DFID HEALTH RESOURCE CENTRE

Title: Reproductive Health Commodity Security Uganda country case study

Commissioned jointly by
The Department for International Development and the Netherlands Ministry of Foreign Affairs

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January 2006

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Title: RHCS Country Case Study: Uganda

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ABBREVIATIONS

CCM	Contraceptive Coordinating Committee
CPR	Contraceptive Prevalence Rate
CYP	Couple Years Protection
DANIDA	Danish International Development Agency
DCI	Development Cooperation of Ireland
DDHS	District Director of Health Services
DFID	Department for International Development (UK)
EmOC	Emergency Obstetric Care
FP	Family Planning
GFATM	Global Fund for Aids, TB and Malaria
GOU	Government of Uganda
HIV	Human Immuno Virus
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
IUD	Intra Uterine Device
JMS	Joint Medical Stores
JRM	Joint Review Mission
LAM	Lactational amenorrhoea
MMR	Maternal Mortality Rate
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MoU	Memorandum of Understanding
MVA	Manual Vacuum Aspiration
NDA	National Drug Authority
NGO	Non Governmental Organisation
NMS	National Medical Stores
PAF	Poverty Action Fund
PEAP	Poverty Eradication Action Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PNFP	Private Not-For-Profit
PSI	Population Services International
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHD	Reproductive Health Division
SIDA	Swedish International Development Agency
SWAP	Sector Wide Approach
TA	Technical Assistance
TFR	Total Fertility Rate
TORS	Terms of Reference
UDHS	Uganda Demographic Health Survey
UNFPA	United Nations Population Fund
UNMHCP	Uganda National Minimum Health Care Package
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Uganda has the highest total fertility rate in eastern and southern Africa with high rates of unmet need for contraception. The high maternal mortality rate is also of considerable concern. Despite this poor performance however the ***national policy environment*** is supportive of efforts to improve reproductive health and also accords high level focus to the role that commodity security plays within this. For example the Poverty Eradication Action Plan makes a clear link between reproductive health (RH) status and poverty, and a contraceptive method is used as one of the markers for monitoring drug stock outs. Strategies and targets to improve commodity security are followed through into the current Health Sector Strategic Plan and into sub-sector strategies for improving RH, and both RH and RH commodities have featured in high profile sector performance discussions between donors and the Government.

Despite the attention given to improved commodity security the ***financing, forecasting and procurement*** of RH commodities is still fragmented with contraceptives being procured and funded vertically, whilst drugs for safe motherhood are included in the national integrated procurement and financing arrangement. Currently, USAID and UNFPA procure approximately two-thirds of the annual public sector contraceptive requirements through parallel arrangements. MoH also has a budget for contraceptives but execution has been poor despite it being a Poverty Action Fund line which should in theory protect it from in-year cuts and ensure better monitoring. It is a particular source of concern to donors that this is not happening in practice. Reliance on donor funding is therefore crucial. Up to the present time, donor and MOH funding has been sufficient to meet 100 percent of annual contraceptive requirements, but the level of funding needed will increase over time and donor funding is not guaranteed.

The national ***distribution*** system channels both contraceptives, and other RH commodities alongside other drug supplies, through National Medical Stores. The change to a 'pull' based ordering system has aimed to reduce wastage but the system is undermined by weak capacity in facilities, which has prompted coordinated TA efforts to carry out training and logistical support. TA has been essential in the development of all aspects of the logistics system with DFID and DELIVER, working with UNFPA, providing vital support. As some of these initiatives end or refocus UNFPA will need to take on more of these roles and offer further logistical and strategic support. The Reproductive Health Commodity Security Group has been key to promoting donor coordinated support and helping to streamline the forecasting, procurement and distribution system.

Various ***strategies to strengthen procurement, financing and supply systems*** have contributed towards improving commodity security. There has been considerable joint donor focus on improving the performance of National Medical Stores, and as part of this the integration of RH commodities into the national pull-based distribution system has helped to create a much more coherent and manageable ordering system which can better respond to integrated service delivery at district level and below. Serious capacity issues remain in its implementation but high utilisation of budget allocations suggest that considerable progress has been made. In support of this technical assistance with the forecasting, procurement management and logistics cycle has been essential, as has joint working by donor, the Reproductive Health Division and National Medical Stores. The formalisation of the RHCS group will underpin this improved coordination. Wider changes in the

health system have also been important for commodity security., including investments in the Health management information system and more reliable payments to staff.

Despite these initiatives, there are still systems issues remaining in attaining better commodity security. Whilst the national level policy environment is supportive of systems improvements the decentralised implementation environment coupled with low capacity at district level means that the translation of national policy and sub-sector strategy into concrete actions plans cannot be guaranteed. Moreover at national level it is not clear how much real meaning there is in the RHD budget which appears to be allocated for commodity procurement, but in reality has been significantly underspent despite special agreements between GoU and donors which should ensure execution.

Part of the reason for this situation may lie in the way that ***international support*** is channelled to the Uganda health sector. Current financing arrangements may be squeezing out funds for RH as hard budget ceilings imposed by the Ministry of Finance and Economic Development mean that significant funding from global funds cannot be additional but end up replacing other allocations. In this aid environment the comparative predictability of donor funding becomes more attractive than budget support to RHD. This orientates RHD and donor behaviour towards retaining parallel funding arrangements for commodity procurement. However this type of donor assistance comes at a price as MoH has to manage the burden of fitting in with donor systems rather than the other way round, adding to the workload of the RH Division which is already low in capacity.

Regardless of the form of financial support for commodity procurement, logistic support by donors will continue to be necessary. The RHCS Group will also play a key function at both an operational and more strategic level.

There are a number of opportunities for ***improving commodity security***, but the context for achieving this is problematic. People receive contradictory messages about family planning and social and economic factors encourage large family sizes especially in rural areas. Also despite fairly favourable policy statements, the political will at national level to really impact on RH is questionable. Persistently poor maternal mortality figures and low rates of family planning uptake have been cited by many interviewees during the field work for this study as evidence that there is insufficient commitment within MoH to really tackling these and other RH problems, including commodity security.

Despite this difficult environment however there are opportunities and initiatives that could impact positively on RHCS including the work of the Family Planning Revitalisation Committee, mobilising the support of high profile advocates of family planning and maximising the potential of the private sector to contribute to service delivery.

1. COUNTRY CONTEXT

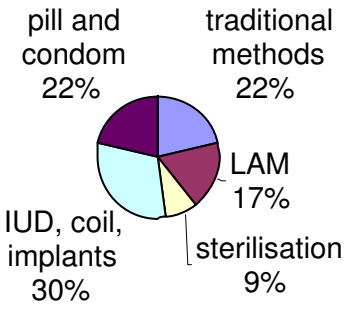
1.1. Reproductive Health Commodity demand and sources of supply.

Uganda has the highest total fertility rate in eastern and southern Africa. The 2000 – 2001 Uganda Demographic Health Survey (UDHS) indicated a Total Fertility Rate (TFR) of 6.9 children per woman, similar to that obtained from the 1995 UDHS. Indeed there had been no significant change in the fertility level in the preceding 20 years, nor is there expected to be one recorded in the next UDHS which is due shortly. Two thirds of Ugandan women have had a child by the age of 20 and the Contraceptive Prevalence Rate (CPR) is low at 23% which is below the minimum needed to impact on fertility. The stated preference fertility rate is estimated at 5.3, which is also high.

The UDHS calculated unmet need among married women as 35% (28% among all women). Although the reasons behind this high figure have not been qualified, one can assume that some of the reasons for non-use of contraceptives among all married women apply to this group, namely; opposition to use, lack of knowledge and significant concern about side effects. Interestingly lack of access and cost are reported as relatively minor reasons for non-use.

Implants, IUDs, and coils are the overall preferred methods of contraception, with Depo-Provera as the single most popular method.

