Mapping the Financial Flow and Expenditures for Select MNCH Medicines in Uganda

March 2017

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March 2017

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Maheen Malik, Moses Muwonge. 2017. *Tracking the financial flow and expenditures for select MNCH medicines in Uganda*, Submitted to the US Agency for International Development by the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program. Arlington, VA: Management Sciences for Health.

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ACRONYMS

EMHS	essential medicines and health supplies
HC	health center
HC II	Health Center Level Two
HC III	Health Center Level Three
HC IV	Health Center Level Four
HSBWG	Health Sector Budget Working Group
MNCH	maternal, newborn, and child health
MoFPED	Ministry of Finance, Planning, and Economic Development
MoH	Ministry of Health
MTEF	Medium-term Expenditure Framework
NMS	National Medical Stores
QPPU	Quantification, Procurement, and Planning Unit
RH	reproductive health
RHCS	Reproductive Health Commodity Security
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
RMNCH	reproductive, maternal, newborn, and child health
SDG	Sustainable Development Goal
SRHR	Sexual Reproductive Health and Rights
UNCoLSC	United Nations Commission on Life-saving Commodities for Women and Children
UNFPA	United Nations Population Fund

BACKGROUND

As countries work to meet the targets for maternal, newborn, and child health (MNCH) established under Sustainable Development Goal (SDG) 3, they need to ensure the continuous availability of essential medicines and supplies to prevent and treat the conditions that cause morbidity and mortality in women and children.

Since the report of the United Nations Commission on Life-saving Commodities for Women and Children (UNCoLSC) was published in 2012, much has been done to highlight the challenges countries face in ensuring the availability of essential commodities and to create resources to assist countries in this endeavor. Procurement was identified as a major challenge by the UNCoLSC, and accurate forecasting was identified as a weak point. Despite the development of guidance on forecasting for the commodities prioritized by the UNCoLSC, in the absence of reliable data on morbidity or consumption, procurement is likely to remain an issue.

Another identified issue is financing these life-saving commodities. In most settings, these commodities are procured with government funds, but there is a lack of documented evidence as to how decisions regarding financing for these commodities are made and executed. An understanding of the financial flows for MNCH commodities is critical as countries pursue the goals of ending preventable child and maternal deaths and of universal health coverage and as many go through processes of decentralization. Understanding financial flows for MNCH commodities may also assist the donor community in making smarter investments and assisting countries in mobilizing additional resources.

Current RMNCAH Status in Uganda

An analysis from the Uganda reproductive, maternal, newborn, child, and adolescent health (RMNCAH) investment case indicates that Uganda has made progress in improving RMNCAH indices over the past two decades, but RMNCAH conditions currently account for more than 60% of Years of Life Lost in Uganda. RMNCAH conditions thus constitute a major public health problem. Maternal mortality rates fell by only 20% over the past 20 years and failed to reach national targets. The unacceptably high annual number of maternal deaths in Uganda accounts for 2% of annual maternal deaths globally. The major causes of maternal deaths are preventable, with the three leading causes being hemorrhage, obstructed labor, and complications from abortion. Nearly 28% of maternal deaths in Uganda occur in women between 15 and 24 years of age[1].

The overall adolescent birth rate in the age category of 15–19 years is 135 per 1,000 live births, which ranks among the highest in Sub-Saharan Africa and is driven by both the total fertility and population growth rates. Adolescents between 15 and 19 years of age account for 17.6% of deaths due to pregnancy-related conditions. Stillbirths and child

[1] Uganda RMNCAH Investment Case

deaths are 50% more likely in babies born to mothers younger than 20 than for those between 20 and 29[2].

