POLICY BRIEF ON **FINANCING OF REPRODUCTIVE HEALTH** IN UGANDA 2012

THE EXECUTIVE SUMMARY

AHEAD for World Bank partners in Uganda are advocating to ensure that Sexual Reproductive Health Reproductive becomes a priority for World Bank lending, and is included in policy documents such as Country Assistance Strategy (CAS), Poverty Reduction Strategy (PRS) and the Medium Term Expenditure Frameworks (MTEF) in Uganda.

Financing is central to the health system performance and effectiveness in curbing the unsatisfactory health indicators. An overview of the funding trends indicates a significant increase in the health funds especially from external sources, although these funding increases do not take into account the increase in population, escalating costs of providing care- in part due to the adaptation of new and expensive medical products and technologies. At the implementation level, funding for health programs remains low than required. Further, the poor disbursement of funds to the operational levels and the marked inefficiencies in the use of available funds pose an additional challenge. The public has demonstrated its willingness to pay for services (see deliveries in private health facilities) by participating in the non- state service provision networks by means of private insurance and out of pocket payments.

Uganda has benefited from significant amount of external health development assistance. Available evidence shows that more and more of it is being channeled through off- budget arrangements and used by non-state agencies. The total public health expenditure per capita decreased from US$ 11.1 in 2009/10 to US$ 9.4 in 2010/11, mainly due to a decrease in external contributions which constituted 14% of total public heath expenditure in 2010/11, compared to 39% in the 3 preceding years.

The government expenditure on health as percentage of total government expenditure is about 9%, as it has been for the last decade, below the Abuja target of 15% but on target for HSSIP 2010/11, which is 8.9%. External funding (both on and off budget) for the health sector surpasses government investment in the sector. The government has increased the budget allocation for reproductive health commodities over years and could do more in order to realize the benefit of investing in reproductive health. However, government contribution remains dismal compared to donor/ development partner[1] contribution for financing reproductive health in Uganda.

POLICY INTERVENTIONS FOR FINANCING REPRODUCTIVE HEALTH

Government should provide the necessary financial resources to:

- Increase accessibility and availability of reproductive health commodities to all persons in the reproductive age group
- Reduce unmet need for family planning at all health units.
- Improve procurements of contraceptives in the government system and prevent compromising services at all levels
- Improve the human resources available (midwives, doctors and anesthetists)at districts for EmOC service provision

Among other recommended actions, the government and its developments partners need to:-

- Improve the timeliness of disbursements and predictability of funds to match the implementation schedules of reproductive health programs
- Improve the costing of policy decisions and service targets or expected coverage levels of vital programs like reproductive health, to ensure that financial mobilization and allocation are well aligned with performance expectations.
- Improve value for money through auditing of both on-budget and off-budget financing arrangements; and
- Expand the decision space for financial allocation at the operational levels so that financial resources are directed to overcome the major constraints in performance.

1 Development partners include the WorldBank, UNFPA and USAID

2.0 INTRODUCTION

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life. The International Conference on Population and Development Programme of Action states that "reproductive health ... implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so"

Implicit in this last condition are the right of men and women to be informed and to have access to and utilize safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods to regulate fertility which are in conformity with the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Uganda's population is estimated at 33 million, as at 2010, with a life expectancy of 51 years for men and 52 years for women. With a population growth rate of 3.4% and total fertility rate of 6.2 children per woman, Uganda's population is projected to reach 58.8 million by 2025. Infant mortality is at 54 deaths per 1,000 live births, with neonatal mortality[1] making 50% of the cases. The population is largely young with about 50% being children below 18 years. This large population of young people and women and men in their reproductive age which has implications for sexual and reproductive health commodities and services. The aim of the sexual and reproductive health is to reduce mortality and morbidity relating to sexual and reproductive health, and rights. Adequate financing of sexual and reproductive health is important as it seeks to reduce maternal mortality, under five mortality and total fertility rates; and improve sexual and reproductive health of the people.