Figure 1 Method use among currently married women using contraceptives[1]



Most women obtain their contraception from the non-state sector. In 2001 only 36% of users were obtaining their supplies from the government sector, and the proportion of those obtaining pills, injectables and condoms from the state, had declined since

[1] Uganda Demographic and Health Survey 2000 – 2001, Uganda Bureau of Statistics, December 2001

1995 as the population grew but usage did not; however the government continued to provide the majority of female sterilisations. Family Planning revitalisation efforts are expected to increase demand from the public sector; the MoH broadly estimating increases of 2.5 -5% for 2005 – 06 on demand from the preceding year. This includes an increase in demand for IUDs and implants and long term methods, though it is expected that limitations in the government system will cap growth[2]. Social marketing plays an important role in commodity provision. For example in 2004 Population Services International (PSI) estimated that their market share as approximately 64% of pills and 65% of depo provera.

The persistently high rate of maternal mortality (505 per 100,000 in 2002/3) is of particular concern to policy makers, service implementers and the donor community. Despite the abolition of user fees, which produced a temporary improvement, the proportion of deliveries conducted in health facilities has declined from 25.2% in 1999 to 20% in 2002/3. In part this is attributable to poor equipment, lack of qualified staffing and the way that women are treated once they are admitted. A shortage of drugs and basic small equipment is also known to deter women from attending a clinic.

1.2. National policy and strategy structures

1.2.1 Linking RH and poverty

The current Ugandan **Poverty Eradication Action Plan** 2004/5 – 2007/8 (PEAP) makes a clear link between RH status and poverty in that it recognises that the high TFR contributes to poverty and needs to be addressed. The PEAP acknowledges that "the very large families that have been observed over the years in Uganda are now becoming an impediment to the speed of economic growth and social and structural transformation[3]" and in response to this, and the fact that "many people, particularly women, would like smaller families" proposes a focus on improving family planning services to make them more accessible and attractive to the population. The PEAP anticipates that "per capita growth will be accelerated if Uganda enters the demographic transition by achieving smaller family sizes.[4]"

In addressing the importance of reproductive health (RH), the PEAP acknowledges the role of commodities including the part that a shortage of supplies has to play in deterring access to maternity services. Contained within the priority actions stated in the PEAP are the provision of additional reproductive health commodities, specifically ensuring free essential drugs and supplies for all pregnant women, and providing family planning supplies for 3 million couples per year. The PEAP also aims to strengthen delivery and Emergency Obstetric Care (EmOC) services in all facilities, which implies reliable supplies aimed at an increase in facility based deliveries from 24.4% (baseline in 02/03) to 50% in 07/08. Improved family planning is also an indicator but there is no target or baseline. However the PEAP also recognises the limitations on achieving these targets, in particular financing adequate maternal health services within a projected envelope of approximately $10 per head by 2014-

[2] Poverty Eradication Action Plan (2004/5-2007/8), Ministry of Finance, Planning and Economic Development, 2004 p 7
[3] ibid, p 7
[4] ibid, p xvi

15. Depo-Provera is also used as a marker drug for evaluating stockouts, which acknowledges its position as the most favoured form of contraception.

1.2.2 Health Policy, the Sector Strategic Plan and reproductive health

Commodity security is acknowledged as a key part of achieving better RH status. RH in turn is a government priority programme.

The ***Health Policy (1999)*** acknowledges the importance of drugs and other essential supplies as part of ensuring a network of functional, efficient and sustainable health infrastructure for effective health care. It also identifies essential ante-natal and obstetric care, family planning and adolescent reproductive health as part of the Uganda National Minimum Health Care Package (UNMHCP).

Specifically in support of addressing population growth the ***National Advocacy strategy in support of RH, population and development programmes*** (2005 – 2009), a multi-sectoral document produced by the Population Secretariat, aims to help increase commitment to and support for population and development issues including reproductive health. The role of various players is identified including MoH, and although commodity security is not mentioned directly the document does provide a framework in which it is an essential part of addressing the focal areas.

The undertakings in the PEAP and Health Policy are carried through into the ***Health Sector Strategic Plan 05/06 – 09/10*** The high unmet need for family planning and EmOC is acknowledged, as is the high TFR. These are translated into specific targets, reducing the unmet need for emergency obstetric care from 86% to 40%, and increasing the CPR from 23% to 40% (increase Couple Years Protection from 223,686 per annum to 500,000 per annum). RH commodities are mentioned obliquely: under 'core interventions for sexual and reproductive health and rights' there is reference to provision of family planning 'with special emphasis on improving logistics' though this is not tied in with the initiatives detailed separately for the improvement of procurement and management of essential medicines and health supplies. Here the issue of supply security is addressed more directly, with an overall objective of ensuring 'the availability of adequate or good quality essential medicine and health supplies required for delivery of the UNMHCP at all levels of the health care delivery system'. Of the four specific objectives the second one is likely to have the most direct impact on family planning supplies because it proposes the integration of all procurement, financing and logistics systems including any third party contributions (i.e. most family planning commodities).

1.2.3 The National Reproductive Health Strategy and commodities

At sub-sector level the ***Strategy to Improve Reproductive Health in Uganda 2005 – 2010 (July 2004)*** produced by the Reproductive Health Division (RHD) in MoH, clearly acknowledges the role of commodity security in attaining better RH status. It states the aim of reducing Maternal Mortality Rate (MMR) from 505 to 408/100,000 live births (note that the PEAP target is more ambitious) through improved access to RH services, notably family planning and EmOC. The need to address commodity security is identified under all three objectives of increasing access to institutional deliveries and EmOC, strengthening family planning service provision and implementing goal oriented ante-natal care. There is the need to improve logistics management for RH commodities, reduce contraceptive stockouts, ensure that drug,

lab tests and other supplies are available for antenatal care visits, ensure that health facilities are using the pull system of drug ordering, monitor stock status at all levels, provide training in logistics management at all levels, and conduct annual national forecasting based on HMIS data.

The ***National Family Planning Advocacy Strategy 2005 – 2010*** (March 2005), again developed by the Reproductive Health Division (RHD), identifies the availability of commodities and supplies as a key issue for sustaining services and states a number of advocacy objectives, strategies and concrete action points to be addressed although, as with the RH strategy these are not supported by indicator baselines or targets.

1.2.4 Costing the RH programme

During the implementation of the first Health Sector Strategic Plan (HSSP I), the health sector has received a modest increase in funding. However within this, and between 1999 – 2003 there has been a significant realignment towards primary health care, from only 5% of overall health spending going to primary health care in 1997/98 to 42% in 2003.

Within the primary health care spend, it is not possible to say to what extent budgets and expenditures on RH have increased. RH is not costed as a separate programme within the sector plan because service delivery and budgeting is decentralised and because of the increasing integration of services at district level and below. This is one of the reasons that an RH tracking study is under consideration, to gain a better understanding of expenditures. It is however easier to identify expenditure on some commodities as will be discussed in section 1.4.1.

1.2.5 Monitoring RH and RHCS

MoH conducts quarterly monitoring of the performance of the health sector at district level and within this includes RH. This involves assessing workplan implementation, service delivery outputs against targets, and budget performance and compliance with national guidelines. In addition, MoH holds quarterly workplan review meeting to assess implementation of central level workplans.

The fact that Depo-Provera is one of 6 indicator drugs for facility stock outs in the new PEAP gives RH commodity security an important profile. In practice, monitoring of stock levels is problematic due to irregular stock recording at facility level. The last annual health sector performance report (2004) found that reports on stock outs for indicator drugs were found to be erroneous at health unit, health sub-district and district levels due to incomplete reporting by health units, denominator problems and aggregation errors. The report also noted only 75% of stock cards were available for review.

On a more regular basis, commodity availability at the national stores is monitored by RHD with information provided by the NMS.

