

Delivering on Policy Promise in the Rural Health Sector in Uganda: Implications on Service Availability for Reducing Under-five Mortality in Northern Uganda

Policy Brief



Richard Ocaya Kica
University of East Anglia, UK
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Introduction and purpose

The policy brief presents the outcome of the study intended to establish the extent to which the government of Uganda and development partners have been able to deliver on the health policy objectives in the rural areas. The study was conducted during the month of April and May 2013 in the rural health facilities in the northern Ugandan districts of Gulu, Amuru, Pader and Agago.

The health policy objectives were defined in term of:

- Establishment of health centre II, III and IV at parish, sub-county and county levels respectively, and posting appropriate staff cadre at the facilities.
- Equipping the facilities with relevant supplies and equipment. In this particular case, packages for malaria, pneumonia and diarrhoea which are the leading causes of mortality in children under-five, and immunization package.
- Ensuring that health facilities compiles, analyse and utilize health information for effective planning.
- Promotion of participation of private sector i.e. private-for-profit and private-not-for-profit providers in health service provision in rural areas.

WHY FOCUS ON RURAL AREAS AND CHILDREN UNDER-FIVE?

First, the Ugandan population is mostly rural, with 87.7% of the population living in the rural areas and practice agriculture as their main occupation. Children under the age of 18 years constitute 56.1% and children under the age of five are estimated at 18.6%.

Secondly, under-five mortality in Uganda is high, estimated at 99 deaths per 1,000 children under the age of five per year. The Millennium Development Goals (MDGs) 4 target for Uganda aims to reduce these deaths to 58 per 1,000 children per year by 2015. Malaria, pneumonia and diarrhoea were identified as the leading causes of the mortality.

Therefore, if the country is to reduce these deaths to the target of the MDG by 2015, there is a need to focus attention on the leading causes of deaths in the population category and directs effort on improving the health system in the rural areas where majority of the population live.

Who the brief intends to reach?

The brief aims to reach the key stakeholders in the health sector at national and local government levels. National level stakeholders are: *national legislators/members of parliament, the Ministry of Health (MoH) technocrats, donor and United Nations agencies, national level civil society organizations and private service providers*. Local government level stakeholders are: *local government legislators/councillors and technocrats, non-governmental/civil society agencies, and private service providers involved in service delivery*.

The two stakeholder levels works in synergy with the national level mainly concern with policy formulation, planning and resource mobilization, and the local government level majorly involved in policy implementation.

Aim and scope

Over the last decade, Uganda have developed and revised its National Health Policy, which is aligned with the National Development Plan (NDP) and MDGs. The key stakeholders at all administrative levels seems to also agree that when the current policy is implemented to the full extent, the country stand a chance of achieving the MDGs relevant to the health sector and realize a remarkable improvement in the health and wellbeing of the population.

The brief therefore is not advocating for development of a new health policy, rather, it aims at establishing the extent to which the current health policy objectives have been fulfilled in the rural areas and identify gaps to be addressed by the stakeholders.

Situational analysis: where to focus in the rural health sector?

The key areas of focus in the rural health sector are the availability of health facilities at administrative levels and staffing; availability of treatment packages for malaria, pneumonia, diarrhoea and immunization; management of health information; and participation of private sector/civil society organizations in provision of health services. These areas of focus are discussed below.

Availability of health facilities and staff

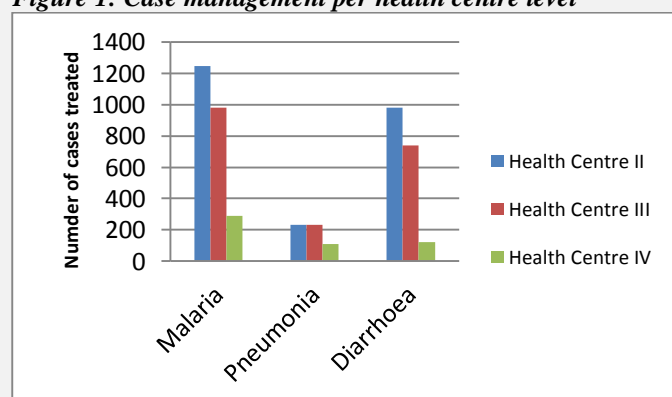
It was established that health centre II is the closest facility to households since they are located at parish level i.e. within a radius of 5km from majority of households. However, its coverage is lower than that of health centre III and IV. This means households seeking care has to travel long distance to access care. This increases the risk of mortality especially where transport is a challenge to the households. Table 1 below presents the summary of coverage of health centre levels by district.

