USAID MEDICINES, TECHNOLOGIES, AND PHARMACEUTICAL SERVICES (MTaPS) PROGRAM

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Increasing Government Financing and Resource Allocation for Family Planning Commodities and Supply Chain Operations in Uganda: A Political Economy Analysis Policy Brief

Uganda

August 2022

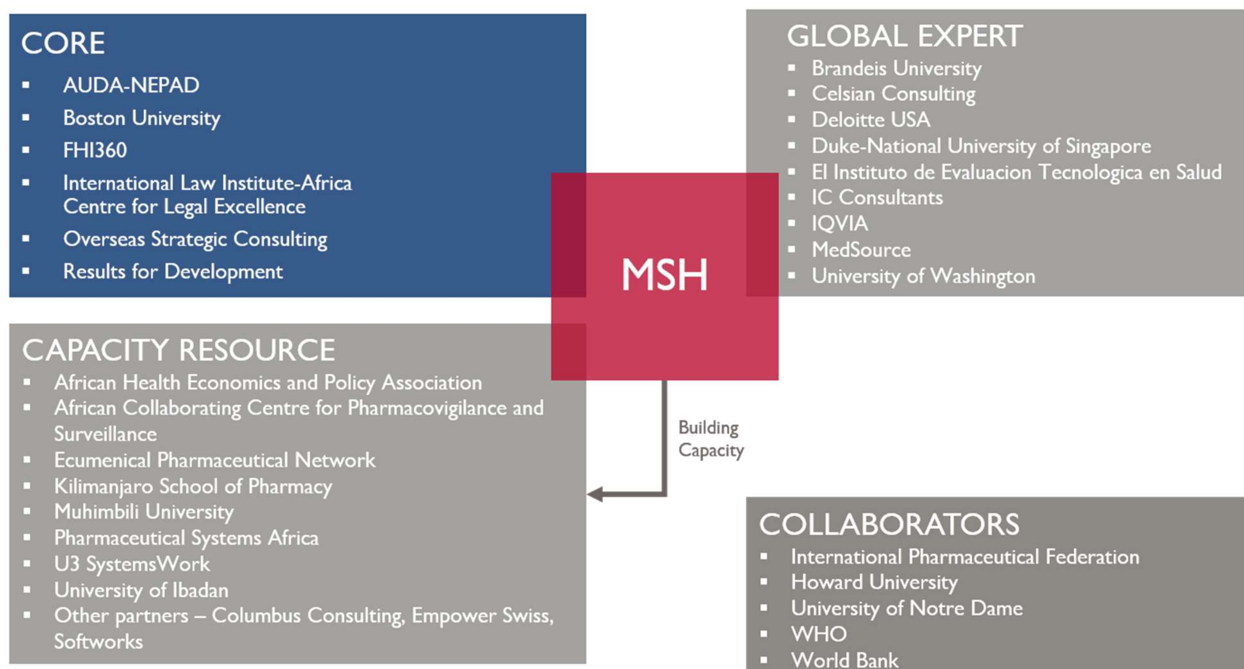
THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

This document is made possible by the generous support of the American people through the US Agency for International Development (USAID) contract no. 7200AA18C00074. The contents are the responsibility of Management Sciences for Health and do not necessarily reflect the views of USAID or the United States Government.

About the USAID MTaPS Program

The USAID Medicines, Technologies, and Pharmaceutical Services (MTaPS) Program enables low- and middle-income countries to strengthen their pharmaceutical systems, which is pivotal to higher-performing health systems. MTaPS focuses on improving access to essential medical products and related services and on the appropriate use of medicines to ensure better health outcomes for all populations. The program brings expertise honed over decades of seminal pharmaceutical systems experience across more than 40 countries. The MTaPS approach builds sustainable gains in countries by including all actors in health care—government, civil society, the private sector, and academia. The program is implemented by a consortium of global and local partners and led by Management Sciences for Health (MSH), a global health nonprofit.