The annual review process in October involves a joint review by government and donors, of the report compiled by MoH on the previous year's performance. Every second year this follows a National Health Assembly in which district representatives and other stakeholders make resolutions on improving sector performance.

The high MMR and TFR, coupled with the low CPR has ensured that RH has consistently been identified as a source of concern during the annual reviews, and as part of this, the issue of commodity security has also been raised. For example the HSSP high profile mid term review of 2003 highlighted commodity stock outs as acting negatively on maternal mortality, and the shortages of contraceptives as contributing to low levels of FP usage. In the National Health Assembly of 2004, the 'Opening Donor Statement' highlighted concern over the high fertility rate and population growth, emphasising the need for political backing to address maternal mortality, and expressed concern that earmarked funds from global initiatives might squeeze out funding for RH or other priorities. There was also a specific resolution by the assembly as a whole that district health managers should prioritise the procurement of RH supplies.

1.2.6 Translating the national agenda into district priorities

One of the main challenges to ensuring commodity security and promoting a demand for family planning that will create greater concern for a reliable supply chain, is the problem of translating the national RH agenda into concrete action at district level. As a result of decentralisation, responsibility for service delivery now lies predominantly with health sub-districts under the overall direction of the District Director of Health Services. However districts face major challenges of very limited resources and a shortage of staff which severely limit their capacity to respond. At the same time, MoH is still growing into its role as policy formulator, standard setter, quality assurer, technical supporter, monitor and evaluator in the face of its own resource constraints and staff shortages. Moreover the scope given to Districts for resource allocation does not guarantee a match with national priorities despite the standards that have to be met and the ring fencing of the conditional grants. This means that insufficient priority may be given to family planning services. The recently introduced league table for district performance against national priorities is intended to help promote standards and improve performance consistency across the country.

Specifically with regard to commodity security, the 'pull' system of drug ordering (see section 1.4.3) is designed to minimise wastage and improve stock control, but it is dependent on local capacity to order and be motivated to be active in supply management, plus adequate supervision and monitoring.

1.2.7 Working groups on reproductive health commodities

Whilst there is a national working group on drug procurement and management this meets rather irregularly and in practice the coordination of RH commodity security procurement and funding is done by the Reproductive Health Commodity Security Group. Up until the middle of 2005 this was an informal gathering, but there is now the intention to ensure continued representation even if individuals move on from their posts. The meeting is chaired by the Reproductive Health Division in MoH, and attended by representatives of National Medical Stores (NMS), the USAID funded DELIVER project, DFID who have a Technical cooperation officer placed with RHD and who provide budget support, and UNFPA. The group aims to monitor the performance of the pull system and take corrective action, and improve forecasting and procurement. The current NMS inventory is regularly reviewed to update knowledge of stock status, distribution problems and their solutions are discussed, and there is planning of future procurement needs. The Group also promotes

coordination between donors, MoH and NMS. The group initially just focused on contraceptives but recently expanded its remit to include all RH supplies.

A further body which has a potential impact on commodity supplies and their security is the Family Planning Revitalisation Working Group. Started in 2005 it aims to mobilise support around improving demand for family planning. It is convened by the Population Secretariat and a wide range of government, non-governmental and political stakeholders attend.

1.3 National policy making, strategy development and co-ordination process

1.3.1 The SWAp context

Uganda has had a Sector Wide Approach since the implementation of the first Health Sector Strategy Plan in 2000. The position of RH and reproductive health commodity security (RHCS) within this document is discussed in section 1.2.3. The strategy provides a meaningful focus for policy and implementation discussion and is the umbrella under which all government priorities and donor support are discussed. Within this, RH (and also commodity security) is one of many programmes to be negotiated, although it is one of the HSSP priorities. Challenges remain in translating the strategy into meaningful work plans for MoH, ensuring priorities are carried through to district level, and managing the variety of funding modalities from donors and the global funds.

High level government and donor policy negotiation and implementation strategy is managed through various fora, including the Health Policy Advisory Committee (HPAC) which meets at least quarterly, and the joint review mission (JRM) in October. This is supplemented by the National Health Assembly held every second year and a Technical Review Meeting every April. Included in these are other stakeholders, notably representatives of the Private Not-For-Profit (PNFP) which plays a major role in service delivery nationwide, being responsible for approximately 25 – 35% of outputs. RH and commodity security have featured in these high profile discussions as mentioned in section 1.2.5. The Health Development Partners Group also meets regularly as a forum for donors to coordinate amongst themselves. In addition, there are various working groups, especially around the time of the JRM, which meet on specific issues, in particular the Sector Working Group which meets at least every six months to formulate and oversee implementation of policies relating to health financing issues.

GoU is clearly attempting to harness all resources in the sector, both financial and technical, in support of HSSP. The current version of the Memorandum of Understanding (MoU) in support of the current strategic plan (HSSP 2 2005 – 2010) lays out the obligations of both parties in regard to cooperation, financing, planning, monitoring, procurement, TA, collaboration with the private sector, and resolution of disputes. This document makes strong statements about ensuring annual increases to the government health budget, the need for partners to synchronise their programming cycles to those of Government of Uganda (GoU), and progression towards using government procurement procedures; it also clearly states that GoU's preferred funding modality is direct budget support. In practice however the SWAp remains a 'broad church' in that several donors continue to provide parallel financing and use their own procurement processes. Moreover there has been a recent

significant increase in project funding to the health sector through Global Health Partnerships and other major health initiatives such as PEPFAR.

1.3.2 Funding the SWAp

As a result of the SWAp and the efforts to channel donor aid through budget support, MoH prepares a central annual plan and budget for joint review which encompasses all MoH programmes including RH. District planning is done separately although MoH does have an obligation stated in the MoU to ensure that district plans are consistent with the HSSP; donors are meant to negotiate all new district programmes or initiatives with MoH before going to the districts, and are meant to ensure that their activities are included in district plans. The reason for this is to ensure that district planning is coherent, and all sector contributions are included in either the district or national budgets.

Those donors supplementing the government budget do so through largely through the Poverty Action Fund (PAF) which is the main conduit for budget support and debt relief funding. The Poverty Action Fund was set up in 1997 to provide a mechanism for strengthening the pro-poor orientation of the budget. It is a "virtual fund" in that PAF resources are part of general government budget resources and therefore an integral part of GOU expenditures; however the budget lines are expected to be protected and immune from cuts and there is meant to be greater transparency on their reporting and monitoring although this has not always been the case in practice (see section 1.4.1). The PAF consists of a subset of the GOU budget which is considered to contribute directly to poverty reduction in line with the PEAP and include primary health care. In FY02/03, the PAF allocations represented 67% of the health sector budget (although outturns were lower than this) and were channelled to both central and district budget lines. Despite these allocations, approximately only 30% of the planned UNMHCP is funded, which indicates a very significant gap in service delivery.

1.4 Funding, procurement and distribution

Financing, forecasting and procurement of contraceptives, except for condoms, is coordinated by the RHD. The contraceptives include pills, injectables, implants, and IUDs. Condom forecasting and procurement is managed separately by the AIDS Control Programme (ACP). The public sector condom supplies are distributed through the NMS to health facilities and other recipients such as the Army and Police. Condoms are ordered by facilities through the pull system under the section for contraceptives. These condoms can be used by FP clinics or distributed through STI/HIVclinics of a health facility.

There have been major problems with condom supplies procurement over the last year (see Box 1) which have impacted on availability for family planning. The Engabu brand, which was withdrawn for quality reasons, is the free public sector condom for FP and HIV/AIDS. There is little linkage between the work of RHD on RH commodity security and with the HIV programme; in practice, the DELIVER project offers the best connection because of its logistical support to both areas.

RH drugs for maternity and delivery are part of the essential drugs list and are therefore funded, forecasted and procured through the pharmacy division in MoH with NMS acting as procurement agent.

