

Concept Note

Strategic framework for health sector recovery in Northern Uganda

Presented to health sector stakeholders
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Introduction

The sub-regions of Northern Uganda have been afflicted by a 21 year long armed conflict resulting in disruption of service delivery. Recognizing the opportunities opened by the current peace talks in Juba and the need to foster a recovery process that can contribute to restoring livelihoods and revitalize social sectors, the Government has recently launched a Peace, Recovery and Development Plan (PRDP) for Northern Uganda.

The PRDP represents the overall framework for recovery activities in the Northern part of the country. It has been complemented by a UN Early Recovery Strategic Framework for Ugandaⁱ. More detailed sector strategies and plans are needed to make the PRDP operational and link it to the current planning and budgeting processes. With the consultation process around the draft document on the recovery strategy, the health sector wants to initiate a policy dialogue on the development of a framework that lays the grounds for a successful sector recovery in Northern Uganda.

The overall **aim of the sector recovery** is twofold: a) to strengthen health systems and restart services that collapsed during the conflict, and b) to gradually expand their coverage in isolated areas, where access is limited. The progress achieved towards these aims will contribute to improving the **health status** of people living in areas affected by the protracted crisis and to stabilizing **peace and security**, and will support people in restoring their **livelihoods**.

Humanitarian situation

A vast humanitarian response programme is ongoing to address the consequences of the complex and protracted crisis in Northern Uganda. Humanitarian assistance is largely funded through a Consolidated Appeals Process (CAP) and delivered by United Nations agencies and international and local NGOs. In 2007 the CAP presented requirements for 319 million US\$ and received 222 million, mostly for food aid. The two main goals of the 2008 CAP, to be launched soon, are: to **save lives** by providing emergency assistance where required and ensuring rapid response capacity in emergency situations, and **facilitate recovery** by promoting durable solutions and re-establishment of livelihoods, including disaster preparedness measuresⁱⁱ.

The improvement in security conditions in conflict-affected areas has led to a spontaneous return of large number of Internally Displaced People (IDPs) to their areas of origin or to intermediate transit locations. The multiplication of IDP sites has led to serious logistic and programmatic challenges, which have resulted in a shift in emphasis from supporting services in IDP camps to delivering assistance at the parish/ sub-county level.

Despite a justifiable interest in moving away from humanitarian assistance towards recovery and development activities, a large part of the population is still displaced. In IDP camps and in other parts of Northern Uganda, various factors still determine a situation of severe vulnerability, which require relief interventions, whereas in other parts of the region there is the need for starting or scaling up recovery activities. As a result, the recovery efforts will be additional and concurrent to

ⁱ Humanitarian and Resident Coordinator, UN Uganda; Facilitating durable solutions for sustained and peaceful communities; Early Recovery Strategic Framework for Uganda, draft October 2007

ⁱⁱ Draft CAP 2008, Uganda

the ongoing relief interventions, building, whenever feasible, upon existing humanitarian programmes and capacity.

Health sector challenges to be addressed by the recovery programme.

This analysis looks at the four functions of a health systemⁱⁱⁱ (stewardship, generation of inputs,^{iv} financing, service delivery) to contribute to its ultimate goal, i.e. improving health outcomes.

For what concerns the **stewardship** function, at Central MoH level, a dedicated task force has dealt with overall coordination of the emergency response to the humanitarian situation in the North. A vital role in coordination of the humanitarian response is also played by the UN Health, Nutrition and HIV/AIDS Cluster, led by WHO. No dedicated structures for health sector recovery activities in Northern Uganda are currently in place.

At district level, a complex interplay of external factors, the presence of multiple stakeholders and funding modalities, weak managerial capacity, under-funding and lack of qualified human resources prevent health authorities from effectively exercising their leadership function. Monitoring and supervision are often incomplete and lines of accountability sometimes unclear.

