEs	Private	8,392,240	Covid-19 Response	Cash
Foreign, Commonwealth and Development Office	Give Directly Support to Uganda's Covid-19 Response	Support to Uganda's Covid-19 response	Bilateral	9,384,851	Covid-19 Response	Cash

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
USAID	Health and Humanitarian Assistance	Will strengthen the prevention and control of infections and case-management practices in health facilities, including by training health workers in new protocols; promote risk-communications and community engagement, including materials and messages to address most vulnerable groups; and improve management systems to ensure the accountability and availability of, and access to, health commodities, essential medicines, and health supplies in health facilities to maintain the continuity of services	Bilateral	4,200,000	Covid-19 Response	Cash
World Bank	Uganda Covid-19 Economic Crisis and Recovery Development Policy Financing		Multilateral	300,000,000	Covid- 19 Response	Cash
Oxfam Novib	CAFOT Covid-19 Project			5,378	Covid-19 Response	Cash
Hirondelle Foundation	"Access to vital information regarding Covid-19 pandemic" - Project Covid-19 - H2H		Private	-	Covid-19 Response	Cash

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
Oxfam Novib	CARITAS HRGF Covid-19 Project	Improved prevention and control of Covid-19 pandemic		47,809	Covid-19 Response	Cash
Foreign, Commonwealth and Development Office	AMP Helpdesk Advised to Disuse Component World Health Organisation Funding to Covid-19 Response		Bilateral	1,328,709	Covid-19 Response	Cash
Oxfam Novib	CO-Legacy Fund to Support Covid-19	To respond to protection threats linked to Covid-19 in communities		21,183	Covid-19 Response	Cash
Finland, Government of 2020	Health Covid-19 | WASH Covid-19	Aid to victims of Covid-19 in Uganda		592,750	Covid-19 Response	Cash
Central Emergency Response Fund	Protection Covid-19	Urgent response to the impact of Covid-19 on the protection of refugees, particularly women and children in Uganda (part of 20-UF-HCR-028)		1,200,000	Covid-19 Response	Cash
Oxfam Novib	PALM CORPS CTP Project	The project will procure and distribute PPE to consortium partner staff and other selected agencies that will support the project implementation, like the private financial service providers against Covid-19.		29,168	Covid-19 Response	Cash

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
Central Emergency Response Fund	Protection Covid-19	Urgent response to the impact of Covid-19 on the protection of refugees, particularly women and children in Uganda (part of 20-UF-HCR-028)		200,000	Covid-19 Response	Cash
Oxfam Novib	PICOT Covid19 Project	To support frontline health service providers and Koboko district Covid-19 coordination task force to effectively play their roles in preventing and responding to Covid-19 pandemic.		32,441	Covid-19 Response	Cash
Government of Germany, 2020	Food Security Covid-19 Health Covid-19 Nutrition Covid-19 WASH Covid-19	Program-based promotion of humanitarian aid in sub-Saharan Africa in relation to the Covid-19 crisis		279,218	Covid-19 Response	Cash
Mastercard Foundation	2020 CRRP - Building Capacity of Frontline Health Workers During and Post Covid-19 Era		Private	1,299,798	Covid-19 Response	Cash
Oxfam Novib	CARITAS CTP Project	Response to Covid-19		29,880	Covid-19 Response	Cash
Oxfam Novib	CECI Covid-19 Project			5,378	Covid-19 Response	Cash

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
Government of Canada, 2020	Food Security Covid-19	In the context of Covid-19, WFP is addressing the significant rise in immediate food insecurity caused by the pandemic in countries where unmet food-assistance needs are the most pronounced, and where there has been the greatest deterioration in the food security situation		2,311,248	Covid-19 Response	Cash
Oxfam Novib	PALM CORPS Covid-19 Project	Conduct Covid-19 risk mapping		32,399	Covid-19 Response	Cash
World Bank	Uganda Reproductive, Maternal and Child Health Services Improvement Project	Improve utilisation of essential health services with a focus on reproductive, maternal, newborn, child, and adolescent health services in target districts	Multilateral	110,000,000	Health	Cash
Oxfam Novib	AHEDI Covid-19 Project	Complementary support to existing health system in care and treatment of Covid-19 cases		31,943	Covid-19 Response	Cash
Oxfam Novib	CECI Saving lives now & future Project			25,099	Covid-19 Response	Cash
Oxfam Novib	CO-Refugee-led Covid-19 Response in Uganda (OSF)	To implement Covid-19 community led responses		41,055	Covid-19 Response	Cash
Mastercard Foundation	2020 CRRP - Covid-19 Prevention, Response and Recovery in Refugee and Host Communities in Uganda	Covid-19 prevention, response and recovery in refugee and host communities in Uganda	Private	952,921	Covid-19 Response	Cash