In 2012, a Ugandan delegation, led by the Minister of State for Health, travelled to Abuja in Nigeria and made a commitment to the UNCoLSC. The commitment was translated into the Uganda reproductive, maternal, newborn, and child health (RMNCH) implementation plan (RMNCH Sharpened Plan for Uganda, A Promise Renewed)[3] that addressed the bottleneck to access to 13 life-saving commodities and provides 10 recommendations to address the problem. Uganda received a USD 3 million grant from the RMNCH Trust Fund to implement the catalytic plan in 2013. Since then, progress has been made, including the addition of 13 life-saving commodities to the Uganda Essential Medicines and Health Supplies List and Uganda clinical guidelines. These 13 life-saving commodities are classified as vital and are tracked at the national and health facility levels on a quarterly basis by the Ministry of Health (MoH). An RMNCH advocacy group was established with a secretariat at World Vision, and Uganda is one of 24 African countries to develop an RMNCH score card to facilitate tracking and reporting on interventions, implementation, identification of bottlenecks around national priorities, and actions to address those bottlenecks.

However, one year into the implementation of the catalytic plan, Uganda was selected in the second wave of Global Financing Facility countries in late 2015 and was required to develop an RMNCAH investment case to be able to access the funds. The country made the decision against developing a completely new document. Rather, it revised and updated the 2013 RMNCH Sharpened Plan to become the Uganda RMNCAH investment case (2017–2020), which will further increase access to RMNCAH medicines. In line with the SDGs and the need for more universal access, the main thrust of the RMNCAH investment case is the prioritization of bottlenecks to scaling high-impact interventions. To achieve this, the investment case focuses on five strategic shifts and the delivery of a priority intervention package at all levels of the health system. The five strategic shifts are:

- Emphasizing evidence-based, high-impact solutions
- Increasing access for high-burden populations
- Geographical focusing/sequencing
- Addressing the broader multisectoral context
- Ensuring mutual accountability for RMNCAH outcomes

The MoH conducts a quarterly assessment of the availability of essential medicines and health supplies (EMHS) to inform decision making. Table 1 shows the most recent information on the availability of MNCH medicines at the health facility level.

[2] Uganda RMNCAH Investment Case

[3] RMNCH Sharpened plan for Uganda, A promise renewed. Available at: http://speed.musph.ac.ug/wp-content/uploads/2015/05/Committing-to-Maternal-and-Child-Survival_A-Promise-Renewed.pdf

Table 1. MNCH Commodity Availability

Oxytocin	• 82% stock available at health facilities • Nearly 40% of facilities are over stocked and more than 25% are under stocked • Between July and September 2016, the National Medical Stores (NMS) had five months of stock, which is an appropriate stock level • Government-owned Health Center Level Three (HC III) and Health Center Level II (HC II) facilities were the most over-stocked facilities, with more than eight months of stock. Oxytocin is expected to be at HC III facilities and above. Despite not being allowed to stock oxytocin at HC II facilities, it was reported that some HC IIs had oxytocin in stock and that was irregular. HC II facilities do not have either maternal health units or delivery beds and are not allowed to conduct deliveries.
ORS sachets with zinc tablets	• 93% stock availability at health facilities • 36% of facilities were over stocked • Government-owned HC II and HC III facilities were the most over-stocked facilities, with more than eight months of stock

Source: MOH: July–Sept 2016 facility tracer medicines stock status report

The National Health Care System

The Uganda National Health Care system comprises both public- and private-sector service delivery outlets. The private sector includes for profit (private practitioners and traditional and complementary medicines practitioners), nonprofit, and faith-based organizations.

The public sector operates under the MoH and includes Health Center Level IV (HC IV), HC III, and HC II facilities and regional and general referral hospitals. The system is decentralized, with districts and subdistricts providing health care services. The types of services provided at each level are as follows.[4]

National referral hospitals serve an average of 10 million people. Comprehensive specialist services are offered at this level, and these facilities are involved in health research and teaching.

Regional referral hospitals serve an average of 3 million people and offer specialist clinical services, including psychiatry; ear, nose, and throat; ophthalmology; higher-level surgical and medical services; and clinical support services. They are also involved in teaching and research.

General hospitals serve an average of 500,000 people and provide preventive, promotive, curative, maternity, inpatient, surgery, blood transfusion, laboratory, and medical imaging services. They also provide in-service training, consultation, and operational research support for community-based health care programs.

[4] Health Sector Strategic and Investment Plan. Available at: https://www.unicef.org/uganda/HSSIP_Final.pdf

HC IV facilities serve 100,000 people and provide curative, preventive, promotive, and rehabilitative health care services. They play an administrative role in the planning, organization, budgeting, and management of health services at the subdistrict level and for lower-level health facilities (HC III, II, and I). HC IVs supervises private for-profit and nonprofit providers within a health subdistrict.

