Health services delivery by PNFP subsector in Uganda.

The case of Medical Bureaus

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Introduction
Introduction

• Established by an ACT of Parliament, UPMB was Founded in 1957
• UPMB is a National PNFP Coordinating body for Protestant health services in Uganda-Anglican, Adventist and Pentecostal Churches.
• UPMB has a network of 278 Health Institutions in Uganda-number growing. (20 Hospitals)
• Approximately 80% of the member institutions are located in rural and poor communities across Uganda.
VISION & MISSION STATEMENT

• **VISION:** “Transformed lives through Christian quality health care”

• **MISSION:** "Supporting members to witness for Christ through the provision of quality health care”

• **GOAL:** “To improve health of communities through provision of Christian based quality health care”
Core Values

• **Christ Centeredness**: Being compassionate is central in the implementation of UPMB activities.

• **Value People**: UPMB treasures the human nature in the implementation of its programs without discrimination, favour or special treatment.
• **Transparency:** UPMB supports consultation and participation of all stakeholders at all stages of their interventions and are accountable to the communities they serve. UPMB will continuously advocate for a responsive and accountable health care system that provides quality health care services to the consumers at all times.
• **Stewardship:** UPMB believes in competence in service delivery at all levels and puts efficiency and effectiveness at the forefront of program implementation as a measure for quality service delivery.

• **Dynamism:** Dynamism is a central principle in the management of UPMB programs which involves being innovative and visionary.

• **Team work:** UPMB values the strength of team work to achieve its goal. Its functional teams are built within the organization and among its partners to efficiently implement its programmes.
Implementation structure

- There are nine (9) Zonal Coordination Committees that bring together Dioceses in similar geographical Location and a Tenth Zone is to be created from Eastern B sub region as it has the highest number of HF (>58)
- Regional Coordinators are to be created in support of the poorly performing Zones so as to improve service delivery
Currently, our programs/projects are being implemented as Health System Strengthening which targets the entire network of 277 Member Facilities. This includes:

a) Institutional Capacity Development
b) Advocacy, Resource Mobilization, Research and Grants Management
c) Patient Safety & Quality Assurance
d) Coordination
e) HIV/AIDS & RH including FP
f) Collaboration with other Bureaux, HDPs, WHO, JHM, CDC, USAID, CCIH, IRH, Pathfinder to mention but a few
Implementation structure

• Increase accessibility to drugs and medical supplies for our member units.
• Undertake accreditation of facilities prior to their Registration
• Representation at National level through the Health Policy Advisory Committee and All Technical Working Groups
• Our Facilities offer Holistic health care which Includes; Palliative Health Care, Obstetrics & Gynecology, General Medicine, Pediatrics, Surgery, Orthopedics, Physiotherapy, Occupational Therapy, Dental Health, Spiritual & Psychosocial support to mention but a few.
Partnership is......

"the formal relationship between two or more partners who have agreed to work together in a harmonious and systematic fashion and being mutually supportive towards common goals, including agreeing to combine or share their resources or skills for the purpose of achieving these common goals” (MoH 2003).
DEFINING NOT-FOR-PROFIT

✗ Aim is not to make profit
✗ Social / civil society concern
✗ Need money to meet cost of services
✗ Surplus is not distributed / shared by owners
✗ Surplus may be used to improve services
  → Quality
  → Scope
  → Volume
  → Reserved for development that improve services
    e.g.
    ✗ Expand infrastructure required for services
Who are the PNFP?

• Civil society organizations that:
  • Operate under guidance of a written charter
  • Do not distribute surplus to owners or directors
  • Are self governing entities
  • Employ staff
  • Have a meaningful voluntary component in their services
Categorization of the PNFP(1)

• Facility based private not for profit health providers
  • Largely faith based
  • Operating out of social concern
  • Have a sizeable capital investment in place; i.e. Health Facilities
  • 75% are organized under national umbrella organizations: the 4 medical bureaus
Categorization of the PNFP(2)

• Non facility based private not for profit health providers
  • Do not directly own or operate health facilities
  • Support/undertake health development activities in partnership with government
  • Include international, national and local NGOs/CBOs
Background to the partnership

In 1954, The Frazer Commission recommended that public subsidies be introduced for the “voluntary health sector”

Under general notice 245 of 1961, GoU initiated support to the “voluntary” health service providers.

In 1986 The Health Policy Review Commission recommended that the collaboration between Public and Private providers be revived.

1993 government White Paper on Health Policy highlighted the need of strengthening collaboration with the private sector.
Background to the partnership

- In February 1996: UPMB and UCMB submitted a Memorandum to the Ministry of Health identifying their respective units as PNFP operating for social goals and denouncing an impending crisis of the sector.
- In December 1996: the Minister of Health established a task force to study options and propose recommendations to Cabinet to justify subsidies to the PNFP sector.
- In 1999 representatives of the PNFP sector participated in the launching of the SWAp at WHO Geneva.
- In 1999 the National Health Policy declared that: “Strengthening the collaboration and partnership between the public and private sectors in health is an important guiding principle of the National Health Policy”.