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
Oxfam Novib	NUWOSO Covid-19 Project	Procure and allocate protective gear to 70 Covid-19 virus task force teams and project staffs		32,435	Covid-19 Response	Cash
Oxfam Novib	SORUDA Covid-19 Project	Increased awareness on Covid-19 pandemic transmission modes and symptoms in line with MoH guidelines and Presidential Directives		32,421	Covid-19 Response	Cash
Oxfam Novib	CECI - Covid Response in Uganda (OSF)			10,096	Covid-19 Response	Cash
Oxfam Novib	YSAT Covid-19 Project	Establishment of Community Information Centres in all the seven zones of Rhino Camp and Imvepi refugee settlements for access to latest updates on the disease, feedback and emergency coordination on coronavirus-related issues and most importantly counter the spread of rumours, fake news and hate generated by Covid-19		29,443	Covid-19 Response	Cash
Save The Children UK	Covid-19 First Emergency Response	The first emergency response to Covid-19	Bilateral	368,856	Covid-19 Response	Cash
Mastercard Foundation	2020 Covid-19 Response		Private	94,237	Covid-19 Response	Cash
Malaria Consortium	Mastercard Foundation PPE Distribution	For building capacity of frontline Workers during and post-Covid-19 era.		1,299,798	Covid-19 Response	Cash

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
Oxfam Novib	CTEN - Covid Response in Uganda (OSF)			20,192	Covid-19 Response	Cash
Trademark East Africa	Safe Trade Uganda Country Programme -Tech Interventions (Covid-19)	Reduced barriers to trade		400,000	Covid-19 Response	Cash
Central Emergency Response Fund	Protection Covid-19	Urgent response to the impact of Covid-19 on the protection of refugees, particularly women and children in Uganda (part of 20-UF-HCR-028)		600,000	Covid-19 Response	Cash
Oxfam Novib	PICOT CTP Project	To amalgamate livelihood and WASH in efforts to promote self-reliance among the refugees and host communities while fighting the Covid-19 pandemic and community infection through WASH practices		29,880	Covid-19 Response	Cash
Oxfam Novib	YSAT Covid-19 Project	To prevent Covid-19 infection and support any efforts to control it		40,638	Covid-19 Response	Cash
Oxfam Novib	SORUDA CTP Project			29,876	Covid-19 Response	Cash
Oxfam Novib	APINO Saving Lives now & future Project			25,099	Covid-19 Response	Cash

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
African Development Bank Group	Uganda - Covid-19 Crisis Response Budget Support Program (CRSP)	To support Uganda's National Covid-19 Preparedness and Response Plan to strengthen the Covid-19 outbreak response mechanisms and mitigate the social and economic impacts of the pandemic	Multilateral	31,902,453	Covid-19 Response	Cash
Mastercard Foundation	2020 Covid-19 Response: Prevention, Recovery and Resilience in Uganda	To provide support to community health workers, including provision of mental health services. To prepare secondary school students for exams during lockdown. To support recovery of impacted MSMEs	Private	4,698,184	Covid-19 Response	Cash
Oxfam Novib	NUWOSO Acholi HRGF Covid-19 Project	Reduced risks and vulnerability to Covid-19 and GBV/land conflict incidence in the 3 focused districts in Acholi Region by end of September 2020		30,202	Covid-19 Response	Cash
World Bank	Irrigation for Climate Resilience Project (ICRP)	To provide farmers in the project areas with access to irrigation and other agricultural services, and to establish management arrangements for irrigation service delivery. The project has three components	Multilateral	169,200,000	Agriculture	Cash