HC III facilities serve 20,000 people and provide basic preventive, promotive, and curative care. They also provide supportive supervision for HC IIs and community health workers under their jurisdiction and laboratory services for diagnosis, maternity care, and referrals.

HC II facilities serve 5,000 people and provide the first level of interaction between formal health care and the community. They provide outpatient care, community outreach services, and linkages with village health teams.

The Uganda Medicine Supply Chain System

Public-sector Medicine Management

Public-sector medicine management of RMNCAH commodities is a function of the NMS and the MoH pharmacy division, with program support from the MoH reproductive health and child health divisions (table 2).

Table 2. Stakeholder Roles and Responsibilities

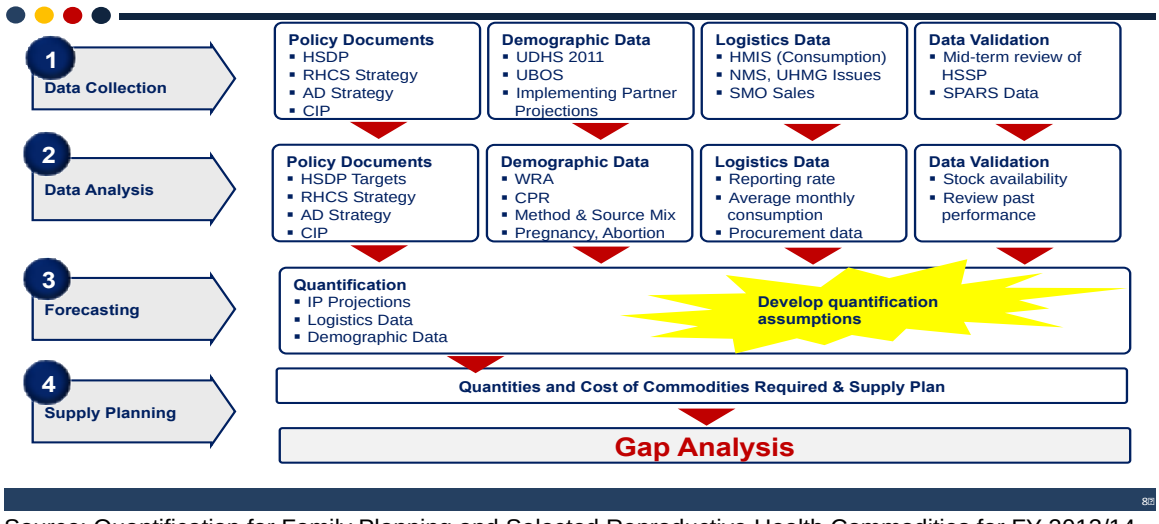
Department/ division/agency	Roles and responsibilities
Bank of Uganda	The Bank of Uganda receives funds for procurement of EMHS and on instruction from the Ministry of Finance, Planning, and Economic Development (MoFPED) pays suppliers directly.
MoFPED	The MoFPED determines and allocates ceilings for the NMS, verifies invoices submitted by the NMS, and instructs the Bank of Uganda to pay suppliers.
Health Sector Budget Working Group (HSBWG)	The HSBWG operates under the Chairman, Commissioner Health Services-Planning Department and the Secretary, Senior Health Economist/Desk Officer Health MoFPED.
NMS	The NMS is a state-owned agency headed by a general manager outside of the MoH. It is responsible for procurement, warehousing, and distribution of all EMHS to all government-owned health facilities. The NMS manages and accounts for the MoH's essential medicines budget.
MoH pharmacy division	The MoH pharmacy division is primarily responsible for coordinating the pharmaceutical sector; developing and disseminating health facility storage and distribution guidelines; and ensuring that health facilities adhere to dispensing, rational medicine use, and national quantification policies. The pharmacy division does not manage the EMHS budget, but it plays an advisory role. It develops and maintains the essential medicines list that the NMS uses to determine procurement. The division provides guidance to the NMS on the types of medicines to be given to each level of health care. It does forecasting and quantification, while the NMS does procurement planning based on available resources.