The **health care network** in Northern Uganda is slim, in particular at the level of Health Centres II. Many facilities have been damaged, either directly through conflict-related destruction, or as a result of neglect. Consequently many health facilities lie in a condition of disrepair and a vast proportion are not functional. Health facilities are also unevenly distributed, with a relative concentration in areas where IDPs are currently located and a severe shortage in others.

Human resources for health represent an area for concern in Northern Uganda. Insecurity, lack of accommodation and basic amenities, inadequate supervision capacity contribute to a permanent under-staffing of health facilities, especially with regards to higher-level cadres. Attracting, motivating and retaining qualified health workers, especially in remote areas, is probably the biggest and most difficult single challenge for improving service delivery.

The supply chain for **pharmaceutical and medical products** encounters several difficulties and many facilities report frequent stock-outs of tracer drugs.

For what concerns the **financing function**, there is uncertainty on the precise resource envelope for health of Northern Uganda. Multiple funding channels are in place and consequently tracking of financial flows is challenging.^v It also seems that there might be significant differences in allocation (especially of external resources) among the different sub-regions of Northern Uganda. Conducting an objective and comprehensive review of the resource envelope has not been done yet and this critical to be able to estimate the actual health spending per capita. Pooling of resources is imperfect, as different funding and disbursement mechanisms are in place.

Service provision in Northern Uganda is fragmented across a variety of actors. International agencies and private non-for-profit (PNFP) providers play an important role in service delivery, in particular in areas with large population displacement. Recent service availability surveys show that the Uganda National Minimum Health Care Package is not fully implemented, as in many circumstances sub-standard services are provided by insufficient and poorly motivated health workers operating in often dilapidated health facilities. Cooperation between Government and PNFP is overall positive, but there is scope for better integration of planning and monitoring at the district level and for strengthening the framework for public-private partnership.

ⁱⁱⁱ According to a WHO health system framework introduced by the World Health Report 2000.

^{iv} Such as infrastructure, human resources, and pharmaceutical products.

^v Uganda Multi Donor Group, 2007. *Northern Uganda Public Expenditure Review*.

In terms of **health outputs and outcomes**, the situation of Northern Uganda needs careful analysis. Some output indicators, such as utilisation of out-patient services, DPT 3 and TT 2 coverage, are overall higher in IDP camps or in the North Region than in the country as a whole or in other rural areas. This finding can be explained with the concentration of population and health providers in camps, where the population can be easily targeted with mass-scale preventive health interventions.

The condition of severe and chronic vulnerability of the population of these areas was however highlighted by recent surveys, especially in Karamoja.^{vi}

In terms of infant and child mortality^{vii}, the sub-regions of Northern Uganda score worse than the national average and the average for rural areas.

Table 1: Comparative mortality figures (Source: UDHS 2006).

Indicator	National average	Rural areas average	North Region	West Nile Region	IDPs	Karamoja
Infant mortality rate, per 1,000 births	76	88	106	98	123	105
Under 5 mortality rate, per 1,000 births	137	153	177	185	200	174

It is also important to consider that, as security conditions improve, IDPs are moving away from camps and return to their areas of origin or to intermediate transit locations. The scattering of the population away from the existing camps will make them harder to reach with health services, and therefore in the short-term a deterioration of health service coverage figures can be anticipated.

Addressing this challenge requires, during this transition period, the expansion of health services in the areas where the population will settle, in parallel with investment in the sustainable recovery of the health system.

Development of a health sector recovery strategy

A **vision** of the health sector in Northern Uganda can be outlined as follows: by 2010 empowered health authorities at district level, with a strengthened capacity and more resources, will be able to steer effectively a health system that will operate at improved levels of efficiency and with a better coordination of sector stakeholders. This will translate in progressively improving health outputs and outcomes.

The development of a health sector recovery strategy which aims at materialising this vision implies the assessment of policy options on each of the key aspects of the health system. This can be achieved through an inclusive consultative process involving the most important sector stakeholders.