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
HelpAge International	Inclusive Covid-19 Response to Older Persons, People with Disability and Vulnerable Persons in North Uganda, West Nile and Karamoja Sub-Regions.	Conduct a rapid capacity-building campaign through sensitisation and access to age-appropriate and easy-to-use IEC materials to communities focusing on older persons on appropriate Covid-19 pandemic prevention, mitigation and response mechanisms as per the Ministry of Health guidelines and in line with the National Covid-19 Response Policy 2020		140,730	Covid-19 Response	Cash
Foreign, Commonwealth and Development Office	World Health Organisation Funding to Covid-19 Response		Bilateral	1,528,716	Covid-19 Response	Cash
Oxfam Novib	Covid-19 Prep & Response	Coordinate the Covid-19 response		58,577	Covid-19 Response	Cash
Mastercard Foundation	2020 CRRP - Improving the Efficiency and Quality of School Inspections at System Level	Provide public health information on Covid-19 prevention to the community and put in place health/ sanitation facilities required for school re-opening	Private	2,061,295	Covid-19 Response	Cash
	WASH Covid-19	Covid-19 (2 projects)		89,780	Covid-19 Response	Cash
UNDP Administered Trust Fund	Health Covid-19	MDTF reprogrammed funds for Covid-19 response in Uganda		130,214	Covid-19 Response	Cash

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
Government of Finland, 2020	Health Covid-19 | WASH Covid-19	CD D0012 – Allocation from the reserve fund - Contribution in response to the Covid-19 appeal.		596,809	Covid-19 Response	Cash
Government of Japan, 2020		Emergency assistance for the prevention of further spread of the novel coronavirus (Covid-19) infection – Uganda (SM200350)	Bilateral	1,428,300	Covid-19 Response	Cash
Government of Ireland, 2020	Health Covid-19	Emergency health assistance for Covid-19 response in Uganda	Bilateral	906,114	Covid-19 Response	Cash
Government of Azerbaijan, 2020	Health Covid-19	OCR S Azerbaijan Strategic and Preparedness Response (SPRP) Covid-19 - Uganda		100,000	Covid-19 Response	Material
Private (individuals and organisations)		COVID-19Uganda		561,020	Covid-19 Response	Material
Government of Germany, 2020	Health Covid-19	Support to Coronavirus Strategic Preparedness and Response Plan - Uganda (AA-S08 321.50 ALL 23/20 COV)		969,755	Covid-19 Response	Material
Government of Germany, 2020	Food Security Covid-19 | Health Covid-19 | Nutrition Covid-19 | WASH Covid-19	Covid-19 – Transnational program-based funding in the health, water, sanitation, and hygiene sectors as well as food aid, food security and livelihoods		179,379	Covid-19 Response	Material

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
European Commission' s Humanitarian Aid and Civil Protection Department	Health Covid-19 | Protection Covid-19	Protection and humanitarian assistance to refugees and host communities in support of the comprehensive refugee response in Uganda (part of ECHO/-AF/ BUD/2020/91011)	Multilateral	5,347,991	Covid-19 Response	Material
Government of Ireland, 2020		Covid-19 response	Bilateral	16,287	Covid-19 Response	Material
Government of Denmark, 2020	Health Covid-19	Covid-19 response		168,584	Covid-19 Response	Material
Private (individuals and organisations)	Health Covid-19	Covid-19 – Uganda (UNHCR CD Description: UNF- WHO Covid-19 May 2020)	Private	1,000,000	Covid-19 Response	Material
Government of United States of America, 2020		Uganda/Covid-19: Emergency food assistance (USAID/FFP)	Bilateral	4,000,000	Covid-19 Response	Material
European Commission's Humanitarian Aid and Civil Protection Department	Health Covid-19	Epidemic preparedness and response and life-saving health services to newly arrived refugees and vulnerable host community members in Uganda (part of ECHO/-AF/BUD/2020/91009)		1,061,476	Covid-19 Response	Material
Government of Denmark, 2020	Health Covid-19	Covid-19 response		91,424	Covid-19 Response	Material
GAVI Alliance	Health Covid-19	GAVI measles funds reprogrammed for COVID-19 response in Uganda		205,941	Covid-19 Response	Material