Table 1: Health centre coverage by district & facility level

District	Health Centre IV Coverage (%)	Health Centre III Coverage (%)	Health Centre II Coverage (%)
Gulu	100	83.3	66.0
Amuru	100	140	57.1
Pader	100	66.6	33.3
Agago	0.0	50.0	30.7

The coverage of health centre IV with the exception of Agago is higher. For Pader and Agago, the coverage of health centre II in less than 50%. Across the districts, although the coverage of health centre II is comparatively low, the facility level was responsible for most of cases of malaria and diarrhoea treated in children under the age of five and an equal number of cases of pneumonia with health centre III during the month of April 2013. Figure 1 below summarises the cases.

Figure 1: Case management per health centre level



On the *staffing* situation, although there has been improvement in filling professional health posts to 76%, the average rate of absenteeism is 48.4%. This implies that improvement in filling the posts may not necessarily results into improved quality of health services to the population. Table 2 below

presents the situation at district and health facility levels.

Table 2: Absenteeism by district & health centre level

District	Health Centre II	Health Centre III	Health Centre IV
	Staff absent (%)	Staff absent (%)	Staff absent (%)
Gulu	59.6	54.9	34.4
Amuru	71.1	17.9	58.6
Pader	36.0	48.6	50.0
Agago	35.5	50.0	0.0*
Total	54.4	43.3	47.3

*Agago district has no health centre IV

The Table raises the need for stakeholders to prioritize addressing the problem of absenteeism to be able to meaningfully reduce deaths among children under the age of five.

Availability of health packages

It was found that health facilities in the districts are still experiencing stock outs of essential medicines despite the government efforts to address the challenges. The essential medicines considered were those that are used in the treatment of malaria, pneumonia and diarrhoea in children under-five. Table 3 below presents the percentage of stock outs at health facility level, which reveals the facility level most affected by the situation.

Table 3: Percentage stock outs at health facility level

Packages/Medicine	Health Facility Levels		
	Health Centre II (%)	Health Centre III (%)	Health Centre IV (%)
Coartem for malaria	20	20	00
Amoxylin for pneumonia	50	20	30
Septine for pneumonia	30	30	00
Oral Rehydration (ORS) Salt for diarrhoea	10	00	00
Zinc for diarrhoea	10	10	30

It is evident from the Table that most stock outs are occurring at health centre II level, which are also the closest to the households.

Much as essential drugs are important in the provision of services, to improve on the overall situation of ensuring timely and quality care, the challenge need to be tackled in combination with increasing the coverage of health centre and addressing absenteeism of health workers.

In planning to tackle the challenge of stock outs, two perspectives needs to be considered i.e. the perspective of the health workers at facility level and that of health managers at the district level:

- Health workers at facility level attributes stock outs to limited quantity of essential drugs supplied by the national medical store and excessive demand/high incident of the corresponding disease incidents requiring treatment.
- Health managers attributed the situation to logistical challenges facing the National Medical Store (NMS), shortage of drugs in the country and limited budget allocation for drug procurement to the Ministry of Health.

The perspectives shows the different understanding of the causes of the problem and points to the need to revisit resource allocation, procurement and logistical management of stocks.

In addition to having the essential treatment available to respond to cases of ailment, timely *immunization* protects children from killer diseases and increases their chances of survival.