Maternal mortality ratio is 435 per 100,000 live births with a life time risk of 1 in 25. For every maternal death, about 20 other mothers will have developed complications, including obstetrics fistula that is estimated at 2.6%, most of which have not been repaired. Infant mortality is at 55 per 1000 live births, with neonatal mortality[2] making 50% of the cases. Though the adolescent age specific fertility rate is dropping, teenage pregnancy rate is at 24% (UDHS, 2011). The HIV/AIDS indicator survey, 2011 indicates that the HIV prevalence rate has recently risen to 7.3% from 6.7% previously. The contraceptive Prevalence Rate is 29.9%, and the unmet need for family planning stands at 34.3% (UDHS, 2011).

In response to the above, the Government of Uganda has developed various interventions to deal with these undesired situations. These include, the development and implementation of the National HIV/AIDS Strategic Plan; Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity; and the Strategy to Improve Reproductive Health in Uganda, among others

The Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity In Uganda (2007-2015), together with the Strategy to Improve Reproductive Health in Uganda (2005-2010) set the basis for development of a Comprehensive Reproductive Health Plan, in line with priority policy issues in the National Health Policy II (2009/10 – 2019/20).

The Reproductive Health Commodity Security Strategic Plan is therefore central to achieving targets

2 Neonatal mortality: the probability of dying within the first month of life

set out in the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda. This was against the background of the poor state of Sexual and Reproductive Health and limited access to and use of reproductive health commodities for the majority of the population in Uganda, due to a number of challenges.

Among the challenges that were identified prior to establishment of the above framework, were weak policy and regulatory environment, lack of commitment by key actors, poor coordination, limited financial resources, capacity, non-availability of reproductive health commodities and lack of client awareness. Therefore the 5 year strategic plan on reproductive Health Commodity Security (2010/11-2014/15) was developed to address the above challenges affecting reproductive health in Uganda. The strategic plan objectives are:

- To increase the contraceptive prevalence rate from 23% to 50% and reduce the unmet need for contraceptive from 40% to 5% by 2015.
- Increase the proportion of health facilities with NO stock outs of selected Reproductive health commodities to 80% by 2015.
- To increase public sector/ government budget allocation and expenditure on reproductive health commodities, including contraceptives to 80% by 2015.

The purpose of this policy brief is to highlight the current progress on the third objective in relation to sector expenditure trends from various sources towards reproductive health commodities.

As the main driver of implementation of health sector programs, financing is central to the health system performance and effectiveness in curbing the unsatisfactory health indicators as will be seen in subsequent chapters in this brief. An overview of the funding trends indicates a significant increase in the health funds especially from external sources, although these funding increases do not take into account the increase in population, escalating costs of providing care- in part due to the adaptation of new and expensive medical products and technologies.

At the implementation level, funding for health programs remains low than required. Further, the poor disbursement of funds and Push system of disbursing drugs and equipment to the operational levels and the marked inefficiencies in the use of available funds pose an additional challenge. The public has demonstrated its willingness to pay for services (see deliveries in private health facilities) by participating in the non- state service provision networks by means of private insurance and out of pocket payments.

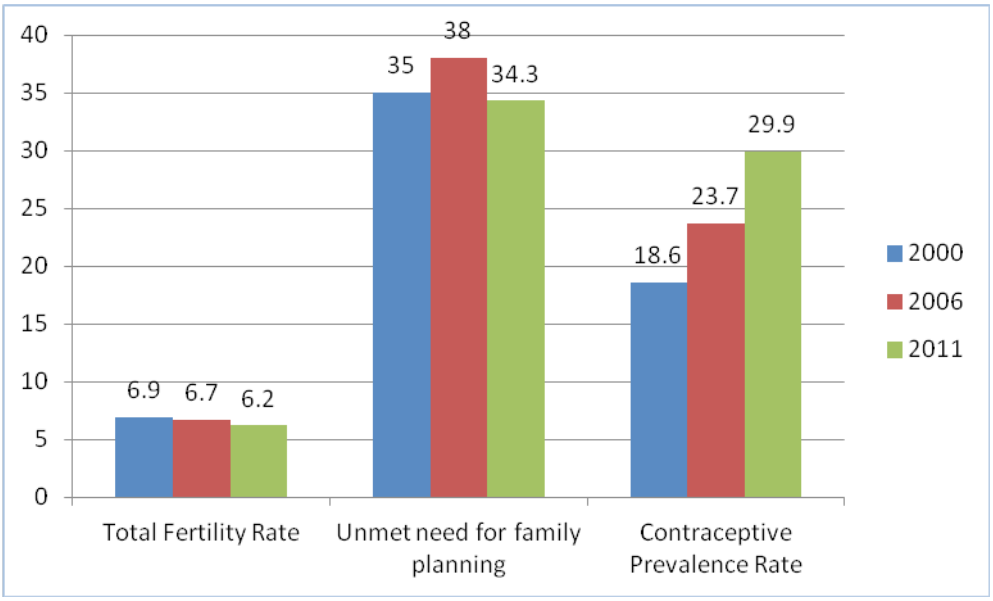
Uganda has benefited from significant amount of external health development assistance. Available evidence shows that more and more of it is being channeled through off- budget arrangements and used by non-state agencies.