Uganda Protestant Medical Bureau
Current structures of coordination

- Facility based PNFP mainly coordinated under the religious/denominational medical bureaus:
  - Uganda Catholic medical bureau (1956)
  - Uganda Protestant medical bureau (1957)
  - Uganda Muslim medical bureau (1998)
  - Uganda Orthodox medical bureau (2009)

- Non Facility based PNFP:
  - Ad hoc coordination structures
  - Disease specific coordination
  - Uganda health NGO network?
Contribution to the health system

- Policy development
- Health service delivery
- Financing
- Community participation
- Human resources development
- Technical assistance
Policy development

• Space for participation created by the sector wide approach structures
• Extensive participation by the medical bureaus in central level policy and plan development
• Health facilities involved to varying extents in planning at district level
• Participation of the Non facility based PNFP has improved in recent years
Health service delivery

**Infrastructure, human resources for health and human resource development:**

- 30 - 35% of all fixed health facilities
- 40% of the Country Hospitals
- 45% of the Country Hospital Beds
- One third of the Work-force serving the country Strategic Plan
  - i.e. about 11,000 of the 36,000 Health Workers
- 60% of the nurses in Uganda are trained in 20 PNFP schools
HEALTH SERVICE DELIVERY

✖ Planning and management of health services at all levels.
  ✗ e.g. 29 PNFP facilities are Health sub district headquarters

✖ Provision of the national minimum health care package
  ✗ Increasing access to the package

✖ Provision of community based services
  ✗ Outreaches, home based care, CORPs
PNFP Contribution to the resource envelope

- For every shilling of the 17.74 bn that GoU allocates to the PNFP
  - PNFP Facilities add themselves to the kitty of the envelope available (user fees, IGA, donors)
  - To the tune of 3-4 UgSh added per 1 UgSh actually received
- It is not a bad arrangement for Government
PNFPs in SWAp (UCMB+UPMB+UMMB networks = 75% of PNFP)

PNFP Receive 7% Govt. Annual Health Budget

3 PNFP Networks contribute 30-35% Health Service
Financing structure of the fb-pnfp sector

- GoU: 22%
- Fees: 39%
- Traditional Donors: 9%
- AIDS and GI related funding: 30%
POLICY FRAMEWORK FOR PARTNERSHIP WITH PNFP
Partnership goal and objectives

Goal:

“To contribute to strengthening of the national health system with the capabilities and full participation of the PNFPs to maximize attainment of national health goals”

Objectives:

1. Increase equitable access to health care
2. Optimize the use of available resources
3. Improve service quality through quality assurance and integrated HRD plans
Rationale for the partnership

– Joint ownership of national policies and plans through SWAp and IHPs
– Shared mission and objectives
– Improving equitable access to services
– Functional integration to optimize available resources
– Resource mobilization
– Human resource development
– Accreditation to support GOU regulatory function
GUIDING PRINCIPLES

- Participatory policy formulation and planning
- Integrated plans and operations
- Service provision ensured through delegation and agreements
- Complimentarity
- Respect of identity
- Respect of autonomy
- Equity, transparency and accountability
- Continuity of care through referrals across subsectors
IMPLEMENTATION FRAMEWORK
AREAS OF PARTNERSHIP

• Policy development, HSSP monitoring and evaluation
  – SWAp structures
  – Recognition of PNFP accreditation systems

• Planning and coordination
  – Through established coordination structures
  – Using innovations and best practices
AREAS OF PARTNERSHIP

- Financial resource allocation and management
  - Sharing information on available resources
  - The FB PNFP already shares all the information about inputs and outputs with Government: these inputs and outputs are captured by the Ministry of Health
  - Subsidising the PNFP
  - Developing contractual arrangements

- Human resources development and management
  - Harmonisation of staffing norms
  - Participation in HRD plan development
AREAS OF PARTNERSHIP

• Capacity building
• Community empowerment
• Service delivery
  – Delegation of management of HSDs
  – Preservation of autonomy and identity
  – Rationalization of service expansion
PARTNERSHIP STRUCTURES – CENTRAL LEVEL

- Joint review mission
- Health policy advisory committee
- PPPH working group
- PNFP sub working group
- PPPH desk of MOH
- Umbrella organizations
- Inter-ministerial standing coordination committee (MoES-MoH)
Partnership structures - district level

- District health management teams
- District PPPH officers
- PNFP coordination committees
- HSD management committees
- Hospital Boards
- Health unit management committees
- Sub county health committees
- Village health teams
Partnership tools

• Existing legislative framework
  – Legislation should aim to mainstream PPPH

• Memoranda of Understanding
  – At Central and local levels to institutionalize relationships

• Contracts and agreements
  – Aimed at formalizing commitments
  – Improved accountability and transparency
Partnership - Global

