

Capacity Building and Support to Primary Health Care Services in the Context of a Health Sector Decentralisation Policy

Final Report on Project SIDA 079/01

Save the Children UK (Rwanda) – December 2003 – Sida/1405/2715



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1 Context

The external context in Gatonde Health District, Ruhengeri, Rwanda (the implementation area) underwent an impressive change during the implementation period of this project, from (post) conflict to development. When the first draft of the proposal was written in 1999, the area was still in conflict. By 2000 this conflict had abated and the proposal was rewritten to reflect this reconstruction and rehabilitation phase. As so often in a post-conflict phase, baseline data were very limited and multiple assumptions had to be made.

On the basis of the 2000 proposal, the work started in February 2001 and continued, with a no cost extension, to September 2003. The external context continued to change fast during the implementation period and the project's objectives and activities were fine-tuned, in consultation with the stakeholders, to match the reality. The donor at Kigali level proved very supportive in this process.

Budget was disbursed according to original budget lines, with a six-month extension at no cost to the donor. Please see Attachment 1 - Financial Report (xxx.xls) and Attachment 2 - Activity Report (activity list.doc).

2 Goal and Objectives

The original goal and objectives were as follows:

Goal

To improve health service delivery of preventive and curative care and thus the health status of the community, particularly women and children.

Objectives

1. To assist and advise the Region as well as develop the capacity of regional authorities in the implementation of the MOH policy of district health care based on decentralisation and community participation.
2. Enhance the quality of, and increase access to, preventive and curative health care services for women and children through material support and human resource and capacity development at the service delivery level in 8 health centres.
3. To assist the District in increasing HIV/AIDS awareness amongst the population as a whole and particularly amongst older children and youth, whilst also assisting people already living with HIV/AIDS.

These were subsequently revised with the approval of the donor as follows:

Goal

To improve the overall health status of the residents of the health district of Gatonde in the Ruhengeri Province, by improving the quality of care by increasing the level of access, affordability and acceptability to preventive and curative health care services, especially for women and children. Capacity

building at all levels of the health district on the health decentralisation system of the ministry of health.

Objectives

1. To assist and advise the region as well as develop the capacity of regional authorities in the implementation of the MOH policy of district health care based on decentralisation and community participation.
2. Enhance the quality of and increase access to the preventive and curative health care services for women and children through capacity building of human resources and material support to the 8 health centres in the Gatonde District.
3. To assist the district in increasing HIV/AIDS awareness amongst the population as a whole and particular amongst children and youth.
4. Reduce the incidence of morbidity and mortality due to malnutrition among children, with emphasis of those below the age of 5 years and reduce the incidence of morbidity and mortality due to malaria.

3 Outputs

There is clear evidence that the output of our activities has contributed to progress on the first three project objectives (see Impact below). Evidence for objective 4, reduction of morbidity and mortality, is not available as no data collection method is currently functioning. After the initial physical rehabilitation and re-equipment phase the emphasis has been on capacity building. Please see Attachment 2 – Activity Report (activity list.doc) for a detailed list of activities undertaken since the progress report in January 2001.

4 Impact

This final report attempts to assess the *impact* of the project and to identify some next steps to improve the health status of women and children in Gatonde Health District.

It is based on three discreet pieces of work, carried out by Save the Children during the final year of the project, including data from the District Health Information System:

1. Child Needs Assessment, October 2002 - Attachment 3 (CNA.PPT)
2. Household Economy and Health Survey, May/June 2003 – Attachment 4 (HEH.PPT)
3. Comparison of raw data from the Rwanda Service Provision Assessment 2001 and updated benchmark survey, Ruhengeri – Attachment 5 (DHMIS.xls)

The data speak for themselves and the conclusions can not be escaped:

- 1) The SC-UK/SIDA health project made a significant contribution to the increased capacity and improvements in quality of the health service in Gatonde Health District.