3.0 REPRODUCTIVE HEALTH COMMODITIES

Availability of commodities contributes to meeting the need for reproductive health in Uganda. However, subsequent Annual Health Sector Performance Reports have indicated poor performance of the indicator on proportion of facilities with Stock out of essential medicines, including reproductive health commodities.

Improving family planning use and access in the country is highlighted in the National Development Plan 2010/11- 2014/15. The NDP acknowledges that limited access to and utilization of family planning services hinders overall development of the society and of women in particular. One of the goals outlined in the plan is to reduce unmet need for family planning by ensuring access to family planning services, especially in the rural areas. Further, the 2008 National Population Policy urges special emphasis on family planning and reproductive commodity security, including use of contraceptives (MFPED, 2008). In addition, some of the strategies in the Health Sector Strategic and Investment Plan (2010/11-2014/15) are geared towards improvement of overall sexual and reproductive health and rights of the population. Goals include provision of integrated family planning services in all health facilities at all levels, procurement and distribution of contraceptives to men and women of reproductive age, and design of programs to engage men in family planning services and use. However, budget constraints serve as a major impediment to these interventions.

Figure 1: Total Fertility Rate, Contraceptive Prevalence Rate and Unmet need for Family Planning in Uganda 2000-2011



According to Uganda Demographic and Health Survey 2011, the unmet need for family planning remains currently high at 34.3%, as government's target in the Health Sector Strategic and Investment Plan is to reduce the unmet need for family planning in Uganda to 20% by 2015. While contraceptive prevalence rate (CPR) for modern methods remains low at 29.9% with minimal increases, below the HSSIP target of 35% in 2015. Contraceptive supplies play a big role in meeting unmet need. In Uganda if all women could access contraceptives leading to reduction of unmet need to below 5%, the CPR would require going up to 65%.

A Ugandan woman would bear an average of 6.2 children in her lifetime if her fertility were to remain constant at current levels as indicated in the figure 1 above. This represents a decrease of 0.5 children in the 5 years since 2006, when the Total Fertility Rate (TFR) was 6.7 births per woman. It should be noted that fertility is significantly higher among rural than urban areas (less than 20%), the low urban fertility has only minimal impact on fertility for the country as a whole.

In regard to accessibility of health commodities, there is a universal awareness about at least one method of contraception. In addition, 3 in 10 currently married women are using a method of family planning, with 26% using modern methods (UDHS, 2011).

The use of modern methods of family planning has consistently increased over the past decade, growing from 14% of currently married women in 2000/1 to 26% in 2011. The government remains the major provider of contraceptive methods for nearly half of the users of modern contraceptive methods (47%) (UDHS, 2011)

About 34% of currently married women have an unmet need for family planning services, with 21% in need of spacing and 14% in need of limiting

3.1 PERFORMANCE INDICATORS FOR REPRODUCTIVE HEALTH SERVICES

Reproductive health services include attention to the issues of family planning, STD prevention and management and prevention of maternal and perinatal mortality and morbidity. Reproductive health should also address issues such as harmful practices, unwanted pregnancy, unsafe abortion, reproductive tract infections including sexually transmitted diseases and HIV/AIDS, gender-based violence, infertility, malnutrition and anaemia, and reproductive tract cancers.