The MTaPS Consortium



This document is submitted by:

Andrew Brown

Senior Principal Technical Advisor

USAID MTaPS Program – Management Sciences for Health

anbrown@mtapsprogram.org

ACRONYMS AND ABBREVIATIONS

CSO	civil society organization
FP	family planning
GOU	Government of Uganda
IUDs	intrauterine devices
mCRP	modern contraceptive prevalence rate
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MTaPS	Medicines, Technologies, and Pharmaceutical Services
PEA	political economy analysis
PS	MOH Permanent Secretary
RH	reproductive health
UHC	universal health coverage
UNFPA	United Nations Population Fund
USAID	US Agency for International Development

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PROJECT SUMMARY

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<tr><td colspan="2">Program Name:</td><td>USAID Medicines, Technologies, and Pharmaceutical Services (MTaPS) Program</td></tr>
<tr><td colspan="2">Activity Start Date And End Date:</td><td>September 20, 2018–September 19, 2023</td></tr>
<tr><td colspan="2">Name of Prime Implementing Partner:</td><td>Management Sciences for Health</td></tr>
<tr><td colspan="2">Contract Number:</td><td>7200AA18C00074</td></tr>
<tr><td rowspan="4">MTaPS Partners</td><td>Core Partners</td><td>Boston University, FHI 360, Overseas Strategic Consulting, Results for Development, International Law Institute-Africa Centre for Legal Excellence, NEPAD</td></tr>
<tr><td>Global Expert Partners</td><td>Brandeis University, Deloitte USA, Duke-National University of Singapore, El Instituto de Evaluacion Technologica en Salud, IC Consultants, Imperial Health Sciences, MedSource, QuintilesIMS, University of Washington</td></tr>
<tr><td>Capacity Resource Partners</td><td>African Health Economics and Policy Association, Ecumenical Pharmaceutical Network, U3 SystemsWork, University of Ibadan, University of Ghana’s World Health Organizations (WHO) Pharmacovigilance Collaborating Center, Kilimanjaro School of Pharmacy, Muhimbili University, Pharmaceutical Systems Africa</td></tr>
<tr><td>Collaborators</td><td>International Pharmaceutical Federation, Howard University, University of Notre Dame, WHO, World Bank</td></tr>
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INTRODUCTION

The Government of Uganda (GOU) set an ambitious goal to reduce the unmet need for family planning (FP) to 10% and increase the modern contraceptive prevalence rate (mCPR) to 50% by 2020. [1] However, the unmet need for FP was 30.5% and the mCPR was 30.4% as of 2020.[2] Although Uganda has signed up for FP2030 commitments and set related Sustainable Development Goals targets, domestic resources meet only a small proportion of resource needs as outlined in costed implementation plans.[3] In the period 2018/19, the GOU provided USD 4.3 million toward reproductive health (RH)/FP commodities, this increased to USD $6.2 million in 2021/2022, now exceeding their FP2020 commitment for procurement and distribution of a range of FP/RH commodities to the health facility level.[4] Partners, including the World Bank, US Agency for International Development (USAID), United Nations Population Fund (UNFPA), UK Aid, Netherlands, Bill & Melinda Gates Foundation, Population Services International, and Marie Stopes International, contributed 88% of the country's FP funding needs for the same period.[5] In 2019, government funding accounted for less than 1% of total funding for contraceptives.[6] While state budget spending compared to donor spending for FP products and the supply chain is low, demand for FP interventions is growing with Ugandan population growth.

While all categories of donors have a significant role in FP intervention funding in Uganda, increasing domestic financing is seen as a sustainable ongoing source of funding for FP products and supply chain. With the COVID-19 pandemic deepening an already anticipated decline in donor funding for FP, Uganda's reliance on donor funding must be reduced if FP targets are to be met.

Through the application of a political economy analysis (PEA) methodology, this brief describes the opportunities, incentives, entry points, and constraints to influencing priority setting, planning, and resource allocation to achieve sustainable funding for FP commodities and supply chain in Uganda, within Ministry of Health (MOH) programming.