Department/ division/agency	Roles and responsibilities
MoH reproductive health (RH) division	The RH division is responsible for demand generation and for ensuring the implementation of the Sexual Reproductive Health and Rights (SRHR) policy guidelines and service standards. It provides guidance to the NMS on SRHR commodity needs and selection. The division does not manage the MNCH medicines budget, but it plays an advisory role to the NMS.
MoH child health division	The child health division is responsible for the demand generation and for ensuring the implementation of the child health policy guidelines, integrated management of childhood illnesses, and service standards. It provides guidance to the NMS on child health commodity needs and selection. The division does not manage the child health medicines budget, but it plays an advisory role to the NMS.

Forecasting and Procurement

Forecasting

The MoH pharmacy division has a Quantification, Procurement, and Planning Unit (QPPU) that coordinates with technical divisions within the MoH for forecasting and quantification to determine EMHS needs. The results are presented at a meeting with the MoH and donors, funding gaps are discussed, and commitments are made. For the last three financial years, despite discussions with donors on funding gaps, the NMS budget has remained the same. There have been calls for additional donor collaboration and support to bridge the gap and to actively engage donors during procurement planning.



Source: Quantification for Family Planning and Selected Reproductive Health Commodities for FY 2013/14–2015/16, MoH QPPU report 2013

Figure 1. The forecasting and quantification process in Uganda

Procurement

Every year, the NMS undertakes an essential medicines needs assessment at the health facility level to develop a health facility-based procurement plan and aggregate individual facility plans into a national plan. However, these data are not considered when the final procurement plan is developed because facilities receive medicines based on the pre-approved budget allocated. This results in prioritizing and cutting the actual needs based on priority programs. Table 3 shows the funds allocated per health facility for FY 2016/17. The same amounts have been allocated for the last three financial years.

Table 3. Government Budget Allocation by Health Facility Level

Level of care	Number of health facilities	Total budget allocated for FY 2016/17 (UGX)
HC II	1,757	11,163,237,000
HC III	955	18,360,000,000
HC IV	180	7,992,000,000
General hospitals	47	14,456,000,000
Regional referral hospitals	15	13,024,000,000

Source: MOH health sector development plan 2015–2020

Inventory Management System

The NMS warehouses and distributes EMHS to public health facilities. It maintains a minimum stock level of three months and a maximum stock level of six months. A mix of pull and push systems has been implemented in Uganda, with HC IIs and HC IIIs operating on a push system and HC IVs and above on a pull system. In the push system, facilities receive a predetermined essential medicines kit every two months. The contents of the kit are determined at the district level and evaluated every six months. HC IVs and above order the EMHS that they need, but the supply is based on the budget ceilings agreed upon at the start of the financial year. Health facilities are expected to maintain a stock level of between two and four months. At the beginning of the financial year, all levels of health facilities receive budget allocations from the NMS. The budget allocations are standard for each level of care and are not dependent on population or patient load.

METHODOLOGY

Purpose

The purpose of this assessment was to track the process of budgeting and the flow of funding, disbursements, and expenditures for select essential MNCH medicines and supplies in the public sector in four countries—Bangladesh, Kenya, Nepal, and Uganda—to inform the development of strategies and interventions that will improve the availability of these medicines.

To gather information on the financial flow for selected medicines, four tracer medicines that have been on most countries' essential medicines lists for five years or more were selected:

- Maternal health: Oxytocin (10 / 5 IU)
- Neonatal health: Injection Gentamicin (20 mg/2 ml and 80 mg/2 ml)
- Child health: Zinc (20 mg dispersible tablets) and ORS (1 L sachets)

Data Collection

The situation analysis employed qualitative and quantitative data collection methods, including a desk review and in depth interviews.

Data were collected in July and August 2016.