- 2) The impact of the improvements on overall health status, certainly for those most vulnerable, has been limited.
- 3) User fees provide a major barrier to access for the majority of the population, effectively excluding the poor from health services.
- 4) The current pre-payment schemes or “mutuelles” are not working well.
- 5) The majority of the population will not be able to afford the proposed pre-payment schemes (even if they were fully functional).
- 6) The project would have benefited from a sharper focus on economics, specifically financing for the poor and vulnerable groups and the opportunity cost to communities of poor accessibility.

The GoR conducted a service provision assessment in mid 2001, using standardised and validated methods, and published this as the Rwanda Service Provision Assessment (RSPA) 2001, disaggregated by province. Please note that this method focuses on the availability of all components needed to deliver a health service not on the quality of delivery.

For the purposes of this impact assessment SC used the 2001 Ruhengeri data as a baseline. The provincial MoH and SC-UK jointly repeated this validation assessment in August 2003 in the SC core operational area. Unfortunately we did not have the resources to assess non-supported facilities as a control, so we do not claim attribution.

A Global Impact Monitoring assessment is under way with all stakeholders, including children, which will give an indication of the contribution of the SC-UK/SIDA project over 5 dimensions of change as perceived by the intended beneficiaries.

The main RHSP 2003, Ruhengeri/Gatonde findings are:

- All health facilities now have a reliable water and electricity supply (2001: 22%).
- All health facilities now have basic client amenities (2001:76%).
- All health facilities now have the ability to provide 24 hour emergency care (2001:10%).
- All health facilities have now at least the minimum staffing in place.
- All health facilities now have a reasonable amount of health education material, and trained staff.
- All health facilities now have committees that meet at least once every three months (2001: 65%) and 88% had reports available.
- Only 25% of health facilities had a “Mutuelle” (Community Prepayment Scheme) in place. These seemed to function at a low level only.
- All facilities received supportive supervision in the last six months and all staff received personal supervision and continuing education (2001:30%).
- All facilities now have a formal client feedback system.

- All health facilities now have functioning vaccine cold chains and reliable supply management (2001:68%), even though only 50% managed to store consistently in the correct temperature range (2001:38%).
- All health facilities now have resources for vaccination in place (2001:6%).
- 85% of facilities now have proper sterilisation equipment (2001:16%).
- All health facilities claimed to burn or bury infectious material, even though in 85% (2001:65%) waste was visibly not disposed of properly.
- All facilities had an essential medicine package in stock, and while some items had at times been out of stock, a minimal essential package seems to have been available at (almost) all times.
- All equipment and supplies for antenatal care and routine deliveries were present, with the notable absence of soap.
- None of the facilities offered any capacity to deal with complicated deliveries (2001:11%) or emergency care of the newborn.
- Only one ambulance is available (even if formally stationed outside the district).
- Family planning and treatment of STI is now almost universally available, while 63% claims to provide HIV counselling and 38% both counselling and testing.
- Virtually all services, with the exception of vaccination, now have to be paid for.

5 Conclusions

Since 2001 tremendous improvements have been made, and all the ingredients for the delivery of a basic health care package are now in place, with the exception of emergency obstetric care.

The sting however is in the tail: Payment.

The RSPA does not assess the actual functioning of the system and this is not easy to measure. We have only used the most fundamental indicator: utilisation rate. The raw data of the health management information system (DHMIS.xls) show that the population is hardly using the system.

No local baseline data on utilisation is available - only aggregated data for the whole of Rwanda is available. The crude utilisation in 1995 was 0.6 visits/person/year and this had dropped to 0.3 in 2001. The Rwanda MoH attributes this to the introduction of user fees (RSPA 2001, 2.6).

The district data for March-August 2003 show a crude utilisation rate of 0.38, with a range of 0.2 to 0.6. Under 5 utilisation stands at only 0.66. It is remarkable that only the best health facility in Gatonde achieved the same utilisation as Rwanda as a whole in 1995, a year with tremendous human resource constraints and an almost totally destroyed health infrastructure. This falls well short of the WHO recommended minimum of 2 visits/pr/yr.

