



Mapping financial flows for immunisation in Uganda 2009/10 and 2010/11: New insights for methodologies and policy



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ABSTRACT

Background: The Global Vaccine Action Plan highlights the need for immunisation programmes to have sustainable access to predictable funding. A good understanding of current and future funding needs, commitments, and gaps is required to enhance planning, improve resource allocation and mobilisation, and to avoid funding bottlenecks, as well as to ensure that co-funding arrangements are appropriate. This study aimed to map the resource envelope and flows for immunisation in Uganda in 2009/10 and 2010/11.

Methods: To assess costs and financing of immunisation, the study applied a common methodology as part of the multi-country Expanded Program on Immunisation Costing (EPIC) study (Brenzel et al., 2015). The financial mapping developed a customised extension of the System of Health Accounts (SHA) codes to explore immunisation financing in detail. Data were collected from government and external sources. The mapping was able to assess financing more comprehensively than many studies, and the simultaneous costing of routine immunisation collected detailed data about human resources costs.

Results: The Ugandan government contributed 56% and 42% of routine immunisation funds in 2009/10 and 2010/11, respectively, higher than previously estimated, and managed up to 90% of funds. Direct delivery of services used 93% of the immunisation financial resources in 2010/11, while the *above* service delivery costs were small (7%). Vaccines and supplies (41%) and salaries (38%) absorbed most funding. There were differences in the key cost categories between actual resource flows and the estimates from the comprehensive multi-year plan (cMYP).

Conclusions: Results highlight that governments and partners need to improve systems to routinely track immunisation financing flows for enhanced accountability, performance, and sustainability. The modified SHA coding allowed financing to be mapped to specific immunisation activities, and could be used for standardised, resource tracking compatible with National Health Accounts (NHA). Recommendations are made for refining routine resource mapping approaches.

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1. Background

Uganda is a low-income country with a population of 34.5 million in 2011 [1]. The Ugandan Expanded Programme on Immunisation (UNEPI) achieved significant performance improvements in the early 2000s. However, performance stagnated after 2007 due to service delivery challenges and districts' varied success in achieving immunisation targets [2]. WHO reported a reduction in DTP3 coverage from 82% to 78% between 2011 and 2012 [3]. The Ugandan

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health care system is funded from public, external development partners and private sources [6,24]. Per-capita health spending was reported to be \$10.29 in 2011/12, well below the estimated requirement of \$48 for a minimum health package [4,5,25]. The Ugandan public financing management performance report (2008) found public sector financial management had generally credible budgeting processes but weak monitoring of expenditures, budget execution and control, and only average accounting and reporting systems [28] with limited detail on specific programmes and illnesses. The review found that donor funding had poor predictability and provision of financial information, and low proportions were managed by government processes [27]. Other sources also note difficulty in tracking funding, coordinating partner efforts, and ensuring that national health priorities are addressed [4,7].

The Global Vaccine Plan (GVAP) emphasises the need to strengthen the understanding of costs and financing of country immunisation programmes [8]. Resource tracking through methods such as National Health Accounts (NHA) and National AIDS Spending Assessments (NASAs) can improve the efficiency of allocations and the predictability and sustainability of health financing [9,10,20]. Resource tracking for women and children's health is also being promoted to ensure that funding commitments are honoured and results measured [11]. Since 1998 the WHO-UNICEF Joint Reporting Form (JRF) has collected coverage and financial indicators from member states, including the percentage of all expenditures for routine vaccines financed by governments using internal public funds as compared to donor or other funding sources [19]. The Ugandan JRF for 2011 reported that 19% of routine vaccines were funded by the government of Uganda (GOU) [29]. Apart from the JRF, which in many cases tends to have limited reporting on financing indicators [19], there have been few resource-tracking efforts for routine immunisation (RI) funding and spending [12,31]. In Uganda, the comprehensive multi-year plan (cMYP) estimated financing for the national immunisation programme at US\$23 per child in 2011 [2,13]. The cMYP provides national estimates but does not examine facility-specific data.

This paper presents a detailed mapping of all government and external funding flows for RI in Uganda in 2009/10 and 2010/11. The study was done as a companion analysis to the detailed facility-costing EPIC studies [30]. The objectives were to:

- Identify and quantify the total envelope of funding available for RI from all sources and evaluate the distribution of the envelope by line items, activity, and health providers.
- Map the funding flows from sources to the ultimate uses of those funds for RI.
- Evaluate differences between the funding envelope and estimated financial costs derived from a companion study [14].