- University Hospitals of Leicester NHS Trust, England
- Countess of Chester Hospital, Chester, England
- James Cook University Hospital, Middlesbrough, England
- St. George’s Hospital, London, England
- Ipswich Hospital NHS Trust, Ipswich, England
- Imperial College Healthcare Trust, London, England
- North Cumbria University Hospitals NHS Trust, North Cumbria, England
- Guy’s and St. Thomas’ Hospital, London, England
- University Hospital Fann, Dakar, Senegal
- CHU Hospital Gabriel Touré, Bamako, Mali
- Port Bouet General Hospital, Abidjan, Côte d’Ivoire
- Komfo Anokye Teaching Hospital, Kumasi, Ghana
- Niger Hospital, Niger
- Yaoundé Central Hospital, Cameroon
- Hôpitaux Universitaires de Genève (HUG), Switzerland
- CHU de Rennes, Rennes, France
- Paris CHU, Paris, France
- Bordeaux CHU, Bordeaux, France
- University of Gondar Hospital, Ethiopia
- Church of Uganda (COU) Kisii Hospital, Uganda
- National University of Rwanda in Butare Teaching Hospital, Butare, Rwanda
- Hôpital Prince Régent Charles, Bujumbura, Burundi
- Mbeya Referral Hospital, Mbeya, Tanzania
- Kamuzu Central Hospital, Lilongwe, Malawi
- Hospital Central Beira, Beira, Mozambique
- Ndola Central Hospital, Ndola, Zambia
Church of Uganda Kisiizi Hospital
South Western Uganda
Change Model

• Based on partnership work
• Based on 6-step process
• Successes and challenges faced in each of the 6 steps
Step 1: Partnership Development

Step 2: Needs Assessment

Step 3: Gap Analysis

Step 4: Action Planning

Step 5: Action

Step 6: Evaluation and Review

Target action to:
- Strengthen health systems to support patient safety;
- Build patient safety capacity;
- Advocate and communicate for patient safety.
Healthcare Associated Infections

- No clear structures and mechanisms for infection prevention and control (IPC)
- No human resources designated for IPC activities
- No written policies and or guidelines in all areas of IPC
- No methods to assess compliance
- No system in place to conduct health worker training
- No hand hygiene system in place
- Lack of fulltime running water in sinks
- No ongoing CPD
Healthcare Waste Management

- A lack of total systems thinking for waste management.
- Nonexistent hospital policy on health care waste management.
- Some guidance on waste segregation, transport and disposal, but no capacity to handle toxic, chemical and radiation waste.
- No facilities for appropriate temporary storage of waste.
- No protocol on environmental cleaning communicated to cleaning and supervisory staff.
- Very limited training in health care waste management.
Safe Surgical Care

- Surgical workload compared to the capacity of the surgical team constituted a high risk for surgical safety.
- No mechanism for recording complications resulting from surgery and hospital deaths following surgery.
- No use of the safe surgical checklist by the surgical team and other staff members involved in surgical procedures.
- No ongoing CPD
Medication Safety

• No key hospital policy documents on medication safety
• A minimally functional drug and therapeutics committee
• No identified hospital staff to address medication safety
• No official job description for the hospital pharmacist, and under-emphasis on the role in medication safety
• No reporting system for adverse drug reactions and medication errors.
• No education mechanisms for health care workers and patients on medication safety.
Outcome

• Significant improvement on hand hygiene compliance and infection rates
• Hospital Infection prevalence which stood at six percent dropped to 1 percent.
• Infections especially during surgeries stood between one and five percent.
• HH Compliance increased to 80% -90% from 10%. 
Health Care Waste management

• Developed policies and procedures adapted them to suit the local needs
• Improvement works on the hospital incinerator and Construction of a new incinerator.
• Production of terms of reference for health and safety committee.
• Early planning on hospital laundry management
• Domestic cleaning schedules
• Educational awareness sessions for porters and staff guardians
• Procurement of a Washing Machine
Safe surgical Checklist

- Established a hospital safe surgery program
- Appointment of a lead professional for the hospital safe surgery programme.
- Conducting an initial training programme on the use of the safe surgical checklist.
- Developing an audit tool to monitor compliance in the use of the safe surgical checklist
- Maintaining on-going audit to assess compliance in the use of the tool
Evaluation and Review

• Repeat patient safety situational analysis - Annual
• Audits and spot checks (observe Health workers) undertaken to assess compliance - Monthly, Quarterly
Challenges/Opportunities

- Culture differences
- Initial fear of change
- Lack of knowledge and experience of working in a developing country
- Communication/maintaining relationships
- Maintaining momentum
- Significant differences in facilities/equipment
- High expectations/Goal setting
- Sustainability
CONCLUSIONS

- PPPH can be beneficial for the health sector when well prepared, implemented, and monitored, including being adjusted in an appropriate and timely manner.
- We strongly recommend the ratification of the PPPH policy by the relevant organs of Government.
- The PNFP is an important partner to government in health care delivery in Uganda and many African countries.
- A stronger partnership with the PNFP is therefore important and necessary especially in poor countries.
- Everyone has a role to play & as such I encourage all of us to get out their and partner with us.
THANK YOU FOR YOUR ATTENTION
Presidential Award
Success story – Peer education for religious leaders