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***Improving the Access of
Poor and Vulnerable
Communities to Health
Services in Northern
Uganda***

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List of Abbreviations

Acronym	Full Title
DANIDA	Danish International Development Agency
DFID	Department for International Development
GoU	Government of Uganda
HDRC	Human Development Resource Centre
IDP	Internally Displaced Person
JMS	Joint Medical Stores
PBF	Performance Based Financing
PNFP	Private Not-For-Profit
NGO	Non Governmental Organisation
NMS	National Medical Store
NUSAF	Northern Uganda Social Action Fund
UNHCR	United Nations High Commissioner for Refugees

1. Background

Between May 24th and 28th 2010, the HDRC undertook a short scoping mission to advise DFID Uganda on how DFID could help communities improve their access to effective health services. Initially it had been proposed that DFID would restrict its programme to only a small number of extremely vulnerable individuals who were still living in Internally Displaced Person (IDP) camps. However early on in our visit it became apparent that the office was considering broadening the scope of the programme to cover the entire population of certain districts – whilst maintaining an equity focus on the needs of the poor and vulnerable. This assessment and proposal is therefore based on improving access to effective health care for the estimated 1.3 million people living in the Acholi sub-region. This consists of the districts of Pader, Lamwo, Amuru, Kitgum and Gulu.

2. Assessment

On a two day visit to Gulu and Amuru districts, Jo Bosworth and the HDRC consultant visited Government and NGO health facilities (both hospitals and health centres) and met with representatives of the public and not-for-profit health sectors. A meeting of private not-for-profit (PNFP) officials convened at Lacor Hospital was particularly useful in determining the state of the public-private health partnership in Northern Uganda. We also held meetings with the District Director of Health Services in Gulu, with UNCHR to understand the situation with respect to IDPs and we were taken on an outreach visit by Marie Stopes International to see their mobile family planning service.

The field visit highlighted a number of major shortcomings of the health sector in Gulu and Amuru which we can be confident apply to the whole region and indeed the whole country. These problems have been highlighted in numerous reports, including the Midterm Review Report of the Health Sector Strategic Plan (2008) and relate to inadequate coverage and quality of basic health services.

Across the region, the public sector is characterised by poor geographical access to services, infrastructure in bad repair, low staffing levels, high levels of absenteeism,

weak management and supervision, and major problems with stock-outs of basic medicines. UNCHR reported that many people are reluctant to leave IDP camps because of low levels of basic service provision in their home areas. It is estimated that only 37% of the 1.3 million people living in the Acholi sub-region live within five kilometres of a functioning health centre.

3. Availability of medicines driving demand for public services

Of all the constraints outlined above, perhaps the one most frequently highlighted by stakeholders as the greatest problem inhibiting access to effective health care was inadequate supplies of basic medicines. At both health facility and district level, officials reported that the level of demand for services was largely being driven by the availability of medicines. When stocks of essential drugs and commodities were relatively high, local populations would tend to visit public health facilities when they needed care, but when stocks fell they would increasingly use the unregulated private commercial sector.

This has been a common feature of health care consumption in Uganda since the removal of patient fees in 2001 but in the latter part of this decade the problem of drug stock outs has become particularly severe. For example, at Anaka District Hospital we were informed that in 2009 there had been a stock out of the preferred anti-malarial drug for six months. During this period the utilisation of the outpatient department reduced considerably but has now recovered since ACT medicines returned in March 2010.

Clearly the public's dissatisfaction with this situation has attracted the attention of local and national politicians. As a result the availability of medicines in public facilities has become highly politicised, to the extent that a special unit has been established in State House to monitor and investigate this issue. It would appear that in this process the majority of the blame for drug stock outs is being apportioned to health workers who are being accused of stealing drugs from health facilities.