The study considered the availability of cold chain system for keeping vaccines and the availability of essential vaccines which are *Bacillus Calmette-Guerin (BCG)*, *DPT-HepB+Hib*, *Oral Polio Vaccine (OPV)* and *Measles*. The functionality of cold chain system in the health facilities were found to be at 79.2%. The situation of cold chain functionality at district and facility levels is presented in Figure 2 below.

Figure 2: Cold chain functionality at district & facility levels

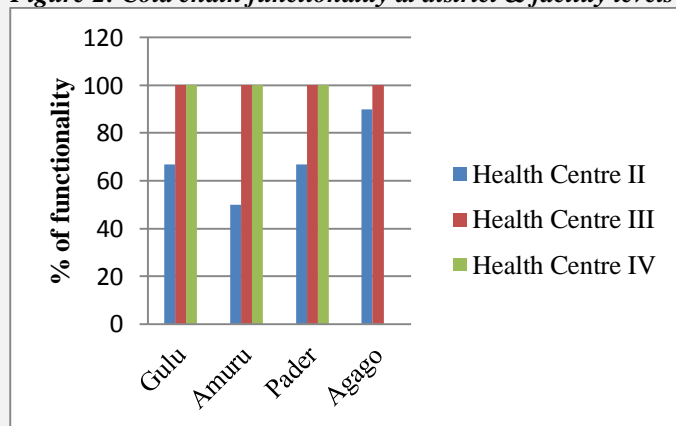


Figure 2 indicates that with the exception of health centre II across the districts, majority of the health facilities have functionality cold chain system. In

addition, health centre II in Agago district has the highest proportion of non-functional cold chain system.

As the situation with essential medicines for malaria, pneumonia and diarrhoea, the districts also lack the essential vaccines. For the benefit of district level stakeholders, Table 4 below presents the percentage availability of the vaccines.

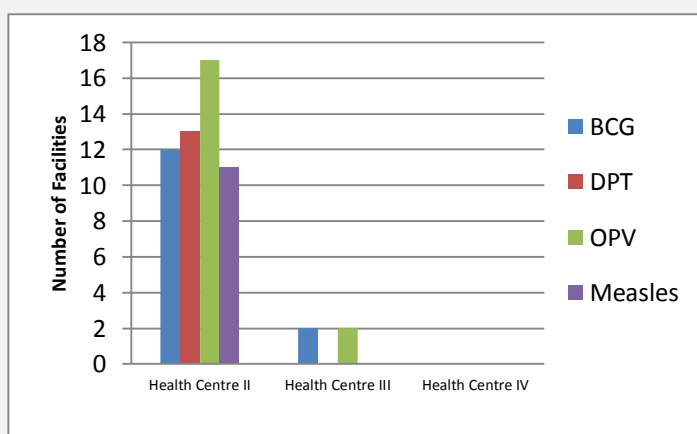
What is important to note from Table 4 is the fact that immunization services guarantee higher chance of protecting children when provided timely. Therefore, stock out means some children will not be able to get timely vaccination hence increasing their risk of suffering from the preventable killer diseases.

Table 4: Vaccine availability at district level

District	BCG	DPT	OPV	Measles
Gulu	58.8%	58.8%	64.7%	70.5%
Amuru	69.2%	69.2%	69.2%	69.2%
Pader	70.0%	70.0%	80.0%	80.0%
Agago	92.3%	92.3%	84.6%	92.3%

Another important question that should be answered in relation to immunization is: at what health facility level are the stock outs of vaccines accruing? Analysis of the information collected indicated that most of the stock outs are occurring at health centre II while health centre IV does not experience vaccine stock outs. Figure 3 below summarizes the situation.