Distribution of RH commodities is more coherent. Contraceptives, RH drugs and family planning condoms for public service use are issued through the national distribution system managed by NMS. Social marketing organisations and NGOs obtain their supplies from the government's National Medical Stores, Joint Medical Stores (JMS) which is the non-government Catholic equivalent of NMS, or through their own procurement arrangements.

Box 1 The condom situation: an example of commodity insecurity

Under the HIV programme, MoH uses World Bank funds to procure condoms according to WB rules. Other condom supplies are provided by USAID and with the support of the Global fund. Condoms are both given away free (Engabu brand) or sold through social marketing initiatives. However the availability of condoms has been hit by the problems in the last year: Uganda, a country which has had internationally acclaimed success in its HIV programming of which condom distribution was an essential part, now has a major condom crisis. In late 2004 the Engabu brand was found to have faults in some of the batches and therefore the government withdrew them from its system with the result that there has been a shortage until early 2005. DFID, SIDA, DANIDA and DCI (Ireland) stepped in with emergency resources to purchase 20 million condoms which are now being distributed. This, plus a recently approved procurement by USAID of 34 million condoms (23 million for public sector, 11 million for social marketing) should cover the minimum requirement of 5 million condoms used per month up until December 2005 UNAIDS.

However longer term problems remain. Although the Global Fund order of 76 million condoms (55 for the public sector, 21 million for social marketing) had gone ahead prior to the current suspension after an audit, there are concerns that delivery to Uganda may be affected. In response UNAIDS has strongly advised GoU "to develop a long term strategy to ensure that condoms are procured and distributed on a timely basis". UNAIDS also expressed concern that the government's plan to now carry out quality checks on import is very slow and will further delay disbursement of condoms already arrived in Uganda.

1.4.1 Funding of commodities

Although funding for RH commodities is complicated and comes from various sources it is to the credit of the distribution and ordering system that from the point of view of the districts it looks coherent when obtaining supplies through one ordering process. Essentially there is a mix of decentralised funding for drugs (including RH drugs) and vertical funding for contraceptives.

Decentralised funding for drugs, (including drugs for maternal health care), is allocated to the districts through the PAF funded conditional cash grants plus a central credit line arrangement which consolidates central funds from various sources. This is supplemented by a DANIDA grant which is pooled with government

money in a separate account which is earmarked specifically for drugs. Credit lines are then are held at NMS against each district (they are effectively a drug budget for each district against which each can draw) with the corresponding amounts indicated in the district budgets and are calculated using the same equity formula for district grant allocations so they therefore have some sensitivity to population and poverty levels. As districts order supplies, the amounts are deducted from their credit lines at NMS who in turn are reimbursed from the MoH/DANIDA account. The funds can therefore only be used for drugs, thereby offering protection and generating consistently high utilisation rates (more than 75% in all cases in 2003/04 with the exception of one hospital). In contrast in the same year there was a marked under-spending of the conditional grants for medicines with less than 50% of indicative cash budgets spent at NMS and / or JMS; this despite the guidelines on conditional grant usage which preclude spending this budget on other items. It is not clear whether these funds not spent on government drugs were used for drugs in the private sector, spent on items other than medicines or simply not spent at all.

Contraceptives are funded vertically and are not included in this pooling a budget for RH and RH Supplies out of which it procures commodities (this was done for the first time in 2002), and these are then available for the districts to order free of charge. This MoH budget is a PAF line. As a result it should be afforded various benefits, firstly that it should be protected from in-year budget cuts in favour of other budget lines, and secondly that PAF expenditures are subject to much more rigorous reporting and monitoring to ensure that the funds are spent as planned. In practice however the budget has been progressively under-spent, by about 50% in the last financial year. The reasons for this are not clear but it is a source of concern to donors who have been pushing MoH for an explanation. This issue is further discussed in section 2.1

One reason for poor expenditure might be the difficulties that RHD has in linking its procurement with resource availability. Unlike the MoH/DANIDA account this budget does not roll over from one financial year to another. Allocations to the RH and RH Supplies budget line become available month by month, a system suitable for supporting running costs but more problematic for gathering together the funds needed to demonstrate that international orders can be paid for. The Government usually only amasses sufficient funds for the necessary order size in June each year, the last month of the government financial year. Any uncommitted or unspent funds held by RHD at the end of June are returned, so timely procurement within that narrow window is essential. In this respect, procurement of contraceptives is less secure than for other drugs in the DANIDA/MOH pool..

In addition to the government allocations for contraceptives, RHD still relies upon a variety of external sources for funding contraceptives. A Contraceptive Co-ordinating Committee (CCM) meets to discuss requirements and for donors to decide who funds what. Although pooling donors are increasingly taking an interest and participating in the CCM, it is USAID and UNFPA who have continued to provide the funding. These funds are diverse and complex to manage due to the fact that neither donor pool their aid or use government procurement systems. This is despite the stated aim of GoU (at least on paper, in the HSSP MoU) to direct as much support as possible through its budget. However these donor contributions are effectively off-budget which makes it difficult for GoU to know what they are. Expenditure is reported retrospectively, if at all. Moreover disbursements for contraceptives do not necessarily match commitments, and sometimes expected contributions have not

materialised at all. As a result, the planning division was still trying to get accurate figures on inputs for 2004/5 from donors at the time of writing in September 05, 2.5 months after the end of the financial year. In summary RHD has to juggle different funding arrangements as well as operate within the central planning function which necessitates competing for funds alongside other programmes and advocating for RH funding to be a priority.

With regard to the total amount spent on RH commodities (approx USD 1million per year) MoH generally has contributed about 1/3rd, with the balance being met by USAID and / or UNFPA (about 1/3rd each). Although the proportions and amounts vary somewhat from year to year the trend over the last two years has been for increased contribution from USAID. With a high dependence on external support which is currently only programmed for a maximum of 2 years due to donor programming constraints, RHD has to shop round on an annual basis among its donors in order to mobilise support for various contraceptive commodities which results in a variation of the relative proportions supported by each donor Essentially RHD looks at what donors are willing to provide and then tries to fill the gaps with its own funds. Uncertainty over long term donor funding is a constant issue. For example UNFPA has been responsive to and supportive of country needs but has to confirm fund availability and negotiate funding procedures at HQ which increases uncertainty.

Not surprisingly there have been persistent problems with stock outs resulting in expensive emergency procurement by donors. Some stock outs are attributable to funding shortages, some to NDA regulatory issues and some because of forecasting difficulties (see next section). IUDs were stocked out March – July 2004, and Ovrette was stocked out Feb- Sept 2004 with the result that in June of that year USAID asked for an emergency shipment; batches duly arrived in Oct-Nov.

1.4.2 Procurement and Forecasting

UNFPA and USAID use their own procurement systems for contraceptives. This is despite GoU's intentions to streamline and integrate procurement. The Health Sector Strategic Plan 05/06 – 09/10 specifically states that third party procurement for all centrally procured items for nationwide distribution will be stopped and contributions channelled through the credit line facility, but there are no indications that this is going to be fully implemented by all contributing donors. MoH purchases its own funded commodities through National Medical Stores which acts as its procurement agent. RH drugs on the essential drugs list are also procured by NMS. Both donors and MoH are expected to meet the costs of verification (0.8%) and to ensure that drugs for import are registered in Uganda. They are also expected to meet distribution costs (10%) and fund storage if customs clearance procedures are delayed for one reason or another or import schedules have not been synchronised with NMS available space (e.g. UNFPA has had to pay for storage for 5 containers of condoms).