Undoubtedly this will be happening to some extent but in reality it is more likely that ongoing drug shortages are due to chronic under funding of essential medicines in

the Government of Uganda (GoU) health budget. In fact, it would appear that since 2003/4, when high volatility of outpatient numbers already indicated inadequate supplies, allocations to essential medicines have barely changed. In the meantime with population growth running at around 3% per year and inflation at around 5% one can see that the real per capita drug allocations have fallen by over 40%. Added to this, with more and more health facilities having opened, it is easy to see that essential medicines allocations have been woefully inadequate and even a leak free system would not have been able to keep up with demand.

Given the importance the population attach to drug availability when accessing health care this is an issue that ought to be addressed by a new DFID health programme in the region.

4. Private sector providers

In addition to public providers, the PNFP sub-sector is very active in the region running three highly respected hospitals (Lacor in Gulu, Kalongo Ambrosoli in Pader and St Joseph's in Kitgum) and around 15 health centres. There is a general perception that PNFP facilities offer services of superior quality in that they are better managed and have better drug availability. Demand for PNFP services is high (Lacor Hospital for example performs 90% of all caesarean-section operations in Gulu and Amuru) but there is a concern amongst both providers and politicians that the existence of patient fees at these units acts as an access barrier to the poor and vulnerable.

PNFP providers (especially those affiliated to the Uganda Catholic Medical Bureau) are aware of this problem and have tried to reduce their fees especially for pregnant women and children. Lacor Hospital for example charges children under 5 one thousand shillings for outpatient care (including medicines) and five thousand for deliveries.

It is evident that many PNFP providers would like to reduce fees further or eliminate them entirely but this would not be feasible given their limited financial resources. GoU budget subsidies to PNFP providers appears to be another area that has suffered substantial real per-capita cuts in recent years with the overall budget not changing since 2003. Furthermore PNFP providers have just been informed that they

will no longer be credited with public funds at the Joint Medical Stores to purchase essential medicines.

With PNFP providers facing ongoing criticism from politicians for charging patients, but with levels of public subsidy falling, it is not surprising that the public-private partnership is under considerable strain.

5. A proposed response

It was very disappointing to witness at first hand the stagnation of key health services in Northern Uganda. Anaka hospital, for example, had started to perform c-sections in the middle of the decade but these operations stopped two years ago. Now women face a two hour journey to Lacor in Gulu for their life-saving surgery.

Given the extent of systems failures across all key inputs and processes (infrastructure, equipment, human resources, medicines, information systems, management and supervision) a new DFID health programme could intervene in a number of different ways. It could provide intensive and comprehensive assistance to a limited geographical area or provide support to bigger population groups but in a more selective manner by tackling one or two priority constraints. In choosing between options, it will be important to weigh up efficiency and equity considerations to maximise value for money from DFID's investment.

Discussions were held with front-line providers in the region and stakeholders at the national level with a long experience of the Ugandan health sector to help design the most appropriate approach. Generally it was felt that ongoing capital investment programmes in the North, notably the Northern Uganda Social Action Fund (NUSAF), were tackling infrastructure constraints and that DFID support would be more useful in supporting recurrent inputs. Of these donors (including the World Bank and DANIDA) and service providers highlighted the desperate need to help sustain regular medicines supplies. Stakeholders also highlighted the need to support both PNFP providers and government units, particularly at lower levels to ensure a more equitable access to services.

It is therefore recommended that DFID Uganda invests in a dual track approach to improving access to health services in the Acholi sub-region. The main objectives of this programme would be to:

- 1) Improve the availability of essential medicines in both Government and PNFP health facilities
- 2) Enable PNFP providers to eliminate fees at the point of delivery, either for the entire population or at least for pregnant women and children

6. Improving drug availability

With drug availability being a major determinant of demand for health services in Uganda any new programme should give a high priority to ensuring that poor and vulnerable people can access effective medicines when they need health care.