Appropriate services must be accessible user friendly to different age groups and they include; information, education, counseling, prevention, detection and management of health problems, care and rehabilitation.

Table 1: Performance of the Health Service Delivery indicators -2010/11

Indicator	Baseline 2009/10	NDP Target	Annual HSSIP Target 2010/11	Achievement 2010/11	Performance Trend from HSSIP baseline
% of pregnant women attending 4 ANC Sessions	47%	60%	50%	32%	Reversal
% of deliveries in Health facilities	33%	35%	40%	39%	Improving
% of children under one year immunized with 3rd dose pentavalent vaccine	76%	90%	80%	90%	Positive trend
% of health facilities without stock outs of any of the 6 tracer medicines in the previous 6 months	41%	28%	50%	47%	Positive
% of approved posts filled by trained health workers	56%	56%	60%	56%	Static

Source: Annual Health Sector Performance Report, 2011

An important component of efforts to reduce the health risks of mothers and children is increasing the proportion of babies delivered under the supervision of health professionals. Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may cause death or serious illness to either the mother or the baby or both. 95% of mothers receive antenatal care from skilled service providers, however, this has not changed since 2006 (UDHS, 2011). This justifies the need to finance adequately the health sector to be able to provide the required human resource to reduce the health risks of mothers and children. However, the level of staffing with trained health workers has continued to remain static at 56% and this is attributed to little or no recruitments taking place at the Local government level overtime.

The proportion of deliveries in health facilities improved from 33% in 2009/10 to 39% in 2010/11 as shown in table 1. The improvement in proportion of deliveries could be attributed to the increased supply of mama kits through the essential medicines kit as districts including hospitals no longer have to pay for mama kits at the National Medical Stores (NMS), as well as availability of other medicines and health supplies. Over a longer period of time, the percentage of births taking place in a health facility has increased in the last 5 years from 41% in 2006 to 57% in 2011 (UDHS, 2011). This has been attributed to the increased education levels of women and wealth. Of the 57% of births taking place in a health facility, 44% are delivered in the public sector health facility and 13% in a private sector facility. This also implies that 42% of deliveries in the last 5 years from 2006 took place at home. To reverse this trend, and have more mothers delivering in health facilities, investment in health infrastructure, human resource needs and improvement of health workers attitude towards patients' needs to be addressed.

The proportion of less than one year immunized with 3rd dose pentavalent vaccine increased from 76% in 2009/10 to 90% in 2010/11; and proportion of health facilities without stock outs of any of the 6 tracer medicines in the previous 6 months increased from 41% in 2009/10 to 47% in 2010/11. The shift from "pull" to a "push" system and re-introduction of the essential medicines kit contributed to the reduction in stock out of tracer medicines in 2010/11 compared to previous periods as shown in table 1. Further improvements have been realized in 2010/11 due to increased allocations to National Medical Stores and tracking of medicine distribution.

The marked increase in, under one year immunized with 3rd dose pentavalent vaccine could be attributed to the recent review of child days' implementation and focus on poorly performing districts, which included catch up immunization services.

The sector has recorded reversal trends recently in the proportion of pregnant women attending 4 ANC sessions from 47% in 2009/10 to 32% in 2010/11 as shown in table 1. This is in contrast to the increase in deliveries at health facilities, and is probably due to the relative effort and campaign on facility deliveries compared to ANC. In addition, failure to appreciate the importance of ANC by mothers remains a challenge. Therefore this needs to be investigated further to establish the causes of the reversal in trends to almost half of the expected target.

4.0 FINANCING FOR REPRODUCTIVE HEALTH COMMODITIES AND SERVICES

Health service delivery is financed by the government, private sources and development assistance under the sector wide arrangement.

The total public health expenditure per capita decreased from US$ 11.1 in 2009/10 to US$ 9.4 in 2010/11, mainly due to a decrease in external contributions which constituted 14% of total public heath expenditure in 2010/11, compared to 39% in the 3 preceding years as shown in table 2.