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
Government of China, 2020	Health Covid-19	Support WHO response to COVID-19 outbreak – Uganda		116,600	Covid-19 Response	Material
Government of United States of America, 2020	Refugees Covid-19	Covid-19 Uganda GUSA02		5,200,000	Covid-19 Response	Material
Government of United States of America, 2020		Covid-19 response - Uganda (SM200405) (State/PRM)	Bilateral	590,000	Covid-19 Response	Material
Government of United States of America, 2020	Health Covid-19 | WASH Covid-19	UNHCR Covid Response Uganda _PRM	Bilateral	1,263,000	Covid-19 Response	Material
Government of United Kingdom, 2020	Health Covid-19	Unearmarked support to WHO for Covid-19 Global- Support to Coronavirus Strategic Preparedness and Response Plan I & II - Uganda		11,785	Covid-19 Response	Material
Government of United Kingdom, 2020	Health Covid-19	WFP Covid-19	Bilateral	232,644	Covid-19 Response	Material
European Commission's Humanitarian Aid and Civil Protection Department		Disaster and epidemic preparedness in Uganda (part of ECHO/-HF/ BUD/2019/91017)	Multilateral	423,782	Covid-19 Response	Material

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
Government of Germany, 2020		Covid-19 global project to protect particularly vulnerable children, adolescents and young women during the Covid-19 pandemic		438,047	Covid-19 Response	Material
US Fund for UNICEF		Coronavirus response - Uganda - CNHF (SM200193)	Multilateral	324,648	Covid-19 Response	Material
Government of Ireland, 2020		Covid-19	Bilateral	30,730	Covid-19 Response	Material
European Commission	Health Covid-19 | WASH Covid-19	Covid-19 Uganda		1,118,770	Covid-19 Response	Material
UNICEF National Committee/United Kingdom	WASH Covid-19	Donation of soap bars - Covid-19 - UNILEVER - Uganda (KM200054)	Multilateral	25,470	Covid-19 Response	Material
Government of Ireland, 2020	Health Covid-19	Strengthening lab diagnosis and community surveillance for the Covid-19 emergency response in Uganda.		1,179,755	Covid-19 Response	Material
Government of Germany, 2020	Food Security Covid-19 Health Covid-19 |Nutrition Covid-19 WASH Covid-19	Program-based promotion of humanitarian aid in sub-Saharan Africa in relation to the Covid-19 crisis		351,620	Covid-19 Response	Material
European Commission's Humanitarian Aid and Civil Protection Department	Protection Covid-19 WASH Covid-19	Integrated WASH and protection response to DRC and South Sudan refugee influx in Western, Southwestern and West Nile regions of Uganda (part of ECHO/-HF/ BUD/2019/91016)	Multilateral	227,531	Covid-19 Response	Material

Funding Source	Funding Title	Funding Description	Donor Category	Amount (USD)	Category	Donation Type
Government of Denmark, 2020	Health Covid-19	Emergency response to Covid-19 outbreak in Uganda	Bilateral	2,445,377	Covid-19 Response	Material
GAVI Alliance	Health Covid-19	GAVI Men-A funds reprogrammed for Covid-19 response in Uganda		603,205	Covid-19 Response	Material
Government of United Kingdom, 2020	WASH Covid-19	Hygiene, Handwashing and Behaviour Change Coalition for Covid-19 Response - Uganda (SM200202)	Bilateral	324,000	Covid-19 Response	Material
Government of United Kingdom, 2020	Refugees COVID-19	Covid-19Uganda		979,089	Covid-19 Response	Material
Government of United Kingdom, 2020	Health Covid-19	Strengthening country readiness to respond to Covid-19 outbreak	Bilateral	1,523,088	Covid-19 Response	Material
Government of United Kingdom, 2020		Covid-19 response - Uganda (SM190414)		565,133	Covid-19 Response	Unspecified

Source: Global Integrity-The Covid-19 Transparency and Accountability Project, 2019-2021- https://bit.ly/3oLDZau

(Footnotes)

1 Inclusive of UGX 20 million returned by the area Member of Parliament
2 Inclusive of Covid-19 response and vaccination (UGX 286,400,000, UGX 8,700,000, and UGX 52,843,00)
3 Inclusive of UGX 20 million returned by the area Member of Parliament

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