APPROACH

The data used to inform this policy brief were obtained through a streamlined PEA conducted during the last quarter of 2021 by the USAID Medicines, Technologies, and Pharmaceutical Services (MTaPS) Program. A COVID-19-safe approach was used that included a literature review, stakeholder analysis, and virtual semi-structured interviews. External MTaPS subject matter experts worked virtually with Ugandan MTaPS and USAID/SSCS colleagues at Management Sciences for Health to implement this MOH-supported approach.

A targeted literature review of online academic, development partner, government, and civil society organization (CSO) websites was conducted to identify relevant academic and grey literature. Sources

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[1] Uganda_Questionnaire_2020-final.pdf (familyplanning2020.org)
[2] FP2020 2020 Full estimate tables: http://progress.familyplanning2020.org/finance
[3] FP2030 Uganda updates: https://fp2030.org/uganda
[4] Uganda_Questionnaire_2020-final.pdf (familyplanning2020.org)
[5] ibid
[6] https://www.ghsupplychain.org/csi-dashboard/2019

were reviewed for their contribution to the research team's understanding of the context and process currently surrounding domestic resource mobilization for FP commodities and supply chain and to inform the questions in the stakeholder interviews. The review also aided in the identification of institutional and individual stakeholders to be interviewed in the context of a wider stakeholder analysis.

Financial information from government and development partner sources was also analyzed to identify funding sources, trends in funding levels, and the role of any underlying legislative or regulatory frameworks in budget formulation and execution. Financial flow data were used to establish how domestic funding for FP is allocated and released to actors throughout the health system.

The research team conducted 30 semi-structured key informant interviews involving 35 interviewees from a cross section of stakeholders using customized interview forms derived from a standard question bank aligned with the study's aims. Interviews were conducted via Zoom and lasted between 30 minutes and two hours depending on respondent availability, connectivity, and level of interest. Findings and recommendations were extracted from the literature review, financial analysis, and interview data using consensus-based and content analysis approaches.

FACTORS HINDERING DOMESTIC RESOURCE MOBILIZATION FOR FP COMMODITIES AND SUPPLY CHAIN

A number of stakeholders are involved in domestic resource mobilization for FP commodities and supply chain. The MOH presides over an intricate, bottom-up quantification and budget development process, but the Ministry of Finance, Planning and Economic Development (MOFPED); Parliament; two procurement and distribution entities National Medical Stores and Joint Medical Store; development partners; and individual nongovernmental organizations all play significant roles in determining both the final funding levels and the mix of commodities that actually reach individual facilities. Commodity and supply chain management are not the primary concern of most of these actors, and FP is not a priority area when commodity and supply chain issues are addressed. Within this complex environment, a range of factors were presented by interviewees as influencing government funding and supply chain operations for FP products.

LEADERSHIP AND POLITICAL WILL

While government leaders have devoted additional resources to FP commodities and supply chain in recent years, many key informants noted a presiding lack of political will to support expanded FP funding and use given current political, religious, and cultural counter narratives. As a result of diligent leadership from inside and outside the health sector, the supportive programmatic and regulatory framework for funding FP commodities is for the most part present in Uganda. A policy for adolescent access has been stalled for some time—possibly for religious reasons—but other policies and plans needed to sustain a robust FP commodity and supply chain system are largely in place. Some stakeholders noted a tendency for politicians to be influenced by the direction set by leaders at the national level and within their constituencies and are reluctant to alienate voters and religious and cultural leaders (see religious and cultural barriers below). The direction that these higher-level leaders set is for larger families due to the political and economic dividends such families provide. Technical experts try to deduce the

direction/preferences of leaders and assemble budgets and priorities accordingly. Key narratives that influence FP funding decisions also include the perception that Mama kits[7] for safe delivery appear to offer more tangible benefits and are particularly prioritized by high-level political leaders and figures and the community, with 80% of domestic FP and maternal, newborn, and child health funding being used to purchase Mama kits. It is also believed by some that religious and cultural views supporting large families predominate, particularly in rural areas.