Table 2: Health Sector financing (Ushs Billion) unless stated otherwise

FY	GoU Funding	Donor projects	Total Budget	Per capita Public Health Expenditure (US$)	Public Health Exp as % of total Gov't Expenditure	Off-Budget Donor support
2007/08	277.36	141.12	418.48	8.4	9	155.00
2008/09	375.46	253.00	628.46	10.4	8.3	265.00
2009/10	435.80	301.80	737.60	11.1	9.6	440.00
2010/11	569.56	90.44	660.00	9.4	9.0	477.57
2011/12	598.60	206.10	804.70		8.9	65.47

Source: Annual Health Sector Performance Report, 2011

The government expenditure on health as percentage of total government expenditure is about 9%, as it has been for the last decade, below the Abuja target of 15% but on target for HSSIP 2010/11, which is 8.9%. External funding (both on and off budget) for the health sector surpasses government investment in the sector.

Figure 2: Health Sector financing (Ushs Billions)

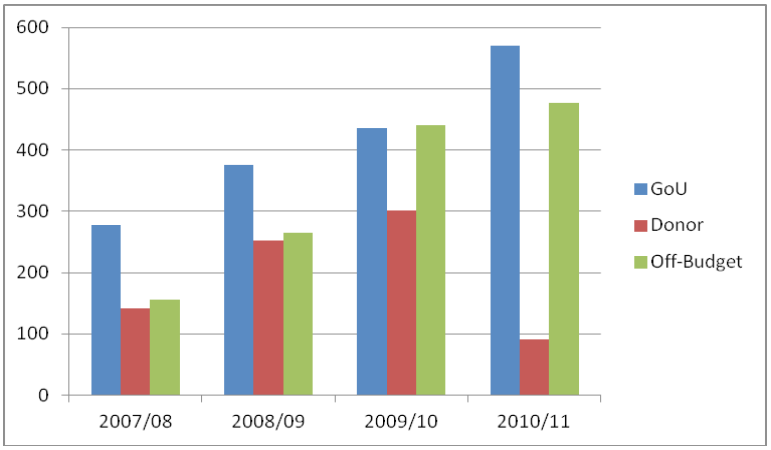


Figure 2 indicates that both government and off budget support from development partners have both been on the increase, while on budget donor support is on the decline from FY 2008/09. This suggests that external finance predictability is uncertain.

Poverty remains a major constraint, even when the poverty rate has fallen recently from 31.1% in 2006, to 28% in 2010, though out of pocket payments remains the highest source of expenditure for reproductive health commodities. The highest limiting factor discouraging women from accessing medical care is lack of financial resources to pay for the health service (UDHS, 2011). This implies that people attach better services to pay services especially those offered by the private sector. Health care services in the public facilities needs to be stepped up significantly to enable more women access care.

Table 3: Reproductive Health Financing between Government of Uganda and Donors (Ushs Billions)

		2010/11	2011/12	2012/13
GoU	Commodities	1.5	7.8	7.8
	Activities	0.143	0.149	0.066
	Total GoU	1.643	7.949	7.866
Donors	Commodities	32.58	21.61	59.56
	Activities	1.872	3.757	8.079
	Total-Donor	34.452	25.367	67.639

Source: Ministry of Health Database

The government has increased the budget allocation for reproductive health commodities over years and could do more in order to realize the benefit of investing in reproductive health. However, government contribution remains dismal compared to donor/ development partner[3] contribution for financing reproductive health in Uganda as shown in table 3.