However given current levels of chronic public under-funding of medicines and the highly politicised debate about who is to blame for drug shortages, it will not be straightforward for DFID to intervene in this area. Historically the preferred mechanism would have been for DFID budget support to reach these populations via higher allocations of the GoU health budget to essential medicines. But given the evidence on the ground this approach would not be advisable at present.

Another approach would be to provide funding to the GoU National Medical Stores (NMS) with the expectation that resources would be ring-fenced for the target populations in the districts concerned. Theoretically the existence of district credit lines in virtual accounts at NMS would facilitate this approach. However during conversations with stakeholders inside GoU and in the donor community major concerns were expressed about supporting NMS in this way. This is because there appears to be a major initiative underway within the GoU to centralise all funds for drug procurement at NMS but this is being done in a very opaque manner. Previously some monies for essential medicines were decentralised to districts but now these have been reallocated to the central level. Given NMS's track record in sustaining drug supplies district officials were extremely worried that this recentralisation of drug funds will further jeopardise their supplies.

In fact, one District Director suggested that to guarantee better supplies to his district DFID would be better advised to fund credit lines set-up at the PNFP- run Joint Medical Stores (JMS). This organisation predominantly supplies PNFP providers but mechanisms clearly exist for them to supply GoU facilities as well. In the current climate, if DFID wants to reduce fiduciary risk and ring-fence drug monies for the population in these districts this option may be preferable to financing NMS.

Assuming that DFID does want to support the provision of essential medicines in its health programme more analytical work may be required to determine which mechanism (or mix of mechanisms) would be the best way to deliver this assistance. Clearly drug supply reforms are highly contentious and fast moving in Uganda and current proposals to recentralise funds may become more transparent in the coming budget round. However given the poor track record of GoU systems in this area, DFID may be advised to consider using at least part of its drugs monies to fund JMS until NMS systems become more reliable.

In terms of financial resources for this element of the proposed programme: additional resources of \$1 per capita per year should make a considerable difference to maintaining appropriate drug supplies. This component would therefore require around \$1.3 million per annum for the target population.

7. Support to PNFP providers

PNFP health units may be providing better quality health services to people in the Acholi region, but while they continue to charge direct patient fees they will be inhibiting demand from the poor and vulnerable. Most of the units concerned say that they operate exemption policies for the poor but evidence from across the continent shows that these systems are not effective at protecting the poor. Furthermore, the existence of fees at PNFP facilities remains a bone of contention between politicians and the units concerned. The former object to their populations being charged but the latter complain that they are unable to reduce their charges because of inadequate and falling GoU grants.

This is an area where DFID can intervene to provide an additional public subsidy which will enable the PNFP units to reduce if not eliminate their fees. In discussions

with individual PNFP units and with the Uganda Catholic Medical Bureau it is evident that many PNFP units would welcome this initiative. Indeed many of them have tried to reduce their fees for vulnerable groups and have been disappointed when they seen attendances drop when they have been forced to increase fees to cover their costs.

Discussions also addressed the best way that DFID could support the PNFP sector. The general consensus was that an optimal funding mechanism should not be overly complicated or costly in terms of administrative requirements. Given the relatively small number of health providers in the region, especially in rural areas, it was agreed that issuing vouchers to health consumers would not be a sensible approach. It would also be extremely costly to issue vouchers to beneficiaries and there were worries that such a system would create a market for vouchers which could adversely affect the poor.

The preference of PNFP representatives was that DFID should provide direct subsidies to individual units to supplement their GoU grants and other funding sources. The understanding would be if these subsidies are sufficiently high the units concerned could eliminate patient fees to allow a more equitable access to their services. Discussions during the mission centred on removing fees for pregnant women and children but the following proposal is based on the more ambitious objective of providing free care to entire population.

In agreeing a funding formula to units it may also be possible to introduce an element of performance based financing (PBF) into their funding arrangements. This approach would be compatible with DFID's greater emphasis on purchasing outputs (eg numbers of babies born in health units) over funding inputs. However given the disappointing outcome of early PBF pilots in Uganda stakeholders advised that any new mechanisms should be relatively simple to administer.

