The role of the Investment Case in Domestic Resource Mobilization

GFF Implementation Workshop
Dar es Salaam, September 2018
M.E. Bonilla-Chacin and Mark Blecher
Presentation Index

• GFF Results and Process
• Domestic Resource Mobilization (DRM) and Universal Health Coverage
• Sources of Domestic Resources for Health
• Making the Case for additional Domestic Resources for Health and the Role of the Investment Case and Role of the Investment Case in DRM for Health
• Importance of Integrating Investment Case in the Budget Process
GFF supports countries to get on a trajectory to reach the SDGs and UHC through three related approaches:

1. Identifying priority investments to achieve RMNCAH outcomes
2. Identifying priority health financing reforms
3. Getting more results from existing resources and increasing financing from:
   - Domestic government resources
   - IDA/IBRD financing
   - Aligned external financing
   - Private sector resources
4. Strengthening systems to track progress, learn, and course-correct
Domestic Resources for Health and Universal Health Coverage
Importance of Domestic Resource Mobilization (DRM) to achieve UHC

- Health expenditure per capita is still too low to ensure universal coverage with a core package of needed health services, including RNMCAH – N services
  - McIntryre and Meheus estimated $89 per capita needed in 2014

### Current health expenditure per capita 2015 (constant 2010 US$)

<table>
<thead>
<tr>
<th>Country</th>
<th>CHE per capita 2014 (constant $ (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>112</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>112</td>
</tr>
<tr>
<td>Uganda</td>
<td>46.06</td>
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<tr>
<td>Cameroon</td>
<td>63.63</td>
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<tr>
<td>Liberia</td>
<td>69.29</td>
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<tr>
<td>Kenya</td>
<td>70.06</td>
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<tr>
<td>Nigeria</td>
<td>97.31</td>
</tr>
</tbody>
</table>

### Sources of Current Health Expenditures 2015

<table>
<thead>
<tr>
<th>Country</th>
<th>Unspecified financing schemes (n.e.c.)</th>
<th>Rest of the world financing schemes (non-resident)</th>
<th>Household out-of-pocket payment</th>
<th>Government schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>70%</td>
<td>38%</td>
<td>33%</td>
<td>20%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>19%</td>
<td>33%</td>
<td>39%</td>
<td>41%</td>
</tr>
<tr>
<td>Kenya</td>
<td>0%</td>
<td>33%</td>
<td>33%</td>
<td>72%</td>
</tr>
<tr>
<td>Liberia</td>
<td>72%</td>
<td>26%</td>
<td>20%</td>
<td>19%</td>
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<tr>
<td>Nigeria</td>
<td>0%</td>
<td>0%</td>
<td>7%</td>
<td>41%</td>
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<tr>
<td>Uganda</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>26%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Source: WHO GHED 2015
Most expenditure on health is domestic. DAH constitute a small part of total health expenditure overall, although it varies across countries.

Source: WHO GHED (2017)
Development Assistance for Health is Leveling off

DEVELOPMENT ASSISTANCE FOR HEALTH (DAH)

Rate of change in DAH by health focus area, 1990-2017

- Total DAH
- HIV/AIDS
- Tuberculosis
- Malaria
- Maternal, newborn, and child health
- Non-communicable diseases
- Other infectious diseases
- HSS/SWApS
- Other health focus areas

Annualized rate of change (%)

1990-2000
2000-2010
2010-2017

HSS = Health systems strengthening
SWApS = Sector-wide approaches
The HFT is not only about DAH, it is also about moving away from OOP spending towards domestic, prepaid/pooled financing for health.
Many factors affect the health financing Transition and thus progress to UHC

Factors Outside the Health System

- Economic growth
- Government revenue effort
- Differing costs of adequate health services (e.g. higher in HIV-affected countries)
- Decline of development assistance

Factors within the Health System

- Different starting points for OOP & THE
- Inefficient use of health resources
- Overpromising benefits/Poor BP design
- System readiness for expansion
- Political will for reform

Source: JLN / DRM collaborative
### Countries Likely to Face Simultaneous Transition in the Next 5 Years