The key stakeholders interviewed were:

- Dr. Dinah Nakiganda, MoH Assistant Commissioner, RH division
- Mr. Lawrence Were, United Nations Population Fund (UNFPA)-Reproductive Health Commodity Security (RHCS) coordinator
- Dr. Jesca Nsungwa, MoH Assistant Commissioner, child health division
- Mr. Sam Balyejusa, Uganda Health Supply Chain Project (QPPU)
- Mr. Tom Aliti, MoH Assistant Commissioner, planning division
- Ms. Julliet Kyokuhirwe, Principle Economist, MoFPED, health desk
- Mr. Morris Seru, MoH Assistant Commissioner, pharmacy division
- Mr. Richard Kabagambe, MoH Assistant Commissioner, finance and budgets
- Mr. Alfred Nantaba, NMS Director of Procurement

RESULTS

The assessment aimed to document the following through an analysis of financial flows and expenditures:

- Budgeting process
- Timelines for activities in the budget development process
- Financial flow and expenditure tracking
- Funding gaps
- Commodity security

Budgeting Process

The process for the initiation, review, approval, and disbursement of funds for MNCH commodities was reviewed, and documentation was collected to support the assessment findings.

In Uganda, the budgeting process takes place concurrently at subnational- (local government) and national-level institutions. The local government level was not the focus of this review because EMHS financing and procurement is centralized at the NMS level. The NMS is a national statutory institution with its own budget (vote on account—vote 116)[5]. The NMS vote on account is specifically for procurement, warehousing, and distribution of EMHS to all public health facilities. Because the NMS serves the health sector, its budget (vote 116) is under the health sector during the budget planning process.

Budget Initiation Stage

The budgeting process in Uganda takes place at four key levels:

- The MoFPED
- Sector budget working groups, line ministries, agencies, and local governments
- Cabinet
- Parliament

Budget preparation involves setting the medium-term fiscal framework and determining the resource envelope. The MoFPED, in consultation with other government institutions, such as the Uganda Revenue Authority and the Bank of Uganda, analyzes current financial year trends in domestic revenue collection, external financing, trends in public expenditure, macroeconomic conditions, inflation, and exchange rates. Based on this

[5] For a vote in Uganda, a code number is given to each government institution receiving government funds, and this can be equated to an organization with different projects by attaching a different code for each project budget. Each institution in Uganda that receives funds from the Government is allocated a reference number in the budget framework documents. If an organization does not have a reference number (vote), it does not receive funds.

analysis, the MoFPED projects the resource envelope for the next financial year as part of the five-year medium-term fiscal framework.

The current financial budget and expenditures forms the basis of resource allocation for the next fiscal year for different sectors. Any additional resource projections above the current year's resource envelope are then allocated based on the policy priorities, with higher priority areas and commitments receiving the first call on the resources.

This becomes the basis for preparation of the indicative medium-term expenditure framework (MTEF) that details the sector ceilings. The MTEF is then presented to the Cabinet for approval. The NMS receives budget ceilings from the MoFPED for each level of health care.

Timeline

The Uganda budgeting process starts in June and ends in July of the following calendar year, and funds are released quarterly. However, the NMS does not receive funds for procurement of EMHS. These funds are retained at the Bank of Uganda, which pays suppliers directly on approval of NMS invoices from suppliers and recommendations from the MoFPED.

Table 4: Uganda Budgeting Process

Period	Budgeting Process
July–September 14	Budget preparation process leading to Cabinet approval of the MTEF with sector ceilings
September 15	First budget call circular • The objective of the circular is to communicate the budget strategy for the following financial year and request sectors to prepare and submit their budget framework papers. The circular shows the indicative budget allocated to each sector based on the projected revenues for that financial year.
October–November	Sector working group consultations • The HSBWG[6] coordinates planning and consolidates the plans of different agencies, including the NMS, in the health sector • The HSBWG organizes discussions with spending agencies within the health sector to agree on sector priorities and the financing required • National budget conference • The health sector or the HSBWG prepares a budget framework paper[7] and submits it to the MoFPED
December 31	Submission deadline for national budget framework paper to Parliament

[6] The HSBWG comprises the MoH; MoFPED; Uganda Blood Transfusion Services; Uganda AIDS Commission; Uganda Cancer Institute; Uganda Heart Institute; Mulago Hospital; Butabika Hospital; and representatives from regional referral hospitals, community service organizations, health development partners, and district health offices.