Informants also noted that within the MOH there is a need to continue and expand efforts to increase capacity, strengthen leadership, and have MOH officials increase their engagement in the financial allocation process for FP. Specifically, it was suggested that the MOH needs to engage more strongly with the MOFPED and be prepared to show strong justifications and advocate clearly for its requests. Many participants suggested that FP is not viewed as a high priority by leaders, the impact and concept of unmet need is not well appreciated, and FP commodities are not seen as critical resources, suggesting that while the MOH understands the value of FP in general, this view is not shared by other politicians, religious leaders, and large sections of the public. This sways the overall narrative as explained above. Further, the government and politicians prioritize medicines that treat the five killer diseases (HIV/AIDS, TB, malaria, respiratory tract infections, and diarrheal diseases) over FP products.

Diffusion of attention also appears to be a major barrier to securing sufficient domestic resources for FP commodities and supply chain. Infrastructure, defense, and education all appear to be higher domestic priorities than health, of which FP is but one small part. FP commodity and supply chain resourcing is simultaneously an area touched by many actors and a somewhat arcane backwater of an already under-resourced health sector.

BUDGETING AND FINANCE

All respondents identified issues relating to budgets and finance as being core to inhibiting efforts to increase FP funding, noting that the issues identified exist within a political and finance system that would benefit from improved transparency, financial governance, and overall availability of domestic resources.

The budget that comes to the health sector is small and demands are high with competing priorities. Many interviewees noted that health is considered an under-resourced area, with only 15% of funding made available compared to the GOU's commitments from the Abuja agreement. There have also been shifts of investments from the social sector to infrastructure and productivity investments, resulting in less funding for health. Meeting the demands of the COVID-19 pandemic has worsened the situation, while there is increasing competition among ministries and within the MOH for funding of various programs in general.

In considering donor support for FP products, many informants noted that for programs such as HIV, TB, and FP, the largest financial contribution comes from donors. During the budgeting process, the government prioritizes domestic funding for areas where there is less donor support, with the suggestion by some that this has contributed to reprogramming of RH funding for Mama kits. Participants mentioned further pressures on sustainable funding, including a lack of clarity on where and

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[7] Mama kits contain essential items for a clean and safe delivery, including a plastic sheet, a preparation sheet, cord ties, surgical gloves, cotton wool, surgical blades, soap, and a child health card.

how off-budget donor funds for FP are being spent, noting that the government has little incentive to put more funding toward FP because donors are perceived as being willing to cover any gaps. Unspent funds from a financial year for FP and the lack of a system for tracking actual funding releases against budget allocations has put further negative pressure on domestic FP funding. Of particular interest was that within the government budget framework, FP is not part of universal health coverage (UHC) but seen as part of primary health care. As a result, FP services are not included in UHC-funded packages.

From 2016 to 2018, the total spending for all FP activities was 225.5 billion UGX (USD 62.5 million), with an annual average of 75.2 billion UGX (USD 20.8 million). The total spending includes implementation activities (including supply chain management), program costs, and commodities. In 2018, about UGX 149 billion (USD 41.3 million) was received for FP activities, but only UGX 137.1 billion (USD 38 million) was spent for the same year. The amount received for FP in 2018 increased by 48% from 2017, compared to a 19% increase from 2016 to 2017 and a 75% increase from 2016 to 2018. The main source of funding consistently for 2016–2018 was donor contributions, representing 73% of the total spending for FP. Domestic funding was 23%, with 4% in private contributions. Donors play a significant role in financing FP activities in Uganda. The results show that they contributed 61% of all income received for FP activities. Among the donors, USAID is the major contributor (39%), followed by Foreign, Commonwealth and Development Office (previously DFID)(31%) and UNFPA (19%).