Forecasting for all public sector contraceptives is supported by the DELIVER project. To forecast requirements RHD and DELIVER rely on shipment data from contributing donors and NMS, bi-annual physical inventory reports obtained from NMS, consumption data from the Health Management Information System (HMIS), NGO reports and NMS issue reports, and MoH programme plans to inform possible changes in demand. Before the HMIS included contraceptive consumption data in its

HMIS, annual forecasting was based on the quantities of contraceptives issued to districts by National Medical Stores. Using this issues data does not provide as accurate a forecast as does consumption data (and stock on hand data) because the latter reflects what is actually given to clients, which is closer to actual demand than is issues data, which is what was given to a district. Now annual forecasting is primarily based on HMIS consumption data which is more accurate and supported by high reporting rates: 90% of facilities and 100% of districts. However there is still no data available regarding stock on hand in facilities, which is the other element required for calculating requirements. Forecasts must also take into account wastage and loss of a product. Leakage to the private sector is estimated at about 10% for 2005-06 for Lo-femenal and Microgynon (based upon independent retail audits), The possible impact of FP revitalisation efforts on contraceptive uptake is not known. Until recently there have been criticisms that UNFPA's procurement process has made it difficult to predict and plan for shipments. . There is no system in place for planning and forecasting of national requirements for RH kits (Tubal ligation, vasectomy, MVA etc.); this needs to be approached in a systematic fashion, in a similar manner tothe annual contraceptive forecasting exercise.

The formation of the RHCS Group has aimed to try to improve forecasting and support better procurement planning in order to avoid stocks outs, by bringing all the key players round the table to review stock levels, forecasts, procurement plans and shipment schedules.

1.4.3 Distribution

Despite the variety of funding arrangements, distribution for RHD contraceptives, including condoms for family planning, is done alongside essential drugs using a common system through National Medical Stores and down to districts. Districts also have the option of ordering maternal health care drugs (though not contraceptives) from the Joint Medical Stores which services the church and NGO sector (in turn, the church and NGO providers can also get supplies from NMS). Some commodities are distributed separately; for example UNFPA's periodic purchase of MVA kits in response to a needs assessment for emergency obstetric care, are still 'pushed' rather than 'pulled' (see below).

In 2003, distribution of health commodities shifted from a 'push' arrangement to a facility-based order 'pull' system, in which the facilities make the decisions about what to purchase, rather this this being determined at a higher level. There were concerns that pushing commodities down to districts was wasteful and it was difficult to get a sense of real demand. RH supplies were some of the first vertically funded and procured commodities to be integrated into this, in order to benefit from a more rational and cost effective process. Under the pull system, health facilities select the commodities they require, subject to approval by the Health Sub District (HSD) and District Director of Health Services (DDHS). The process is facilitated by a pre-printed order form and should be done according to a schedule which aims to enable NMS to meet all districts' needs in turn. Based on calculations of previous usage, facilities order according to their estimated need but for those that cannot make these estimates there are kits; they are discouraged from using this option unless really necessary, as correct ordering based on calculated usage gives more assurance that there will be no stock outs. However even with the use of the kits the system still relies on capacity at facility level to manage existing stock levels on an ongoing basis and to calculate orders and place them according to the national schedule. This

capacity does not exist everywhere which has prompted DELIVER, UNFPA and MoH to work together to support training. The successful roll out of this programme will be essential to making the pull system work effectively and increasing contraceptive availability at facilities.

Of the marker drugs for this study, the Uganda essential drugs list includes lidocaine, ferrous sulphate, folic acid and magnesium sulphate but exclude oxytocin, misoprosotol and MVA equipment (marker items for this study). They are available to order and are costed on the order form. There is a separate form for contraceptives which consists of male condoms, Depo-Provera, IUD, lofemenal, microgynon, norplant and ovrette; the form indicates that they will be supplied to the district at no cost.

After the order forms have been approved by the DDHS, they are sent to National Medical Stores to effect delivery. NMS delivers supplies to the district headquarters which then distributes the commodities to the various HSDs. Health sub-district credit accounts are charged with the order and the invoice sent to MoH for reimbursement on delivery to district headquarters.

1.5 Role of non-state providers

Social marketing plays a substantial role in distributing contraceptives. There are two NGOs which do social marketing in Uganda, namely Marie Stopes and PSI.

Marie Stopes International and Marie Stopes Uganda get funding from the same source (German Development Bank Kreditanstalt fur Weideraufbau.) but undertake different activities. Marie Stopes International (MSI) does social marketing of condoms under the HIV/AIDS Control Program. The organisation sends out 'health men' in 'Life Guard' branded vans to rarely reached rural areas to undertake sensitization on behavioural change communication, (an HIV/AIDS control approach emphasized by the government of Uganda) as well as sensitization on the right use of condoms. Condoms are then sold to communities at a subsidized rate mainly to cover some of the operational costs. MSI also issues STI treatment vouchers which enable clients to access full treatment in health facilities including private for profit, regardless of price; the balance is paid by MSI. MSI collaborates with MOH to share information on condom demand and utilization. Marie Stopes Uganda (MSU) operates established clinics for family planning services and also works at health facilities with operational theatres. Services are also provided at a very small fee aimed at recovering some of the operational costs. The health centres mobilise people while Marie Stopes comes well equipped to provide services such as tubalisation and vasectomy. This is done on a schedule in the various districts e.g. every third Thursday of the month.

PSI, funded by USAID, has a wider coverage of health programme activities including social marketing of family planning services, some of which are targeted to low income groups.

Joint Medical Stores (JMS), the only competitor to National Medical Stores is a Catholic Church based foundation. It does not stock contraceptives. Hence contraceptive stocking and distribution is undertaken solely by the National Medical Stores. JMS does stock other reproductive health commodities for safe delivery.

Although the private sector contributes greatly to reproductive health, the Government of Uganda does not recognise or acknowledge this fully. Many people make use of private clinics and pharmacies for reproductive health services and commodities despite the free services provided at the public health facilities. This is because private services are often perceived as being more friendly and consumer oriented, are more accessible in terms of distance to travel and associated costs, and because they are usually better stocked than government facilities. The private sector also puts emphasis on quality and cultivating trust in their clients.

Although more could be done to include the contribution of the private sector, it is invited to various fora to present experience and through this, has some influence on advocacy, strategies and policy. The Ministry of Finance Planning and Economic Development (MoFPED), through the Population Secretariat is in the process of developing a resource mobilisation strategy in which the private sector may be given a prominent role.

1.6 National drugs policy, legal and regulatory issues, and entry procedures

Uganda has a national drug policy which was issued in 2002. It aims to make essential drugs accessible for all those that need them by ensuring affordability and availability throughout the country. It also aims to ensure that all drugs available to the public are of an appropriate quality, safety and efficacy. There is also an essential drugs list which is used as the primary tool for drug selection at all levels of the heath system. The national ordering system is based on this list. As previously discussed, the marker RH drugs used for this study which are included on the list are lidocaine, ferrous sulphate, folic acid and magnesium sulphate but misoprosotol, oxytocin and MVA equipment, are excluded. The National Drug Authority controls regulation and registration, treating commodities for private and public sectors the same. Similarly branded drugs and generics go through the same process of registration. NDA generates its income from fees for drug regulation procedures such as verification of import, factory inspection and licenses for the private sector. Donor procuring and importing drugs and commodities, are - like MoH - expected to meet the cost of these charges and need to budget accordingly which has not always happened.

Internal quality control is being introduced; for example the World Bank is supporting in-country testing of condoms by provision of testing equipment. With regard to taxation, at the moment, drugs and condoms may enter Uganda tax free regardless of whether they are destined for the private or public sector, although an external tariff by the East African Community had been applied for the first 4 – 6 months of 2005. Some RH commodities were caught up in this with the result that either the additional funds for the tax had to be found or they had to remain outside the country. In the event the tax was temporarily suspended although it is expected to be back on the agenda for discussion.

2. KEY ISSUES

2.1. Strengthening procurement, financing and supply systems

Various strategies to address procurement, financing and supply systems have contributed towards improving commodity security.