[7] The budget framework paper spells out health sector objectives; past performance, including outputs; future plans; and proposed expenditure allocations.

Period	Budgeting Process
February	• Approval of the national budget framework paper by Parliament • Parliamentary committee consultations on budget framework paper • Permanent Secretary MoFPED issues the second budget circular
March	Minister of Health presents ministerial policy statements to Parliament
April	• Annual budget and tax bill presented to Parliament • East African Community finance ministers prebudget meeting held
May	Approval of annual budget
June	• Minister of Finance, Planning, and Economic Development presents budget speech to Parliament • Permanent Secretary MoFPED issues the budget execution circular
June 15	Presentation of budget speech
July	Budget execution

Source: MoFPED 2016: A guide to engaging on national budget process; MoH, 2016: New budget preparation process in Uganda: Health sector supplement

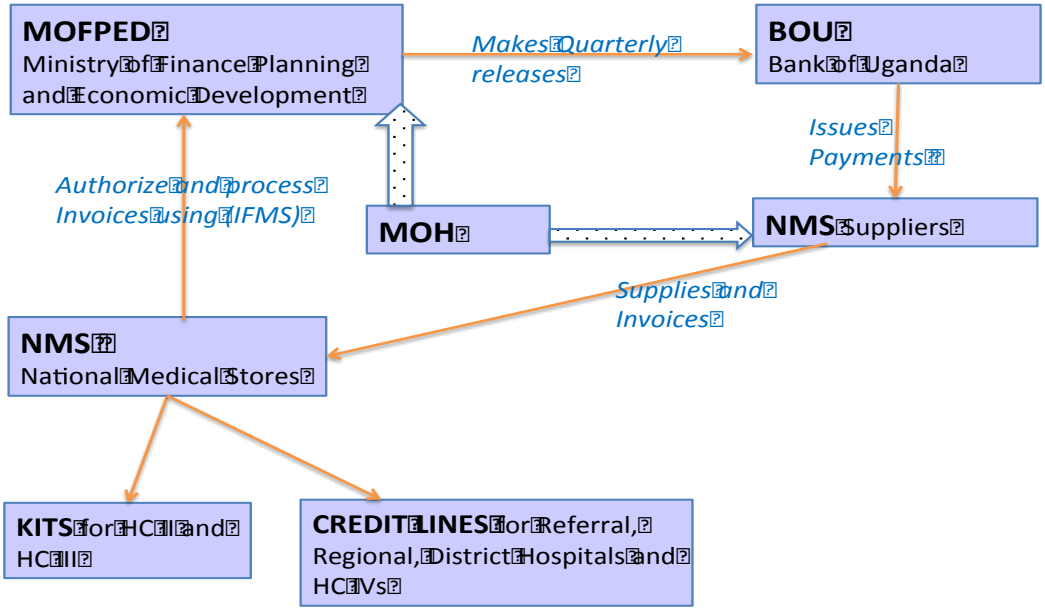


Figure 2. Flow of NMS funds

The NMS has two budgets: one for procuring commodities and the other for managing human resource and maintaining warehouses and vehicles. The funds for commodities are not released to the NMS because it does not pay suppliers. The NMS has framework contracts with suppliers and orders commodities on a regular basis. The suppliers are paid only when the NMS is satisfied with the deliverables. To date, the NMS has not faced problems with the Bank of Uganda failing to pay suppliers. No delays have been reported on the flow of funds for commodities, although salaries have been delayed.

Expenditure Tracking

At the beginning of each financial year, the MoFPED approves the budget for procurement of EMHS to vote 116 of the NMS. The approval is reflected in the approved budget framework paper, which indicates the funds allocated per health facility level. The appropriations bill is passed by Parliament. Upon notification, the NMS allocates equal funding to each health facility level. Health facilities do not receive funds for procuring commodities. Once the amount allocated per health facility level has been determined, the NMS informs the health facilities of available credit for the procurement of EMHS. Each health facility has an account with the NMS through which they order EMHS for that year. Each higher-level health facility can determine the type of commodities to be procured, while lower-level facilities receive predetermined essential medical kits at a fixed price. Each district determines the content of the kit.