Figure 3: Stock outs of vaccines by facility level



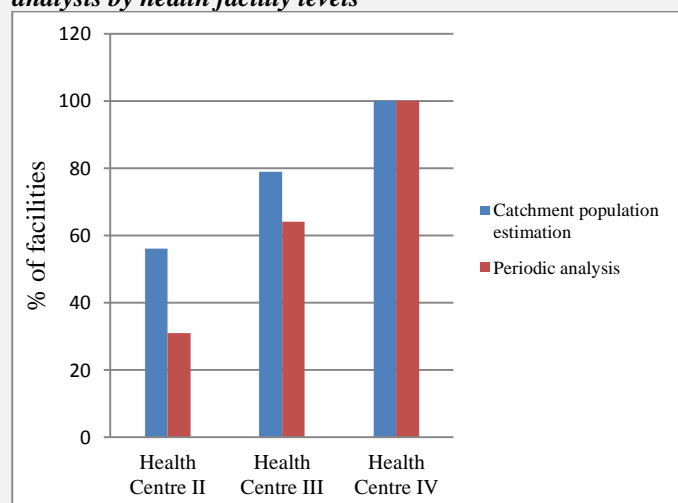
Health information management for effective planning

It is important for health system/facilities to know the size of population in the area served. Health workers also should systematically compile health data and periodically analyse to understand the trends of major illness affecting the population and the rate of service uptake by the targeted population. Below are the highlights of key findings.

- 64.2% of the health facilities were evidently estimating catchment population.
- 43.4% conducts periodic analysis of disease burden and service coverage, particularly for immunization.

As to which facility level conducts computation of catchment population estimates and performs periodic analysis, it was found that health centre IV performed better than the lower health centres. Figure 4 below presents the situation.

Figure 4: Computation of catchment population and periodic analysis by health facility levels



Therefore, with more than half of health facilities not knowing the trends of common diseases affecting the catchment population or the service coverage for essential services such as immunization and 35.8% of the health centres not knowing the size of population they are serving, planning for health service delivery at facility level is evidently done on an ad hoc basis by majority of the facilities, a practice that makes it almost impossible to measure performance against any target.

Participation of private providers in the rural health sector

To better understand the participation of private service providers in the rural health sector, comparisons has to be made with the government facilities in term of facility coverage, proportion of the professional health posts filled, rate of absenteeism, level of stock outs of essential medicines and health information management for effective planning. The findings are summarised below.

- 9.4% of health facilities are owned and operated by either NGO or private providers with facilities operating as private-for-profit being 3.8%.
- 80% of the private facilities are operating at health centre II level.
- 77% of professional posts are filled in the private facilities compared to 76% in the government facilities.
- Rate of absenteeism of health staff is 33.3% compared to 48.4% in the government facilities.
- Level of stock outs of essential medicines for malaria, pneumonia and diarrhoea is higher in private facilities than in government facilities
- 40% of private facilities computes catchment population and conducts periodic analysis of health information compared to 64.2% and 43.4% of government facilities computing catchment population and conducting periodic analysis respectively.

The above evidence indicates that the vast majority of health services in the rural areas are provided by the government facilities. Therefore, unless the stakeholders devised incentives to encourage private providers to invest in rural health system, the population can only hope to rely on government owned facilities to access health care.

What policy options are available?

The following policy recommendations relevant to both national and local government stakeholders are proposed.

- Government and partners should invest in increasing the coverage of health centre II in particular, which is much closer to the households and is the first point of reference for treatment, including for the leading causes of under-five mortality. Currently, the coverage is only 48%.

- Much as the government has recently filled a number of the vacant posts, raising the average to 76%, there is a need to adopt or strengthen as a matter of policy, strategies for attracting and retaining health workers in the rural posts and take firm measures to address absenteeism.

Strengthen the procurement and supply chain management for medicines and vaccines by the National Drug Store which is the primary supply source for government health system. The supply estimation should prioritize validated catchment population estimates and trends in disease burden for health facilities.

- Increase training and mentoring of health workers on health data management and utilization. This could be done through supporting the district biostatisticians who supports the lower health facilities and the use of appropriate technology such as the recently introduced MTrac.
- The government should explore and create conducive environment through incentives for private providers intending to set up facilities in rural locations.

Most implementable options

In the light of the policy options, the following are implementable almost with immediate effect.