Focusing on the performance of NMS has been an essential part of creating the capacity in Uganda to carry out international procurement, and improving supplies management. This has been the result of considerable support by donors, DANIDA in particular, and after several years of concern at their capacity, accountability and transparency. A technical review of NMS in 2004 identified the need for additional investments in working capital, warehousing, vehicles and technical support, to which DANIDA responded, and at the same time there have been efforts to streamline working arrangements between MoH and NMS. Although there have been estimates that NMS is only operating at about 60% capacity, there is evidence of improved performance.

The integration of RH commodities into the national pull-based distribution system, has been a major step towards improving the security of the supply chain because it has created a much more coherent and manageable ordering system and responded to integration of service delivery at district level and below, even though funding remains more fragmented. RH commodities were amongst the first to be incorporated into the new system with a resultant reduction in wastage although other problems have emerged such as districts failing to meet the ordering schedule and having stock outs as a result. Operating the new system requires capacity right down to HC2 level which is not yet there, although much needed training is underway. Health Sub Districts are stepping in to make orders on behalf of facilities that are perceived to have limited capacity to order but where this is done without consulting the health facilities the result may not necessarily be any more accurate. Although the system has been standardised, in practice there are still variations with health centres 'borrowing' supplies from each other, or some districts near Kampala just going straight to NMS to get supplies without following the system. However the high utilisation rates of the credit lines indicates a good response to the new system both by NMS and those ordering. There now needs to be a consolidation of these achievements supported by improved monitoring and supervision and adequate injections of finance at district level to enable, for example, better transportation of supplies rather than recourse to patient ambulances.

Technical assistance with the forecasting, procurement management and logistics cycle has been essential. Both the DELIVER project through its TA and the DFID Technical Cooperation Officer have played an important role both together and individually in supporting the Reproductive Health Division in these aspects of its work both in terms of technicalities and also in supplementing the limited capacity in RHD to be on top of the processes. RHD is short staffed with a multitude of tasks to perform which require a broader set of skills than are currently available.

Joint working by donors, RHD and NMS has been very important in promoting better coordination between various procurement and funding arrangements. The previous fragmented multi-donor financing mechanism has been replaced by a more 'joined up' approach with fewer donors and a single annual forecasting and planning exercise led by RHD. In the course of joint working the donors have also concentrated on being more proactive in problem solving without getting tied up with bureaucracy. This has been particularly important on the issue of stock outs. The RHCS group has a zero tolerance policy towards stock outs which means that it aims to anticipate problems and address them pre-emptively. In practice this has been difficult to do because achieving long term zero stocks is dependent on the system having greater capacity in all aspects. It is also dependent on the policy being taken

seriously by MoH, and these wider capacity problems being addressed. However the regular meetings of the group, common review of stock levels and other data, and increased emphasis of information sharing has certainly contributed towards an increased focus on commodity security.

Wider changes in the health system have been important for commodity security. Although problems remain with the HMIS it is now more reliable than it was thanks to considerable efforts in this area by GoU and donors. Also the fact that staff are being paid more reliably has increased their motivation to operate the distribution system properly. The ending of user fees in 2001 has had a major impact on attendance at outpatient health facilities which has stimulated drug usage and improved the quality of prescribing, as patients are relying less on poor prescribing practice from pharmacies. This should have an impact on RH contraceptive and drug consumption the impact of which may be apparent in the next UDHS.

Despite these initiatives, there are still systems issues remaining in attaining better commodity security.

Inadequate translation of national policy and sub-sector strategy into concrete actions plans undermines attempts to improve commodity security. The Sector Strategy and National Reproductive Health Strategy provide a basis on which to make concrete costed action plans at sub-sector level to address both RH and commodity security. During the Joint Review Mission in 2002 MoH had been asked to come up with the costed strategy for RH which it duly did in 2003. Annual workplans based on the strategy are now in place which are discussed and scrutinised jointly with donors. They have been fed into district level plans through district planning guidelines. However these plans need to be owned by districts where planning and implementation capacity is low and where RH may not be a priority. The capacity of RHD to support district level implementation and encourage RH to be seen as a priority is limited. The Family Planning Advocacy and RH Communications Strategies are both part of a wider effort to strengthen FP and RH and to build commitment and understanding at district level.

It is not clear how much meaning there is in the RHD budgets. As discussed in section 1.4.1 there was very poor budget execution of the RH and commodity budget last year with a less than 50% outturn. Accounts have varied about why this was so low, including suggestions that it was 'not a real budget in the first place', to the money having to be returned because it was underspent – this despite a clear need for it (see section 2.2 below for further discussion of this problem). It is of concern that there is no transparency and common understanding about the 'cut' particularly because that commodity budget is within the PAF which should afford it a greater degree of protection and monitoring and ensure its execution. Donors have expressed their displeasure at both the poor outturn as well as the lack of a coherent reason for it. In addition to this there is no agreement on what the money would have been spent on had it been available. This suggests that there not a strong little link between procurement, activities and budgets and outputs, despite the close relationship between RHD and its donors and the annual process of reviewing RHD plans and budgets.

2.2. The impact of international support

The sector wide approach has helped to create a common concern for the status of RH and commodity security. The fact that RH is one of the government's priorities, has meant that it has been high profile in joint reviews and the subject of various prominent donors statements and discussion at the national health assemblies.

It seems likely that current financing arrangements are squeezing out funds for RH. Although the RH and RH commodity supply line in the MoH budget is a PAF item, and should therefore have protection against cuts and reallocation, the increasing underspend (more than 50% last year) of this budget suggests that this is not the case, as discussed above. One reason for this might be that MoFPED has set a hard budget ceiling for the sector as a whole regardless of the source or scale of any additional funding. When the significant amounts from various global programmes such as GFATM are added into this they do not come as additional, but rather squeeze out other allocations. So there is a mismatch of funding against priorities and those programmes such as RH which are funded from budget support lose out. (In fact it could be said that effectively the RH programme misses out twice – it neither seems to get the budget support nor has it got the condoms that global funds procured before they were suspended). In response to this budget pressure imposed by MoFPED, and despite its statements in the new MoU signed with donors, MoH seems to have 'returned to an earlier pre-SWAP position, in which donors are urged to add "extra" money for programs such as Malaria and Reproductive Health[5]'.

In this aid environment the comparative predictability of donor funding becomes more attractive than budget support. If there were no government budget 'cuts' RHD may be motivated to advocate for a greater share of GoU resources because in some ways they offer better flexibility and more predictability. However in practice it is easier for RHD to mobilise resources from the donors than to compete with other programme interests, and coupled with uncertainty about the state budget they become a more reliable source. The donors are not going to let commodities run out and are ready to step in when necessary and they can respond very quickly when doing emergency procurement. There is also not the pressure to spend within the year to ensure that government money is not clawed back to the centre.

However parallel funded donor assistance comes at a price for whilst USAID and UNFPA are using their own procurement methods and operate on relatively short timescales for commitments (in contrast to commitments for budget support which may be up to 5 years) MoH has to manage the burden of fitting in with donor systems rather than the other way round. This adds to the work load on a division which is already low on capacity both in terms of technical skills and numbers of staff.

The key issue then becomes making donor support more flexible and predictable with lower transaction costs. In this situation the DANIDA / MoH arrangement of a separate bank account which pays against drug invoices may be a

[5] as observed during the April 05 Technical Review days. Energizing the SWAp - proposals for Ugandan Health Development Partners working year 2005/06. Örtendahl, C., de Loor, R., May 2005

better option. The money can be rolled over, it is clear what the government is paying in, it offers a lot of flexibility to fund procurement through the government system with relatively low transaction costs and the donor contributions can obviously be identified as additional to government funds rather than part of budget support to be diverted out of the sector to maintain budget ceilings. Within UNFPA's current considerations about providing some budget support it could consider contributing to the MoH/ DANIDA account for expenditure on RH drugs. They could also consider how UNFPA funding for contraceptives could be channelled through this route.

However where a donor needs to continue to procure under its own terms the work already stated should continue, i.e.