The importance of strengthening the Government's **stewardship** function through sustained capacity building efforts cannot be overemphasized. Capacity building will need to concentrate the focus on core **governance and management** functions, without which the provision of material inputs is unlikely to have an impact. The importance of effective and inclusive **coordination** is to be stressed, and various policy options are explored in the draft strategy paper.

^{vi} Uganda Nutrition Bulletin, November 2007 (draft).

^{vii} Uganda Demographic and Health Survey, 2006

The strategy will advocate for the provision of inputs to be based on a realistic forecast of the resource envelope and a fair assessments of the implementation and absorption capacity. For what concerns **infrastructure**, in an initial phase the priority should go to the rehabilitation of health facilities, with a limited construction of new health units in strategic areas. In a second stage new health facilities should be constructed, to increase access and reduce inequity in supply of services. Infrastructure development plans should be based on expected population settlement patterns.

The strategy will recommend the strengthening of the **human resources** management system, with measures implemented for motivating staff to work in remote areas.

The pharmaceutical **supply chain** should be assessed in its totality and measures identified to address the weaknesses at the appropriate level.

A pre-requisite for a successful sector recovery is to guarantee an adequate amount of **financing**, and a more efficient flow and use of funds. The draft strategy will present a tentative and preliminary estimate of the resources required to revamp the health services in Northern Uganda. The relative merits and limitations of different funding channels will be examined. Strategies for enhancing technical and allocative efficiency will also be explored.

The strategy for a more effective **provision of services** will require a streamlining of public-private partnerships. Solutions that seem promising in light of the positive results achieved in other countries (such as performance-based financing and contracting of health services) can be considered.

Road Map.

The following table presents a **road map** for moving ahead the policy dialogue around the recovery strategy over the next few months. The need for inclusive consultations is stressed, together with the importance of linking the formulation of the recovery strategy to the planning and budgeting cycle at central and district level.

Table 23: Road map and milestones.

Activity	Timeframe/ milestones	Responsibility	Notes
Identify a working group with clear terms of reference and mandate for the recovery process in health	Early November	MoH/ WHO	Working group to include representative(s) of development partners and PNFP
Development draft 1 health sector recovery strategy	Mid November	MoH/ WHO	
Draft 1 circulated to sector stakeholders, including Local Government, development partners, PNFP	Late November	MoH	
Presentation of draft 1 to HPAC	Early December	MoH/ WHO	Information sharing on process also with Health Cluster
Link health component of PRDP to budgeting process	Mid December	MoH/ HPAC	Should involve Sector Budget Working Group
Negotiation and advocacy on MTEF ceilings to accommodate recovery	Mid December	Sector Budget Working	Needs high-level political backing

activities	- June	Group	
Dedicated TA to Central MoH in Planning Department	Late December	WHO	
Maintain and strengthen policy analysis capacity in WHO country office	January - June and beyond if needed	WHO	Ad hoc technical assistance
Finalisation and official endorsement of Health Sector Recovery Strategy (including macro-costing model)	Late January	MoH/ WHO, all health sector stakeholders	Inclusive workshop, possibility of donor conference to mobilise resources Finalisation requires development of a monitoring and evaluation framework
District level planning supported by Central MoH	December-March	DHOs/ MoH/ WHO and local partners	Needs development of specific guidelines based on Strategic Framework
Consolidation of district-level plans into one comprehensive health sector PRDP plan	April-June	MoH/ WHO	Includes discussion on financing flows and disbursement mechanisms
Filling information gaps through ad hoc surveys	January - June	MoH/ health sector stakeholders	Service availability mapping surveys in West Nile, Teso, Karamoja. Analysis of health sector resource envelope, etc.
Deploy technical advisers to district level	Gradual, depending on needs and resource availability (extends into FY 2008/09)	Health sector stakeholders	

Note: the preparatory activities described above can be roughly costed at approximately 500,000 US \$.