- Increase budget allocation for infrastructural development and direct the resources for the development of more health centre II. This will enable increased accessibility of households to health facilities within 5km radius. For the case of Northern Uganda, the stakeholders could take the advantage of the current Peace Recovery and Development Programme (PRDP) with multi-stakeholder contributions.
- Health managers and district health team (DHT) at district level could strengthen support supervision to rural health facilities. This could ensure that health workers at least stay at the facilities during working hours and provide the necessary services. What need to be addressed for the option to work is to provide the DHTs with transport means.
- District biostatisticians could increase support to health workers through on job training and mentoring on health data management. This will improve the quality of health information required for effective planning, monitoring and evaluation. The opportunities for this option are the availability of development partners, including UN agencies with resources earmarked for the activity and the fact that most districts have qualified biostatisticians.

Stakeholders and the policy options

Below are the analyses of how each of the stakeholders in the health sector is linked to the policy process and how they could influence the policy options.

Legislature/policy makers and Ministry of Health: in addition to passing policies, legislators in the parliament are responsible for the deliberation and approval of health budgets presented by the Ministry of Health (MoH). The aim here is to ensure that the presented budgets are in line with the implementation of activities relevant to the National Health Policy. For an effective deliberations and decision, the MoH has to present an objective budget backed by evidence and a clear definition of the expected outcomes of the implementation. The MoH proposal is also critical in mobilizing resources from donor and other development partners. Therefore, the health plans and budgets should take the interest of the different stakeholders into consideration.

The local governments: In addition to mobilizing local resources, the local governments are primarily responsible for the implementation of policy options. In a bottom-up approach to planning, their critical role is forwarding the prioritized options to the Ministry of Health, donor, and other civil society organizations (CSOs) for funding. Therefore, they need evidence based prioritization.

Donor community and United Nations agencies: Donor and UN agencies have been instrumental in mobilizing resources for the health policy implementation through both programme support and basket funding – where government have the liberty for allocation. In addition to resource mobilization, they could play an instrumental role in influencing the legislators and the MoH to prioritize the implementation of the identified health policy options through either advocacy for prioritization or earmarking resources for the health sector to the identified options through programme support. UN agencies in particular have further leverage of influencing government through the United Nations Development Assistance Framework (UNDAF) which specify priorities and linked to both national and global commitments.

Civil society organizations: Like the donor agencies, CSOs has the leverage of influencing the

government to prioritize policy options for implementation. In addition, some CSOs have been involved in direct programme implementation through donor support. As such, they could as well promote the options through targeted interventions with emphasis on rural areas.

Private sector: the role of private service providers in respect to the options could be in the form of establishing health facilities in the rural areas. However, with the perceived low effective demand in the rural areas, the effectiveness of this suggestion depends on government initiatives to provide incentives. Private providers could also demand for the incentives.

The community/intended beneficiaries: the health and wellbeing of this stakeholder is the ultimate objective and outcome of efforts by the other stakeholders. Their influence on the policy options is through forwarding their demand/interest so that it is on the policy agenda at both district and national levels. This could best be approached through ensuring that policy formulation and implementation strongly embrace the human rights based approach to programming (HRBAP) where intended beneficiaries (claim holders) are empowered to demand for services from the duty bearers. In respect to the options, beneficiaries should be empowered to express the need for more health facilities and quality services which could provide the MoH with evidence for justifying allocation of resources.

Conclusion: Fulfilling health policy requirements to an extent that could witness a significant reduction in under-five mortality and potentially achieve the MDG 4 still require the government and development partners to invest resources and efforts in increasing coverage of health centres; attracting, retaining and addressing absenteeism of health workers; improving supply chain management; training and mentoring rural health workers on health data collection, analysis and utilization; and providing more incentives for private providers to invest in the rural health sector.

About the Author

Richard Ocaya Kica, School of International Development (DEV), 2013

University of East Anglia, UK

Emails: r.kica@uea.ac.uk, kicaocaya@yahoo.com

Tel. +256(0)772 304044 / +256(0)712 304044