<table>
<thead>
<tr>
<th>Country</th>
<th>Region</th>
<th>Gavi Transition Status (2017)</th>
<th>Global Fund Transition Status</th>
<th>IDA Transition Status</th>
<th>GPEI</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMEROON</td>
<td>Africa</td>
<td>PHASE 1</td>
<td>ELIGIBLE</td>
<td>BLENDED FINANCING</td>
<td>PRIORITY</td>
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<tr>
<td>CONGO, REPUBLIC OF</td>
<td>Africa</td>
<td>PHASE 2</td>
<td>ELIGIBLE</td>
<td>BLENDED FINANCING</td>
<td>BY 2020</td>
</tr>
<tr>
<td>COTE D’IVOIRE</td>
<td>Africa</td>
<td>PHASE 1</td>
<td>ELIGIBLE</td>
<td>ELIGIBLE</td>
<td>BY 2020</td>
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<tr>
<td>INDONESIA</td>
<td>South Asia</td>
<td>PHASE 3</td>
<td>ELIGIBLE</td>
<td>not eligible</td>
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<tr>
<td>KENYA</td>
<td>Africa</td>
<td>PHASE 1</td>
<td>ELIGIBLE</td>
<td>BLENDED FINANCING</td>
<td>BY 2020</td>
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<tr>
<td>NIGERIA</td>
<td>Africa</td>
<td>PHASE 2</td>
<td>ELIGIBLE</td>
<td>BLENDED FINANCING</td>
<td>PRIORITY</td>
</tr>
</tbody>
</table>

Source: Action Global Aid Advocacy Partnership
Sources of Domestic Resources for Health
Macroeconomic Conditions: Economic Growth and Revenue Growth

Source: JLN / DRM collaborative
Re-Prioritization: Often Key for Fiscal Space

Government expenditure share of GDP

Larger share goes to health

Source: JLN / DRM collaborative
Sector-Specific Revenue Sources for Fiscal Space

- Public expenditure on health per capita

Source: JLN / DRM collaborative
Most GFF countries have the potential to raise more revenue

General Government expenditure (GGE) as a share of GDP (2014)

<table>
<thead>
<tr>
<th>Country</th>
<th>GGE - Percentage of GDP (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congo, Dem. Rep.</td>
<td>14</td>
</tr>
<tr>
<td>Madagascar</td>
<td>14</td>
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<tr>
<td>Central African Republic</td>
<td>15</td>
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<tr>
<td>Uganda</td>
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<td>Sierra Leone</td>
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<td>Ethiopia</td>
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<td>Tanzania</td>
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<td>Burkina Faso</td>
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<td>Afghanistan</td>
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<tr>
<td>Haiti</td>
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<td>Senegal</td>
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<td>Guinea</td>
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<td>Liberia</td>
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<td>Malawi</td>
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<td>Mozambique</td>
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<tr>
<td>Congo, Dem. Rep.</td>
<td>27.65</td>
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<tr>
<td>Madagascar</td>
<td>29.02</td>
</tr>
</tbody>
</table>

Source: GHED 2016
Several countries are below the median for prioritization of the health sector of general budget.

**Government Priority to health in the budget**  
**GGHE as a % GGE**

<table>
<thead>
<tr>
<th>Country</th>
<th>GGHE % of GGE (2014)</th>
<th>LIC median</th>
<th>LMIC median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haiti</td>
<td>6</td>
<td>8.4</td>
<td></td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>7</td>
<td>8.4</td>
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</tr>
<tr>
<td>Senegal</td>
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<td>Mozambique</td>
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<td></td>
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<td>Guinea</td>
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<td>Rwanda</td>
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<td>Myanmar</td>
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<td>Cameroon</td>
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<tr>
<td>Bangladesh</td>
<td>6</td>
<td>9.9</td>
<td></td>
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<tr>
<td>Indonesia</td>
<td>6</td>
<td>9.9</td>
<td></td>
</tr>
<tr>
<td>Cambodia</td>
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<td>9.9</td>
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<td>Kenya</td>
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<td>Vietnam</td>
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<td></td>
</tr>
<tr>
<td>Guatemala</td>
<td>18</td>
<td>9.9</td>
<td></td>
</tr>
</tbody>
</table>

GGHE % of GGE

GGHE % of GGE (2014)  
LIC median

LMIC median
Making the Case for Additional Domestic Resources for Health and the Role of the Investment Case
Ten Minute Break - Discussion

- What issues finance/treasury considers when deciding whether to increase resources for health?
- What do you think would the role of the Investment Case in budget bids?
- How should the IC be done differently to get it anchored into the budget?
Arguments / inputs to further the agenda – role of the IC

- Efficiency improvements in the use of current resources allocated to the sector
- Execution rate of budgetary funds to the sector
- Refer background strategic plans when making the case. Need for this plans to be realistic, costed, and include results to be achieved
- Improved accountability in the use of resources
- Discounting all scenarios (“due diligence”) before making the case for investment in health
- Show how increases in health can have benefits on economic growth
- Demonstrate the linkage between health and the political economy
Role of the Investment Case