By sector, 54% of FP resources are channeled through the private sector, and the MOH and National Medical Stores are the major public organizations that receive and spend FP resources. The Ugandan resource flow also analyzes expenditure levels on different FP methods and by different providers. From 2016 to 2018, condoms, injectable contraceptives, implants, intrauterine devices (IUDs), and pills were the methods with the highest expenditures, with condoms, injectables, and implants comprising nearly 62% for the three years of commodity expenditure from all resources.

SUPPLY CHAIN MANAGEMENT ISSUES AFFECTING AVAILABILITY OF FP PRODUCTS

Many interviewees highlighted the lack of data visibility and poor quality of data in relation to medical products, including FP products. Facility-level data on commodity consumption and stock levels is not available on a timely basis. This lack of data means that FP product use and unmet need (supply and demand) cannot be calculated accurately to support funding requests, procurement, and the optimal use of FP commodities at the facility level. Local stock-outs resulting in discontinuation and local oversupplies resulting in stock expiry have significant long-term negative impacts. In addition, some participants noted that implementing partners influence method mix, site-level use, and availability through direct project work, which may change patterns of use and availability (e.g., direct delivery of FP products to donor-supported facilities).

CULTURAL AND RELIGIOUS FACTORS INFLUENCING FUNDING FOR FP

Many respondents noted that religious leaders have a high level of influence within Uganda and that politicians generally avoid confrontations in such constituencies. Issues relating to the availability of FP products for adolescents, family size, and the use of modern methods may impassion these leaders to directly or indirectly influence both funding decisions and availability. Some interviewees noted that social factors lead to a reluctance and or resistance to increase funding for FP. For example, Mama kits,

unlike FP commodities, are seen as tangible by male heads of household and traditional views support the need for large families, especially in rural areas.

ENTRY POINTS AND OPPORTUNITIES

LEADERSHIP AND POLITICAL WILL

A strong majority of participants described a need to recast domestic funding for FP commodities and supply chain as an investment in the future of Uganda and its families rather than simply a health issue. While several CSOs have already adopted this approach, development partners can further facilitate localization of this argument, leveraging the ambitious objectives of NDP II and Vision 2040 wherever possible. Available Uganda-specific evidence demonstrating the link among FP, rapid economic development, and achievement of middle-income status should also be marshalled and persuasively presented to political, cultural, and religious leaders.

Several interviewees noted that the MOH can remain more closely and continually engaged with the MOFPED and Parliament throughout the budgeting process. The MOH Permanent Secretary (PS) is particularly well positioned to fulfill this role and could leverage existing relationships with the National Planning Authority and MOFPED. Within the MOH, increasing the role of the Department of Pharmacy and Natural Medicines, Department of Reproductive and Infant Health, Department of Planning, and Department of Information in the budgeting process will ensure that the right people are at the table.

Numerous respondents highlighted the importance of high-level CSO, donor, and GOU-led advocacy for increased FP funding—particularly vis-a-vis Mama kits—and adherence to international commitments. In addition to seeking champions in Parliament, the Health Policy Advisory Committee platform, commodity security working groups, and national planning forums are potential entry points, as is ambassadorial engagement.

Many interviewees also suggested that civil society could do more to identify, support, and collaborate with FP champions inside and outside government on issues ranging from demand creation to adjustment of the FP ratio within the RH envelope. This engagement with the MOH, MOFPED, and Parliament needs to be sustained over the long term rather than simply reacting to funding crises. Several participants noted that the current reactive advocacy model often leads to pressure being brought to bear only after the budget has been formulated. Several participants noted that a reinvigorated approach to advocacy should include more sustained and vocal efforts to raise the salience of FP in the national dialogue through mainstream and social media channels that amplify local, typically marginalized voices.

BUDGET AND FINANCE

FP funding is only likely to reach and maintain optimum levels when overarching financial constraints on health funding are addressed. At the national level, GOU funding for FP commodities and supply chain may best be improved by situating such funding clearly within the broader dialogue surrounding the Abuja Declaration, UHC, and the need for a larger health budget overall. GOU and development

partners should gather and highlight evidence showing that district-level funding of FP commodities and supply chain improves access and perceived service quality and ultimately produces social and economic benefits. As decentralization continues, opportunities to expand local funding for FP, currently in its infancy, should be explored.