The financial procedures for the NMS budget (vote 116) are:

1. In accordance with the Public Procurement and Disposal Authority, the NMS requests bids for supplying EMHS.

2. The NMS uses Public Procurement and Disposal Authority regulations to determine EMHS suppliers.

3. The NMS enters into a three-year contract with the selected supplier.

4. The NMS places orders for a supply of EMHS when the stock in inventory reaches the minimum stock level of three months.

5. The suppliers apply for a certificate of importation from the National Drugs Authority to ensure the quality of EMHS to be imported. Once the products are in customs, the National Drugs Authority inspects the EMHS and clears the goods.

6. The NMS receives the supplies, verifies the quantities, and undertakes quality checks using the in-house quality assurance laboratory.

7. The NMS instructs the MoFPED to instruct Bank of Uganda to pay the suppliers.

8. The Bank of Uganda pays the suppliers.

Because the funds remain with Bank of Uganda, there are no issues of failure to release funds for procurement. The NMS has not experienced any problems in expenditure on allocated funds for procurement of EMHS on the non-wage recurrent budget.

All essential medicines and medical supplies budgets, including immunizations, are centralized into NMS vote 116, which includes wage and non-wage recurrent expenditures. The essential medicines and medical supplies are budgeted under non-wage recurrent expenditures. The NMS vote 116 mission statement is to effectively and efficiently supply

essential medicines and medical supplies to public health facilities in Uganda. The vote function output 0859 within NMS vote 116 is for procurement, warehousing, and distribution of pharmaceutical and medical supplies, including medicines and medical supplies, health products, instruments and equipment, specialized items, immunization supplies, procurement, and management services. The specific vote functions and budget allocation are shown in table 5.

Table 5. NMS Vote Function 0859

Vote Function Output	FY 2015/16 Allocation (UGX)	FY 2016/17 Allocation (UGX)	Comment
085906: Supply of EMHS HC II (basic kit)	11,163,237,000	11,163,237,000	Budget allocations have not changed despite increased population/patient /client load
085907: Supply of EMHS HC III (basic kit)	18,360,000,000	18,360,000,000	
085908: Supply of EMHS HC IV	7,992,000,000	7,992,000,000	
085909: Supply of EMHS general hospital	13,106,000,000	13,106,000,000	
085910: Supply of EMHS regional referral hospital	13,024,000,000	13,024,000,000	
085911: Supply of EMHS national referral hospital	12,365,600,000	12,365,600,000	
085915: RH commodities	8,000,000,000	8,000,000,000	

Source: MOH: Health ministerial policy statement FY 2016/17.

The NMS does not have a budget for each commodity line item and does not plan to buy certain quantities of commodities; orders are placed when stock levels drop below the minimum. Throughout the year, the NMS spends more on fast moving commodities than on slow moving commodities. It is the NMS's responsibility to ensure that the commodities supplied are exactly what was ordered.

Funding Gap

The NMS and the MoH pharmacy division conducted an EMHS needs assessment for health facilities using the Clinton Health Access Initiative quantification tool for lower-level health facilities and the NMS in-house commodity management platform for higher-level facilities.

The tool uses historical data from the health management information system to determine each health facility's needs. However, the quantities that are ultimately ordered are based on the funds allocated. The total budget allocated to health facilities is not based on any calculation of formula but on the budget ceiling provided by the MoFPED for each level. The NMS divides the total amount allocated per level by the total number of health facilities at that level.

The overall funding gap was found to be 51% (table 6). Each level of health facility receives the same funding (credit) for commodities. The budget allocation for procurement of EMHS is not based on population/client load.

Table 6. Funding Gap for Government Health Facilities

Health Facility Level	Total Budget Allocated FY 2016/17 (UGX)	Desired Demand (UGX)	Funding Gap
HC II	6,353,578	13,941,672	54%
HC III	19,225,130	36,257,532	47%
HC IV	44,400,000	123,762,906	64%
General hospital	307,574,469	527,833,608	42%
Regional referral hospital	868,266,666	2,002,867,182	57%

Source: NMS, October 2016: FY 2016/17 Procurement Planning national quantification report.