The level of funding required for this component of the project would depend on the level of ambition for removing fees – clearly more resources would be needed for a total elimination of user fees as opposed to just removing them for certain groups. In discussions with PNFP providers we were also told that fee income varied considerably from unit to unit, with individual units rising between 8 and 20% of their revenues from this mechanism.

Lacor Hospital (by far the biggest and busiest health unit in the region) raised around \$600k from user fees in 2008/09. Assuming that the two other PNFP hospitals raised about the same amount between them and that the 15 or so lower levels raised about half this amount [even this might be a high estimate] one can calculate that a rough estimate of PNFP user fee income would be around \$1.5 M per annum.

Therefore were DFID to provide a subsidy of this order of magnitude and allow PNFP units to access additional drug monies held at JMS then it should be feasible for these units to abolish their patient fees. Clearly more detailed negotiations would need to be held with the units concerned and the relevant medical bureaux to determine the exact requirements for this element of the programme. But as an initial estimate \$1.5 M per annum should be sufficient to enable people living near PNFP units to benefit from health services free at the point of delivery.

Summing these two elements the total estimated cost of a health programme that will improve the access of 1.3 million people to essential health care in both GoU and PNFP units would be \$2.8 million per annum.

Annex 1: Terms of Reference

TERMS OF REFERENCE - SCOPING STUDY

Background

DFID has allocated £100m for the Northern Uganda Post-Conflict Development Programme (PCDP) which will run until 2014. Some initial design work has been done on health, and an indicative £1m has already been approved for a healthcare component to run 2010-12, though the funding level and programme duration are not yet fixed.

DFID Uganda has asked the DFID HDRC to organise a scoping study by Rob Yates of DFID London, under the terms of the HDRC framework contract. The reimbursable costs will be covered by the CPHF TA budget.

Objective

The objective of this study is to enable DFID Uganda to make an informed decision on the next step in the design of this healthcare component.

Scope

The consultant will:

1. read the latest available evidence on health and its financing in Uganda;
2. review the current and likely future situation of health financing in Uganda;
3. consider the options open to DFID to enable the most vulnerable in northern Uganda to access healthcare. (This is likely to be through the Private Not For Profit sector, but the alternatives, such as vouchers redeemable at for-profit providers, should also be considered);
4. analyse the pros and cons of different approaches;
5. identify a recommended option for DFID support
6. recommend a list of key issues to be addressed in the next stage of the design (assuming a project memorandum will be needed).

This will require five days work in Uganda, with at least two working days to be spent in northern Uganda; plus one day's preparatory reading and one day afterwards for report-writing and follow-up discussions. Total 7 days.

Tasks

1. Establish what the poor and very poor currently do when they or their families are ill.

2. Identify the services for which this group has the greatest need, with reference to government health policy, DFID's overall programme in the region, and the GoU's Peace and Recovery Development Plan (PRDP).
3. Assess the reach of the government, for-profit and not-for-profit sectors.
4. Identify the critical constraints to increased access to PNFP health services for the target group in northern Uganda.
5. Consider the pros and cons and costs and benefits of alternative approaches for DFID support (£1m or £5m over 2 years or longer) taking account of other donor funding and what the target population will do when the DFID funding comes to an end.
6. Consider whether there is data available for a satisfactory baseline; and if not, recommend how best to remedy this.
7. Recommend a preferred option for DFID support
8. Recommend what if any further studies or research should be carried out before DFID Uganda can reach a decision.
9. Identify the key issues to be addressed in the subsequent design.

Deliverable

A brief report (max 10 pages), following the list of tasks above, with a one-page summary and annexes containing extracts from the key supporting documents.

Reporting

The consultant will report to the HDRC Health Specialist assigned to this task, who will QA the report and forward it to DFID Uganda and DFID London.

Saul Walker,
on behalf of DFID Uganda
May 20th 2010

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