Many GOU, development, and civil society participants suggested that the successful efforts to track funding flows, both GOU and donor, at the national level should be extended to the district level. While challenging for technical and political reasons, comprehensive district-level funding flows would enhance transparency by showing whether committed funds are in fact allocated and highlighting resource gaps. Small-scale efforts led by individual CSOs have already met with some success in this area. Accompanying national assessments or external reviews that facilitate benchmarking or comparison to peers would be valuable for highlighting areas in need of additional support and areas where significant value for money is already being delivered. They would also serve as a jumping off point for linking funding to outcomes, further strengthening the case for robust funding and supply chain management.

Many participants noted a need for improved donor coordination to produce a clear, consistent message that increased GOU funding is needed to offset declining donor support and ensure that GOU commitments are met. The 10-Year Supply Chain Roadmap is a logical focal point around which this coordination can revolve. By projecting coordinated funding levels two to three years in advance and creating incentives such as matching funds, donors can encourage increased GOU funding while disincentivizing "donor shopping." With the addition of well-designed, mutually agreed upon indicators, the Roadmap can also play an essential role in ensuring accountability on all sides, particularly when combined with improved tracking of commodity gaps at the district and facility levels.

SUPPLY CHAIN MANAGEMENT

Many participants stated that more accurate and timely consumption and commodity flow data would strengthen the case for increased FP funding and increase system efficiency while undercutting arguments that increased funding for FP is likely to be wasted. A well-supported roll out of the planned electronic logistics management information system that addresses hardware, connectivity, and human capacity challenges is therefore crucial in the medium term. Short-term solutions for improving the availability of FP-specific data—generally less available and of lower quality than that available for other essential medicines—such as sentinel sites should be explored in the interim. More granular data on FP knowledge, attitudes, and practices would further strengthen both planning and advocacy by providing a fuller picture of unmet FP demand.

CULTURAL AND RELIGIOUS FACTORS

FP advocates should take advantage of public attention and high-level political support for safe motherhood and its associated Mama kits to frame FP—or birth spacing depending on the audience—as a matter of mothers' health. More detail-oriented messaging focusing on specific methods and associated services may also be needed. Emphasizing FP's ability to avert unintended pregnancy, particularly among teenagers and adolescents, and thus maintain healthy families may also persuade religious and cultural authorities to support increased domestic funding for FP. Development partners can encourage this shift by supporting the execution of the costed implementation plan and funding the development of

customized, audience-specific messaging, preferably paired with increased availability of services tailored to these audiences, emphasizing self-efficacy and empowerment at the national and subnational levels.

CONCLUSION

This PEA suggests that any approach to mobilizing additional domestic resources for FP commodities and supply chain will need to be multifaceted, sustained over a number of years, and well-coordinated among government and development partners if it is to succeed. With improved coordination, the development partner community can play an instrumental role in encouraging a gradual transition to full domestic financing while simultaneously supporting development of the leadership, supply chain, and data management capacities needed to ensure that the unmet need for FP declines during this period. In addition to guiding this process, the 10-Year Roadmap could offer a framework for binding commitments from both the GOU and the development partner community. Fulfillment of these commitments, both financial and technical, can serve as the basis for enduring cooperation and the establishment of incentives that extend well beyond a single fiscal year.

These technocratic adjustments will need to be accompanied by commensurate shifts in the political discourse surrounding FP if they are to be impactful. As the CSO community and MOH well recognize, FP needs to feature prominently in the ongoing discussions of development, economic growth, maternal health, and UHC that animate political and social leaders in ways that more siloed discussions of IUDs and stock-outs do not. Informed by reliable, locally relevant data and tailored so as to resonate with audiences ranging from the most senior government decision makers to teenagers, this reinvigorated approach to FP advocacy will ensure that Uganda's transition to domestic FP financing is not only well supported but also a driver of uptake.