• National plan for improving maternal, child, and adolescent health and nutrition
• Improved efficiency in the use of resources given prioritization process and alignment of funds towards a national plan
• These are costed plans with monitoring and evaluation frameworks and with a theory of change
• On the health financing, they often includes plans to improve public financial management – improve budget execution
Role of the IC: Lessons learned from first years of GFF implementation

- Initial data suggests IC in majority of countries has not been entering domestic budget process
- Appears historically IC not serving as basis for budget bids from domestic MoH to MoF in annual budget cycle
- Most MoFs not fully aware of IC and its funding and not consulted early on
- Most ICs essentially forming basis for donor funding, albeit more coordinated donor approach.
- But if domestic government does not fund the national RMNCAH-N plan as in IC, then:
  - It is likely the country government is using a different plan for domestic funding purposes
  - There is little financial sign of support from the domestic government
  - If the domestic government really supports this as the national plan, why do they not put funds to it
  - If the IC is only a small plan for say 1% of the country health expenditure, then it will almost by definition be limited in scope and is unlikely to significantly impact domestic resource allocation
  - It is also unlikely to be sustainable
  - If a country government does not put money to a plan....does that government really support that plan as the national plan at a political level?
- Major weakness is that IC currently largely not part of the domestic funding and budgeting process and this perhaps core reason it is currently not succeeding with DRM, which is a core objective.
- Propose IC needs to be reconsidered as the national RMNCAH-N plan (with additional annexures) largely for domestic funding and implementation and for which the GFF is playing only catalytic support role
Integrating the Investment Case in the Budget Process

How will the objectives of the IC be translated into the government’s budget?

How will IC implementation be tracked and monitored?
Promoting Alignment of the IC with the Budget Process

• **Understand** the budgeting process
  - Medium-term expenditure framework (MTEF)
  - Timeline and process for annual budgeting
  - Budget classifications system and chart of accounts (CoA)
  - Spending units and responsibilities

• **Align** investment case targets with the budget structure
  - Establish a baseline of current spending allocations and levels
  - Set targets on how the IC will shift expenditures

• **Engage** throughout the budgeting process
  - Discussions with the budgeting and finance departments
  - Promoting dialogue between the finance and health ministries
Country Experiences
Mozambique - Nigeria
DOMESTIC RESOURCE MOBILIZATION – THE NIGERIAN PERSPECTIVE

DR NNEKA ORJI
FEDERAL MINISTRY OF HEALTH, NIGERIA
GFF IMPLEMENTATION WORKSHOP, TANZANIA.
SEPT.2018
OUTLINE

INTRODUCTION:
- BACKGROUND
- POOR BUDGETING
- POOR HEALTH OUTCOMES:

NEED FOR A PARADIGM SHIFT:
- Legal and policy basis for new approach: NHAct
- Operational and Implementation basis for new approach: NSHIP, Investment case, BHCPF, NSHDP II

OPPORTUNITY TO DO SOMETHING DIFFERENT:
- Advocacy efforts.
- Resources for implementation from GFF
- GFF PRESENTED AN OPPORTUNITY TO SHOWCASE WHAT WILL BE DIFFERENT:

KEY HIGHLIGHTS OF BHCPF IMPLEMENTATION – SHOWING THE EFFICIENCY AND ACCOUNTABILITY FEATURES OF THE BHCPF:
- Efficiency
- Accountability
- All the above led to a strong case to the parliament leading to increased resources

CHALLENGES AND SUMMARY:
BACKGROUND

- Governance Structure
- Total Population
- GDP per capita
- HF mechanisms
Health Budget Allocation 2012–2018

Year
2012 2013 2014 2015 2016 2017 2018

% Allocation
6 5.7 5.7 5.8 4.23 4.1 3.9
Public spending on health (in real prices) slightly increased in 2006–07, but stagnated then after. Although there is an increase in public spending nominal prices, the increase is offset by the high inflation and population growth rates.
Increasing population and decreasing public expenditure on health

Population and GGHE/GGE(%)
Poorest 40% of Population Accounts for 56% of all U5 Mortality

Child from the 2 poorest income quintiles has 2.6 times higher risk of dying in childhood.
% of Children who are Malnourished by Income Quintile – 2013 NDHS

- Stunting
- Low Weight for Age
Coverage of Key Health Interventions by Income Quintile – NDHS 2013
NEED FOR A PARADIGM SHIFT – Legal basis for a new approach

- National Health Act–2014
- BHCPF as a legal instrument for additional financing for health.
- Three sources – 1% CRF, Donor contributions and from any other source.
- Three gateways for disbursement of the BHCPF
- BMPHS for all Nigerians
Operational basis for a new approach/1 – Investment Case

- The problem with Nigeria’s health sector is not just inputs and so the IC was envisioned to implement strategies that will foster dramatic, cost effective and sustainable results.