- Forecasting should be as accurate as possible to demonstrate long term need
- Efforts to support the supply chain should continue
- The possibility of stock outs should of course be minimised to avoid redirection of support into emergency procurement.
- Commitments should be made in line with the government budget cycle

There are opportunities here for UNFPA to make a more strategic contribution. UNFPA is currently negotiating its next country programme with RHD which could offer opportunities for a more effective working relationship and funding arrangement focussed on priority issues, as long as UNFPA moves swiftly to reformulate its programme. Moreover UNFPA HQ is going some way to encouraging UNFPA work more within sector wide approaches, including pooling funds, and is aware of the weight of programme management brought about by projects of the sort that UNFPA is supporting at district level.

There will also need to be continued support to RHD. At the moment the insight into commodity security status is provided by DELIVER and considerable support is also given to RHD by the DFID TCO whose contract is ending in January 2006. Although there is likely to be another USAID project, it is not clear what form this will take, although USAID expects that RH commodity security will be covered in some way. Also there could be a hiatus between the two projects, and this should be planned for. Regardless of the outcome, long term technical support will be needed and it makes sense for UNFPA to become a much more active partner in this area. UNFPA should become more involved in forecasting, encouraging RHD to ensure timely procurement by NMS, and facilitating communication between partners, for all procurement, not just their own. This should become part of UNFPA's next country programme which is currently under discussion, and the capacity to do this should be based within RHD. UNFPA should consider presenting its plans to the wider donor group in RHD with a view to including support for forecasting and procurement within the TA support role currently under discussion to supplement staffing in RHD; and they should consider scaling back on some of their other activities to create capacity to support this area of work.

A key issue is how to facilitate leadership by RHD in addressing commodity security. The TA support from UNFPA will be of valuable assistance, as will the input from DELIVER. There is also a need for MoH to give a greater priority to the work of RHD and provide adequate supervision and support. However the capacity and staffing levels in RHD, coupled with the wide remit and heavy workload of the staff mean that it is difficult for its personnel to take a strong leadership role when faced with the greater technical capacity and better resources of the donors and their projects.

The RHCS Group has an important contribution to furthering commodity security and can help the build the leadership role of RHD. The remit of the RHCS Group should be expanded to not only look at immediate forecasting issues, but also to be the main forum for discussion and coordination by RHD of *all* donor activity relating to RHCS, i.e. that it should be the forum in which donor plans are discussed openly in front of all partners and the ministry, down to the level, if possible, of ToRs of staff specifically working on RHCS. This should be formalised into ToRs (which include working arrangements). It would also be worth delineating the roles and responsibilities of individual members of the RHCS Group, and to do this within a broader look at the development partners' relationships with RHD which will promote greater ownership of commodity security problems and solutions by RHD, and which will reduce the tendency of some donors to operate as parallel working partners. Moreover the RHCS Group should consider not just operational issues and immediate coordination problems, but under the leadership of RHD endeavour to take on a more strategic vision, to see how it can influence the wider environment in favour of better security. This could be through, for example presenting key influences on commodity security to the Family Planning revitalisation committee and its partners, encouraging the participation of other partners (such as NGOs and private sector) in the RHCS Group perhaps on a quarterly basis for more strategic discussions, and inviting JMS to join the group either as an occasional or regular member.

2.3. New opportunities for improving commodity security

There are a number of opportunities for improving commodity security, but the context for achieving this is problematic. In particular:

The wider social and political environment in Uganda is not supportive of family planning, better RH or ensuring the quality or volume of contraceptives.. People are receiving contradictory messages about family planning:

- Some local politicians oppose it, not just to the extent of influencing resource allocations for FP programmes but giving incentives to women to have children;
- Staff at health facilities let their personal values on family planning influence the way they counsel clients;
- Family planning is still widely perceived as a woman's responsibility (because most methods are used by women), and interventions have largely focused on women without taking account of the supportive role of their partners and extended families;

More broadly, various social and economic factors mitigate those pro-FP messages that do exist such as

- A lack of women's empowerment, which precludes their expression of demand for FP
- The rural economy needing children for family income, exacerbated by high infant mortality.

The political will at national level to really impact on RH is questionable. Persistently poor maternal mortality figures and low rates of family planning uptake have been cited by many interviewees during the field work for this study as evidence that there is insufficient commitment within MoH to really tackling these and other RH problems, including commodity security. There needs to be greater mobilisation of

resources, more accountability for performance, and stronger messages going to the districts to ensure that RH, particularly family planning and maternal health are tackled properly. Public services are failing to ensure safer delivery than home birth to the extent that the ending of user fees did not increase demand for HC birth rates. Women do not go to government facilities to give birth partly because of the lack of supplies and trained staff, but also because of the poor and sometime violent attitudes they encounter there. RHCS cannot be tackled alone but has to be addressed within a context of greater commitment to RH as a whole. High maternal mortality rates are an indicator of the health of the service delivery system overall and can only be addressed by looking at a broad set of quality, performance and accountability issues and addressing service delivery problems in the system as a whole. The proposed RH tracking study under discussion could help to also mobilise government, donors and other stakeholders around the question of what is really being spent on RH and how more attention can be focussed on it. The lack of high level political will may be exacerbated by the fact that other issues such as HIV attract greater funding and therefore attracting higher priority and greater levels of attention by MoH, and by this funding sending strong messages from donors as to their own political will and priorities for programmes over tackling RH.

Despite this difficult environment however there are opportunities and initiatives that could impact positively on RHCS.

The work of the Family Planning Revitalisation Committee could highlight the importance of RHCS, and mobilise support to address it, if the correct messages were conveyed to them, and meaningful linkages were created between RHD and the considerations of the committee. Population Secretariat is a potentially useful ally in this as are the networks with whom they work. Some sensitisation to RHCS might be useful, for example a presentation which highlights both the systemic and social contributors to poor security.

Despite a fairly negative social and political environment to support family planning there are high profile advocates of the programme, for example there are politicians who strongly advocate for fertility control as a poverty reduction strategy. This includes Members of Parliament who sit on the Parliamentary Forum for Food Security Population & Development. UNFPA in conjunction with the Population Secretariat has packaged IEC materials in a friendly manner and worked with Members of Parliament to carry the message to communities and other political leaders in the districts for dissemination. UNFPA has also done work with religious groups, cultural leaders, Family Planning Association of Uganda and other NGOs on youth reproductive health programs. All these may present valuable lessons for RHD to help widen its influence on RH and to help local politicians understand the need to support family planning services and better commodity security.

The private sector offers further potential for widening the reach of family planning programmes and improving delivery, especially to hard to reach groups. The contribution of the non-state sector is already considerable and important and private / public initiatives should be taken further with a modality of getting reproductive health commodities dispensed by the private sector. There is a large population that is not being reached by the current arrangement. The RHCS Group should also consider opening up to include other non-state members addressing RHCS such as the Family Planning Association of Uganda, Uganda Private Midwives Association.

2.4. Further recommendations

Observations from the field trip to Wakiso district suggest that consolidation of the ordering system is essential in order to enable facilities to order effectively. The training currently being given will not be enough and on the basis of the people we met the cascade approach may not be the best one, given its potential to spread misinformation unchecked. There needs to be a system for ensuring the quality of training down the line is undiluted, and also that all necessary people are reached. For example a district supplies officer that we met did not attend the training but is responsible for following up and supporting those who have received it. RHD and DPs need to consider urgently how these issues can be addressed and also how support supervision can be given to the people in the field on an ongoing basis. However we acknowledge that RHD, DELIVER and UNFPA who funded the training are aware of its shortcomings.

There may be opportunities for improving communication with NDA. The consultant team was not able to evaluate the complexity of NDA requirements and the extent to which these could be simplified given the status of NDA and its role. However we do recommend that NDA be invited to attend some of the RHCSG meetings, perhaps quarterly, in order to improve communication, facilitate understanding and anticipate forthcoming changes in tariffs for example.