Figure 3: Sources of Financing Reproductive Health in Uganda

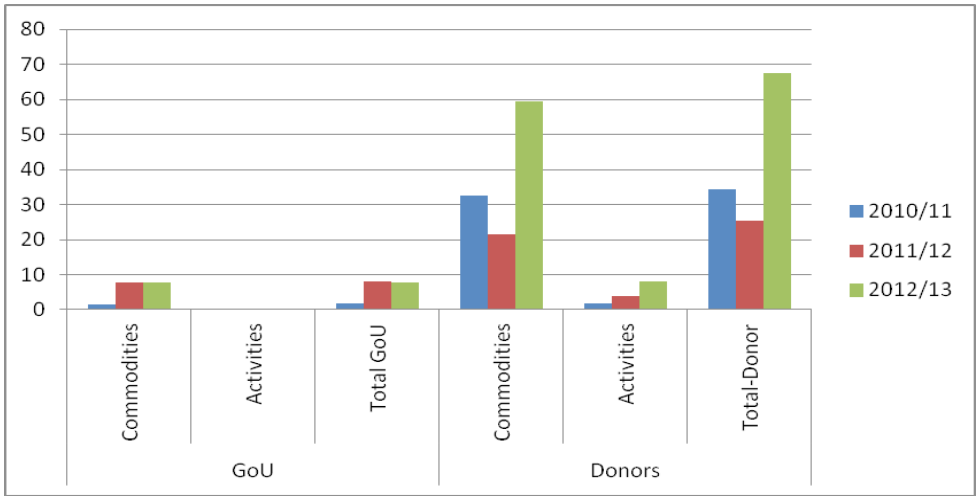


Figure 3 shows government of Uganda contribution towards reproductive health commodities and reproductive health activities compared to donor contributions respectively. Government of Uganda financing has significantly increased for reproductive health commodities since 2011/12. However, reproductive health activities remain neglected under government of Uganda financing modalities.

On the other hand figure 3 shows significant investment in reproductive health commodities and activities is undertaken by external financing. The implication of this is that external forces are likely to influence reproductive health agenda.

3 Development partners include the WorldBank, UNFPA and USAID

5.0 POLICY INTERVENTIONS FOR FINANCING REPRODUCTIVE HEALTH

A number of core interventions were identified to tackle the poor reproductive health indicators. Among them include scaling up focused antenatal care (FANC) including the provision of intermittent Preventive Treatment in pregnancy (IPTp); improving reproductive health logistics management, among others. However progress on the above and many others has been mixed as discussed in the previous sections of this brief. Therefore government should provide the necessary financial resources to

- Increase accessibility and availability of reproductive health commodities to all persons in the reproductive age group
- Reduce unmet need for family planning at all health units.
- Increase efforts to operationalise emergency Obstetric care services at all HC IIIs, IVs and hospitals
- Improve procurements of contraceptives in the government system and prevent compromising services at all levels
- Improve the human resources available (midwives, doctors and anesthetists) at districts for EmOC service provision
- Get rid of the Push system and allow the health centres to request for drugs and equipments which they need in high quantities, in order to reduce stock out in health facilities.

Among other recommended actions, the government and its developments partners need to:-

- Improve the timeliness of disbursements and predictability of funds to match the implementation schedules of reproductive health programs
- Improve the costing of policy decisions and service targets or expected coverage levels of vital programs like reproductive health, to ensure that financial mobilization and allocation are well aligned with performance expectations.
- Improve value for money through auditing of both on-budget and off-budget financing arrangements; and
- Expand the decision space for financial allocation at the operational levels so that financial resources are directed to overcome the major constraints in performance
- Carry out once in a while surprise inspection and supervisionto health facilities especially in the hard to reach areas. This will keep the health workers alert and more focused at addressing the clients/ patients' needs.

6.0 CONCLUSION

The core challenge of health governance in Uganda lies in achieving consensus and accountability when implementing health policies with the limited health care resources from the Government of Uganda. Since most health financing resources comes from external sources, power imbalances have arisen as Health Development initiatives increase in number, size and prescriptions. Country ownership is in balance, as guidelines from external funders become more influential in driving national policy matters, resource allocation and implementation of programs.

Vital regulatory functions are poorly resourced while the burden of regulation, oversight and supervision has expanded as evidenced from poor funding of reproductive activities. This is in addition to decentralization policy where the number of districts has increased from 56 to 113, doubling the burden for regulatory activities. The creation of new administrative structures threatens the service delivery effectiveness especially since the financial envelope has not been markedly expanded.

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This Policy is a joint effort of Ahead for World Bank Advocacy Coalition with support from:

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