2. Methods

The analysis identified financial and commodity flows for immunisation, and focused on disbursements and flows in 2009/2010 and 2010/2011. The rationale for focusing on funding flows is that they reflect the total funding envelope available for RI, whereas expenditures are a function of the efficiency and effectiveness of government and donor disbursement mechanisms [21]. This mapping represents an alternative way of tracking resource flows specific to RI, defined as facility and outreach-based services providing traditional vaccines,¹ but excluding supplementary immunisation activities (SIAs). Private, for-profit sector financing was also excluded. The methodology was adapted from the NHA

¹ BCG; 3 doses of pentavalent diphtheria, pertussis, tetanus, Hepatitis B, *Haemophilus Influenza* Type b; 3 doses of polio; and measles first dose.

Table 1

Additional disaggregated SHA health care function codes for immunisation mapping in Uganda.

HC.CODE	HC.Description
HC.1	Curative care
HC.6	Preventive care
HC.6.1	Information, education and counselling programmes
<i>HC.6.1.1</i>	<i>Social mobilisation, advocacy</i>
HC.6.2	Immunisation programmes (not disaggregated)
<i>HC.6.2.1</i>	<i>Facility-based routine immunisation service delivery</i>
<i>HC.6.2.2</i>	<i>Outreach routine immunisation service delivery</i>
<i>HC.6.2.3</i>	<i>Training</i>
<i>HC.6.2.4</i>	<i>Vaccine collection, storage and distribution</i>
<i>HC.6.2.5</i>	<i>Cold chain maintenance</i>
<i>HC.6.2.6</i>	<i>Supervision</i>
<i>HC.6.2.7</i>	<i>Programme management</i>
<i>HC.6.2.8</i>	<i>Other routine immunisation programme activity</i>
HC.6.5	Surveillance
<i>HC.6.5.1</i>	<i>EPI Surveillance</i>
<i>HC.6.5.2</i>	<i>Record-keeping and HMIS</i>
HC.7	Governance and health system financing & admin.
HC.99	Not disaggregated
HC.RI.3	Prevention and public health services
HC.RI.3.3	Prevention of communicable diseases
Cap.Invstmt.	Capital Investment

The inserted dis-aggregated activities are shown in italics.

approach that uses the System of Health Accounts (SHA) for coding financing sources, agent service providers, and health care functions/activities [20]. The 2011 SHA codes were further disaggregated for the Health Care Functions (HC6.2) to provide a common framework for analysis of immunisation-specific financial flows across the six EPIC countries [16] (see Table 1).

Data were collected from all government and external sources of immunisation financing or commodities in financial years 2009/10 and 2010/11 using a standardised questionnaire and methods developed for the EPIC studies [15]. The questionnaire was adapted from the NASA and NHA tools, and aimed to collect quantitative financing data linked to sources, agents, service providers and activities of immunisation.² Data were analysed based on a matrix of immunisation activities and line items.

The national-level analysis traces UNEPI funding from the ministry of health (MOH) for all national-level activities and EPI staff salaries, as well as for central vaccines funding. Disbursements to Uganda from the secretariat of the Global Alliance for Vaccines and Immunisation (GAVI) for vaccines were channelled through the national medical stores. Public financing for RI at the facility level includes staff salaries and MOH primary health care (PHC) grants to district health offices (DHOs), which cover overhead and operational items such as maintenance, fuel, and supplies. These cater for all PHC services and it was not possible to track immunisation-specific funding apart from village health workers' outreach stipends. Therefore, total funding flows for salaries for district and facility-level RI activities were based on estimates obtained from the detailed costing [14] of a stratified random sample of 52 facilities in 12 districts conducted for the EPIC study in Uganda [30]. For salary and vaccine financing, 60% were allocated to routine facility-based immunisation and 40% to outreach, based on costing study estimates. Salary costs in 2009/10 were 2011 costs deflated by a CPI of 5% [22]. Data are reported using a 2011 exchange rate of 1 US dollar to 2290 Ugandan shillings (US \$1:2290 USh). Non-profit organisations that deliver RI services on behalf of the government receive vaccines free of charge from UNEPI, and data were not available on their service volumes or funding. The analysis consequently categorised them as public providers.

² Refer to supplementary materials for the questionnaire.

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