The links between RHD and the condom procurement team should be further developed as they are limited at the moment, RHD simply being allocated some of the condoms when they come in. RHD should at least be aware of condom programming issues and the likely impact on FP security. At the moment this is provided by DELIVER, but is an issue in which UNFPA could also take more of a role.

ANNEX 1 LIST OF PEOPLE MET

#	Name	Designation	Organisation
1	Dr. Miriam Sentongo	Senior Medical Officer	Ministry of Health
2.	Raveena Chowdry	TCO	DFID
3.	Steve Wilbur	Chair of Party	DELIVER
4.	Becky Copeland	Deputy Director Tech & Operations	DELIVER
5.	Jennifer Luanda	Sales/ Marketing Officer	National Medical Stores
6.	Dr. Chris Baryomunsi	Program Officer	UNFPA
7.	Zipporah Gathiti	Program Officer	UNFPA
8.	Dr. Mbonye	Assistant Commissioner RH Division	Ministry of Health
9.	Joseph Serutoke	Essential Drugs Advisor	World Health Organisation
10.	Martin Oteba	Principal Pharmacist	Ministry of Health
11.	Pascal Mujasi	Commodity Logistics Advisor	DELIVER
12.	Hanif Nazareli	Drug Management Advisor	Ministry of Health /DANIDA
13.	Annie Kaboggoza Musoke	PMS	USAID
14.	Doreen Thaddeus	Senior RH Advisor	USAID
15.	Claes Ortendahl	Health Advisor	SIDA
16.	Edward Zzimbe	Marketing Manager	Marie Stopes International
17.	E. Katumba	PMO RH	Ministry of Health
18.	Nina Shalita	Executive Director	Uganda Private Midwives Association
19.	Dr. Olive Sentumbwe	Focal RH Person	World Health Organisation
20.	Stephen Wodulo	Programme Officer	Uganda Private Midwives Association
21.	Dr. Christine Kirunga	Planning Officer, MoH	Ministry of Health
22.	Vasta Kibirige	Procurement Officer, MoH	Ministry of Health
23.	Dr. Angela Akol	National Program Officer-Family Planning Health Department	Population Secretariat
24.	Dr. Emmanuel Mukisa	District Director of Health Services	Wakiso District Council
25	Mrs. Esther Kato	District Nursing Officer	Wakiso District Council
26	Junior Musoke	District Assistant Supplies Officer	Wakiso District Council
27	J. Sengendo	Records Officer	Wakiso District Council
28	Ruth Margaret Hariat	Midwife	Wakiso HC IV
29	Alex Ruth Mukasa	Dispenser/Stores Assistant	Wakiso HC IV
30	Joseph Bawudula	Clinical Officer	Kakiri HC III
31	Annet Tondo	Senior Nursing Officer	Kakiri HC III
32	Joseph Katongole	Nursing Assistant	Kakiri HC III
33	Justine Nakatamba	Nursing Aid	Sentema Health Centre II
34	Klaus Rasmussen	First Secretary,	SIDA

		Development, (Health)	
35	Claes Örtendahl	Advisor to Swedish Embassy, Uganda	SIDA

ANNEX 2 DOCUMENTS CONSULTED

A Strategy to improve Reproductive Health in Uganda 2005 – 2010, Reproductive Health Division, Department of Community Health, MoH, July 2004

Advocacy sub-programme under Fifth Country Programme 2001 – 2005, UNFPA/GoU

Aid memoire: the 2nd national health assembly and 10th health sector joint review mission of government of Uganda and Development Partners on the health sector strategic plan, 25th – 29th October 2004

Aid-memoire: 8th Health Sector Joint Review Mission of Government of Uganda and Development Partners, Kampala 23 – 25 April 2003

Annual health sector performance report, financial year 2000/2001, September 2001, MoH Uganda

Annual health sector performance report, financial year 2001/2002, September 2002, MoH Uganda

Annual health sector performance report, financial year 2002/2003, October 2003, MoH Uganda

Annual health sector performance report, financial year 2003/2004, October 2004, MoH Uganda

Budget framework for Health Sector 2004/05 to 2006/07, Health Planning Department, MoH, May 2004#

Concept note on UNFPA thematic trust fund on reproductive health commodity security, UNFPA

Decentralisation and National Health Policy Implementation in Uganda – a problematic process, Jeppsson, A. 2004

Discussion paper 9: Population Growth and Poverty Eradication, Ministry of Finance, Planning and Economic Development, December 2004

Draft GoU / UNFPA Country Programme Action Plan 2006 – 2010, draft 2005

Energizing the SWAp - proposals for Ugandan Health Development Partners working year 2005/06. Örtendahl, C., de Loor, R., May 2005

Financing health services in Uganda, 1998/1999 – 2000/2001, National Health Accounts, MoH, June 2004.

Health policy statement 2004/2005 by Hon. Brig. Jim K. Muhwezi, Minister of Health, MoH June 2004

Health sector reforms and increasing access to health services by the poor: what role has the abolition of user fees played in Uganda? Tashobya, C.K, McPake, B., Nabyonga, J., and Yates, R.

Health sector strategic plan 2000/01 – 2004/05 Mid-term Review Report, April 2003

Health sector strategic plan 2000/01 – 2004/05, MoH

Health Sector Strategic Plan II, 2005/06 – 2009/2010, Volume 1, Final Draft March 2005, MoH

High level forum on the health millennium development goals: harmonisation and MDGs, a country perspective, Tanzania and Uganda, 2003

Memorandum of Understanding between the Government of Uganda and Development Partners, MoH January 2005

Ministry of Health headquarters Annual work plan for FY 2004/05 (July 2004 – June 2005), MoH

National Advocacy Strategy in support of Reproductive Health, Population and Development Programmes (2005 – 2009), Population Secretariat 2005

National budget framework paper for financial years 2005/06 – 2007/08, part 1, 2 &3, the Republic of Uganda

National family planning advocacy strategy 2005 – 2010, March 2005, MoH

National pharmaceutical sector strategic plan (NPSSP) 2002/3 – 2006/7, MoH, October 2002

National policy guidelines and service standards for reproductive health services, MoH, May 2001

National service delivery survey, 2004, Uganda Bureau of Statistics

NGOs and Development: Lecture Notes prepared for Masters students of Nkumba University, Nyamugasira, February 2005

Population and Development Strategies Sub-Programme under Fifth Country Programme 2001 – 2005, UNFPA/GoU

Poverty Eradication Action Plan (2004/5-2007/8), Ministry of Finance, Planning and Economic Development, 2004

Public Sector Contraceptive Requirements 2005 – 2006, MoH Reproductive Health Division, JSI/DELIVER, April 2005

Reproductive Health Sub-Programme under Fifth Country Programme 2001 – 2005, UNFPA/GoU

Status of emergency obstetric care in Uganda. A national needs assessment of EmOC process indicators, October 2004

Strengthening health systems, WHO report 2004, WHO Uganda Country Office

Uganda Demographic and Health Survey 2000 – 2001, Uganda Bureau of Statistics, December 2001

Uganda MoH Contraceptive physical inventory survey, estimation of current national contraceptive stocks. Final report September 4, 2003, prepared by JSI DELIVER / Uganda Office and MoH Reproductve Health Office

Uganda Participatory Poverty Assessment Process: Second Participatory Poverty Assessment Report. Deepening the understanding of Poverty, MoFPED, December 2002

Uganda poverty status report 2003, MoFPED, 2003

Uganda procurement case studies report, June 2003 Final Draft, Raja, S. JSI/DELIVER

Ugandan health units are reporting a doubling in patient visits. What lessons can be learnt by other sectors and by DFID? Yates, R.

UNFPA Fifth Country Programme 2001 – 2005, UNFPA/GoU