Over the last three financial years, the Government of Uganda has allocated the same funding for procurement of EMHS, and the funding gap analysis indicates a need for advocacy. One of the main challenges for the budget gap is that donors focus on specific programs and a select number of commodities managed under specific programs (e.g., TB medicines, antiretrovirals, immunizations) and less attention is paid to other vital essential medicines and health supplies, including MNCH medicines.

Quantification Process

Because no specific budget is allocated to a particular commodity in the budget process, procurement is based on consumption data from health facilities. The NMS conducts an annual needs assessment for health facilities for procurement planning purposes based on the government vote 116 budget allocations. A more detailed quantification, which is coordinated by MNCH programs, takes place at the national level on a three year rolling cycle, and technical support is provided by the QPPU. The QPPU is located within the pharmacy division and receives technical support from the USAID Uganda Health Supply Chain Project. Figure 1 summarizes the quantification process adopted from the 2016 MOH quantification report.

Based on the most recent RMNCAH quantification (MoH 2016 forecast and quantification report) exercise that was supported by UNFPA with technical assistance from JSI, quantities and valued for RMNCH commodities were determined (table 7).

Table 7. Quantities and Values for MNCH Commodities (in USD)

Commodity	2016	2017	2018	2019
Oxytocin: Quantities	581,037	594,322	606,457	618,786
Oxytocin: Cost	159,785	163,439	166,776	170,166
Gentamicin: Quantities	980,063	1,002,471	1,022,940	1,043,735
Gentamicin: Cost	39,203	40,099	40,918	41,749
ORS/Zinc: Quantities	930,000	1,513,110	1,628,740	1,744,370
ORS/Zinc: Cost	483,600	786,817	846,945	907,071

Source: QPPU, Pharmacy Division, MOH, November 2016: National Quantification of contraceptives and selected RMNCAH commodities FY 2016/17–2019/20

The cost of the commodities was determined using the current unit market prices from the UNFPA catalog.

Commodity Security

The MoH RH division has a full-time RHCS coordinator supported by UNFPA. A family planning/RHCS technical working group reports to the Maternal Child Health cluster. This working group comprises community service organizations and is co-chaired by the pharmacy and RH divisions. The family planning/RHCS technical working group meets quarterly to review the RMNCH commodity stock status, budget allocations and expenditures, challenges in the supply chain, and supply plans.

SUMMARY OF KEY FINDINGS

The financial flows for resources meant for procurement of EMHS in Uganda are clear and transparent in terms of block allocations to health facilities. However, the allocations are not based on services or on demographic or logistics data but on a figure whose determination is not clear. The impact of the financial flow system is felt at three levels:

- **National level:** The NMS availed half of the budget needed for EMHS for public health facilities. This leads to extreme rationing and prioritization of procurements. If health facilities don't prioritize MNCH commodities, the likelihood of the NMS procuring adequate MNCH commodities is diminished.

- **Higher-level health facilities:** Higher-level health facilities determine the types and quantities of EMHS needed (pull system) based on available credit with the NMS. For MNCH commodities to be prioritized in the ordering process, the facility in-charge must consider them a priority.

- **Lower-level health facilities:** Lower-level health facilities use a push system and receive a predetermined kit that is determined at the district level. If the district team does not prioritize MNCH commodities, the kit will lack adequate supplies of these commodities.

It is not possible to track financial flows for MNCH commodities in a system that runs an integrated budget line for all commodities. In addition, an integrated budget does not guarantee allocation of adequate resources to MNCH commodities. The best option is to ring face budgets for MNCH commodities and track those specific resources within the system.

Two recommendations to address these issues have been made:

1. MNCH commodities should be removed from the general EMHS commodity budget and classified as full supply commodities with 100% budget allocation for the quantified needs at the health facility level. This scenario would mirror the current situation with vaccines, TB medicines, malaria medicines, and contraceptives, which are not part of the essential medicines credit line (which is funded to approximately 50% of the need). Health facilities order what they need knowing that it does not impact the credit line resources.

2. Advocacy efforts are needed to sensitize the health facility in-charges to prioritize MNCH commodities when placing orders because NMS procurements are based on orders placed by health facilities.

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