- Specifically, it will support and strengthen the commitment of GoN on improving RMNCAH+N services over the next five years and beyond.

- It lays out strategies for targeting rural population where most maternal and perinatal deaths occur

- Strategies to engender strategic purchasing to increase efficiency and build trust for more investments in health in line with the provisions of the NHAct
Operational basis for a new approach/2 – Lessons from NSHIP

- A performance based health financing intervention to improve PHC.

- Focuses MCH, System strengthening including HMIS

- Lessons learnt from DFF and the PBF showed efficiency and accountability – HF were able to use operational funds to improve on service delivery and staff were motivated to work.

- These lessons formed the operational basis for operationalizing the BHCPF using GFF funds

- These results and improvements also led to additional financing credit for expansion from the WB of about $125 million and a GFF grant of $20m
Strategic Advocacy efforts

Results of advocacy efforts –
- The Legislative arm constituted a legislative network for UHC and swung into action.
- Results of Political engagement – 1% CRF in 2018 budget
- Additional resources from GFF and other partners
  - Domestic resources to implement the BHCPF,
  - CSO groups played critical role in advocating for more resources for health
PATHWAY TO UHC:

KEY HIGHLIGHTS OF BHCPF IMPLEMENTATION – SHOWING THE EFFICIENCY AND ACCOUNTABILITY FEATURES OF THE BHCPF

The BHCPF establishes systems and approaches that will be very critical in accelerating UHC in Nigeria:

- The government will buy services from both public and private providers of services using a level playing field for all.
- The BHCPF establishes a system of accreditation in order to improve quality of care.
- It will finance a rigorous system of verification that helps to ensure value for money.
- Creates a robust payment systems via electronic transfer to providers and thus reducing corruption.
CHALLENGES

- Federal Level
- State Level
- Diverse Stakeholders
- Sustaining the gains
SUMMARY

- Showcased how poor budgetary allocation to the health sector has resulted in poor health outcomes over the years.
- The need for a paradigm shift and how the Act provided a legal basis.
- Lessons from NSHIP and NSHDP review including the development of the IC and operationalizing the BHCPF provided an operational basis for new strategies.
- Strategic advocacy provided new opportunities for DRM and GFF in Nigeria.
- Efficiency and Accountability features of the BHCPF.
Case study
Mozambique

Aligning IC priorities to the budget process
Agriculture experience showed that IC doesn’t automatically translate into more money

► Mozambique developed a sector strategy and investment plan for the agriculture sector (PNISa) for 2013-2017

► PNISA used a separate program structure without linking to the budget

► Evaluation in 2016 found that expenditures were not aligned to PNISA targets
Expenditures in PNISA Components Compared to Targets in 2015

- Large gaps between targets & actual expenditures
- Donors contributed to misalignment because no guidance on funding allocations
What happens when a sector strategy is not aligned to the national budget process?

No realistic targets or prioritization:
- Without realistic targets, stakeholders do not have to prioritize spending to the priorities defined in strategy
- Institutions continue to spend as before

No monitoring or accountability:
- Tracking a sector plan that is not aligned with the government’s budget is time- and labor-intensive, and may not take place regularly
- Without monitoring or reporting on progress, institutions can not make course-corrections during implementation

Reduced sector support:
- With no accountability for increasing spending or meeting targets, many may choose to allocate resources elsewhere

► Need to develop a strategy to make sure IC priorities are aligned with the budget
Expenditure analysis helped understand how resources are currently spent & challenges in budget classification

**HEALTH EXPENDITURES BY FACILITY LEVEL FROM 2009-2015**

- Lessons:
  - Budget is structured as line-item budget with little information on programs
  - Only 14% of all expenditure records use program classifiers and 85% are classified as “unknown”
  - Most consistently tracked budget classifiers are administrative, economic and functional.
  - ‘Functional’ classifiers have several limitations which makes it difficult to track if IC priorities are aligned with budget
Second step: What changes are we expecting if expenditure follows the IC priorities? (set targets)

Figure 2: Initial Estimate of current spending levels (baseline) and proposed increases (targets) to achieve IC priorities

**Lessons:**
- One Health tool was used for IC costing. This methodology didn’t link to budget activities, spending units and existing budget classification system.
- We create initial estimate (figure 2) of baseline and target spending level but IC costing needs to be redone to align with government budget classification system.
Third step: Understanding the budget process and how to influence it