These utilisation data contrast sharply with Ruhengeri's success in vaccination. Through a routine EPI system almost universal coverage has been achieved. This points to both a robust health system and excellent community mobilisation. Immunisation also happens to be the only part of the health system that is free of charge.

In October 2002 SC-UK did a Child Needs Assessment in Ruhengeri, together with the World Bank (see attached presentation CNA.ppt). This indicated that around 85% of the children were not having their health needs met, and was strongly suggestive of financial constraints as the main reason.

During the no cost extension period of this project SC-UK performed a Household Economic and Health Assessment in Ruhengeri. We used validated methodologies and capitalised on SC-UK's experience in the region. The presentation of summary results is attached (HEH.ppt).

The survey goes beyond the context of this project, but some of the main findings are summarised below.

Standardised wealth ranking (as defined by the community) showed:

Very poor:	15-25%
Poor:	35-45%
Medium:	25-35%
Well off:	5-15%

Average spending on social services (Health and Education):

Very Poor:	5-15% or 3750-7500 Frw per family per year
Poor:	10-15% or 8000-12000 per family per year

Minimum basic needs basket: minimum calorie requirements, salt, soap (no clothing, no health, no education, no shelter) is 90 Frw/day .

"Disposable income" after absolute minimum for the very poor is Frw 45/d.

Treatment of one malaria episode costs Frw 1000 or 22 days of "disposable income". Membership of a Mutuelle costs Frw 5000 or over 110 days "free money".

The work also indicates that the loss of income potential due to illness for the poor is larger than initially assumed. This might be very relevant for chronic illness such as HIV/AIDS. Opportunity cost in seeking health care needs further work.

This high financial barrier is reflected in Mutuelle membership, disaggregated by wealth group. Very poor: 5%, poor 14%, medium 21%, better off 31%. In addition the poor tended to enroll only breadwinners.

The mutuelles did not seem to function very well, with entitlements not clearly defined and absent formal MoU's with the health facilities. The provincial health authorities are also not clear about the budget implications. We have

commissioned a study into this with the MoH, from the final Sida budget. (See Attachment 6 or tormutuelles.doc).

6 Recommendations

We have demonstrated in Ruhengeri that the current health sector financing strategy effectively excludes the poor from accessing services. We have indications that the total cost of illness is much more than the “cost recovery” aspect, and should include both opportunity cost and loss of income generating potential.

Total loss to Rwanda’s capital, both financial and social, due to illness is very high. This will be even more so if the impact of chronic illness such as HIV/AIDS is taken into account.

These factors must be taken to the debate on the Rwanda Poverty Reduction Process in order to develop a poor friendly, sustainable, health financing system.

Our data indicate that the proposed roll-out of “mutuelles” will effectively exclude the majority of the population. Pilots with alternative financing models, such as community managed exemption schemes, are urgently needed, and need proper documenting and feeding in the policy debate, to enable fast roll out of successful models. SC-UK is in an excellent position to assist with this, funding permitting.

The long term macro-economic impact of any financing strategy needs to be carefully assessed: both the costs of putting equitable access in place, for GoR budget provisions and donor allocations, and also the long term costs to Rwanda of NOT providing equity of access.

The GoR plans large-scale introduction of anti-retroviral therapy. This will only be effective if barriers to access to health services are minimised. The introduction of fairly complicated, and very expensive, therapy, such as anti-retrovirals, will need a considerable increase in the capacity of the whole health system. SC-UK has proven that a large capacity increase is possible in a short time frame. We believe that we are in a position to pilot this, document it, and assist with a fast scale-up.

1 Attachment – Financial Report

2 Attachment – Activity Report

3 Attachment – Child Needs Assessment

4 Attachment – Household Economy and Health Survey

5 Attachment – RSPA 2001 – 2003 Comparison

6 Attachment – Mutuelle Survey Terms of Reference