- Mapped out annual budget formulation calendar & IC engagement action plan

<table>
<thead>
<tr>
<th>Months</th>
<th>Annual Budget Calendar</th>
<th>Priority Actions for Engaging with Government on IC Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct - Dec</td>
<td>--</td>
<td>Begin discussions with MOF and MOH on last year budget</td>
</tr>
<tr>
<td>Jan – Mar</td>
<td>Districts review plans and collect statistics to inform spending needs</td>
<td>Review previous year’s data according to expected increases in investment with suggestions of changes for the upcoming year</td>
</tr>
<tr>
<td>Feb – Apr</td>
<td>The medium term fiscal framework (CFMP) is elaborated – initial budget limits are communicated, and budget proposals are submitted for central government review</td>
<td>Begin discussions with provincial focal points about the budget and expected budget targets for each spending unit</td>
</tr>
<tr>
<td>May 31</td>
<td>The central government communicates the second budget limit and budget guidelines</td>
<td>Adjust IC targets based on CFMP projections and budget limits for the year</td>
</tr>
<tr>
<td>Jun – Jul</td>
<td>Provincial and sectoral planning meetings are held</td>
<td>MOH budget unit working with Provincial budget units to discuss priorities in the provincial budgets</td>
</tr>
<tr>
<td>Aug</td>
<td>Budget proposals are submitted and consolidated for provinces, districts and sectors</td>
<td>Review the Global Economic and Social Plan (PES) in comparison to IC targets and discussions with MOH budget unit before their meeting with MEF on total sector allocations</td>
</tr>
<tr>
<td>Sept</td>
<td>The PES and government budget are submitted to the Council of Ministers for approval by Sept 15th, then to Parliament for approval by Sept 30th</td>
<td>Review the final spending approved for the health sector in the government budget</td>
</tr>
<tr>
<td>Dec 15</td>
<td>Final date for the approval of the PES and government budget by Parliament</td>
<td>Begin discussions with MOH budget unit on allocations in the execution module (MEX) and funds flow to local facilities</td>
</tr>
</tbody>
</table>

Work program to improve alignment between IC and national budget process:

- **BASELINE ANALYSIS**
  - Redo IC costing and map to associated budget lines → more reliable baseline and target
  - Train IC provincial focal points in the provincial budget process
  - Review annual budget data and report on annual progress to IC targets

- **STRENGTHEN PLANNING AND BUDGET CLASSIFICATION SYSTEM TO ALIGN WITH IC**
  - Training of local finance officers and accountants on the correct use of functional classifiers (as 37% of expenditures are classified as “other”) to improve tracking in the future.
  - Workshops with districts and provinces to discuss changes in expenditures to reflect IC priorities
The End..
## Structure of Mozambique Budget (Classification system)

<table>
<thead>
<tr>
<th>Classifier</th>
<th>Objectives/Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional</td>
<td>Aggregates public spending according to government action areas related to the nature of State functions - largely in accordance with COFOG.</td>
<td>Detailed use of the functional classifier, especially in hospitals, however 37% of health expenditures used ‘Health, Not Otherwise Classified’ as their third level of functional classifier.</td>
</tr>
<tr>
<td>Administrative</td>
<td>Aggregates public spending for each the state institution / spending unit (UGB) responsible for budget formulation and execution.</td>
<td>UGBs in the health sector include the Ministry of Health (MISAU), hospitals (except for district hospitals), provincial health directorates (DPS) and district health units (SDSGCAC).</td>
</tr>
<tr>
<td>Programmatic</td>
<td>Tracks the government activities into programs and sub-programs in pursuit of government policy objectives and enables monitoring of results.</td>
<td>Only partially applied to expenditure records: for example, the first level ‘Health’ program classifier was only applied in 14% of all expenditure records in 2015, while 85% are classified as ‘Unknown’.</td>
</tr>
<tr>
<td>Economic</td>
<td>Identifies the economic nature of the expenditure such as salaries, allowances, goods, services, subsidies, transfers etc.</td>
<td>The economic classification is reasonably elaborate and consistently tracked.</td>
</tr>
<tr>
<td>Geographic</td>
<td>Allows separate tracking for the central government and each of the sub-national governments at provincial and district levels.</td>
<td>Complements the administrative classification in terms of identifying the level of the UGB and helps defines the state accountability with each level.</td>
</tr>
<tr>
<td>Sources of Funds</td>
<td>Identifies the source of funding (treasury, loans, donations, own revenues). Detailed source ID identifies the specific development partner.</td>
<td>Can be used to track project disbursement receipts and expenditures in case of externally-financed projects.</td>
</tr>
</tbody>
</table>

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[1] Servicos Distritais de Saúde, Género, Crianças e Acção Social, previously known as SDSMAS.