Private sector engagement to deliver maternal, newborn, child health and family planning services during COVID-19 in Uganda

Introduction

The spread of COVID-19 - together with the need to harmonize national and international health emergency response - has made it clear that efforts to achieve Universal Health Coverage (UHC) and to respond to health crises are reliant on a whole-of-society approach. Leveraging the private sector for healthcare service delivery is key to advance the UHC agenda and to efficiently respond to health emergencies, ensuring that all health-related services and goods are available, accessible, acceptable, and of high-quality for all, irrespective of where people seek care.

In this context, teams at WHO have intensified their work on private sector engagement to achieve UHC goals. The Health System Governance and Financing (HGF) department in 2020 launched the WHO Private Health Sector for COVID-19 Initiative (WHO-PCI) to offer rapid, real-time, evidence-based, and tailored support for countries to better respond to the pandemic and to prepare their health systems for the post COVID-19 period. Likewise, the department of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA) has been supporting 19 countries in five regions to mitigate the impact of COVID-19 on essential maternal, newborn and child health (MNCH) and family planning (FP) services.

Building on the existing efforts of WHO's HGF and MCA departments, this study will document the experience, benefits, challenges and lessons of engaging with the private sector to maintain the delivery and use of MNCH and FP services and protect UHC outcomes (quality, access, financial protection, etc.) during and post-COVID-19 pandemic. Three countries, corresponding to three different WHO regions, have been selected for this study: Bangladesh, Pakistan and Uganda. This paper summarizes the literature review conducted for Uganda.

Methodology

A literature search was performed in August 2021 utilising a comprehensive search strategy on the WHO COVID-19 electronic bibliographic database for articles published between January 2020 and June 2021. The search strategy was developed with Medical Subject Headings (MeSH) and text words, using Boolean operators to combine the search strings. We initially combined private sector related terms with MNCH and FP terms in the WHO COVID-19 electronic bibliographic database search string. However, this produced zero results. We therefore removed private sector related terms from the search string which yielded 57 citations. We also performed a google scholar search through Publish or Perish software, filtered per country of interest. This yielded another 200 citations.

We used Rayyan as support software to screen and select the studies identified though the strategy search. Through Rayyan the titles and abstracts of the articles were firstly screened with the aim to exclude articles with titles and/or abstracts unrelated to essential service delivery during COVID-19. Through the search and screening process, we identified 18 citations for full analysis. These included eight research articles (inclusive of one modelling impact on essential services), five commentaries (one was not specific to Uganda but included two authors from Uganda) and six articles from the grey literature; these included Government of Uganda guiding documents, a case study and presentations/reports. The research literature covered communicable diseases (HIV, malaria), non-

communicable diseases (cancer), maternal, neonatal, child, sexual and reproductive health as well as cross cutting areas (self-medication, equity and human rights). The literature included a mix of Ugandan and international authors but was predominantly a Ugandan authorship.

Framework

Findings have been structured using the WHO governance behaviours, a framework adopted in the WHO strategy, "Engaging the private health service delivery sector through governance in mixed health systems". Behaviours have been operationalized for essential health services as follows:

- Align structures: alignment of public and private structures for the continuation of essential health services during the COVID-19 response
- Foster relations: coordination arrangements and sectoral engagement for the continuation of essential health services during the COVID-19 response
- Build understanding: private sector data capture and information exchange for the continuation of essential health services during the COVID-19 response
- Enable stakeholders: the development and implementation of financing mechanisms and regulations, to authorize and incentivize health system stakeholders for the continuation of essential health services during the COVID-19 response
- Nurture trust: recognition of competing and conflictive interests for continuation of essential health services during the COVID-19 response
- Deliver strategy: organisational learning and innovation to improve engagement of the private sector for the delivery of essential health services during the COVID-19 response

Align structures

This behaviour considered the alignment of public and private structures for the continuation of essential health services during the COVID-19 response

Uganda's health system includes approximately 7,000 health facilities with just over half of these privately owned and operated. Private providers include for profit and not-for-profit facilities, located in rural and urban areas. They play an "outsized" role in urban areas and comprise almost all of the health facilities in the capital city of Kampala [1]. Despite their contribution to the health system in Uganda, a clear role was not established for the private sector in the initial phase of the COVID-19 response [1].

The Government of Uganda prepared guidelines for continuity of essential services, prioritizing services based on the primary health care package [2]. A program criticality matrix was used to aid prioritization using four scenarios (no COVID-19 cases, sporadic cases, clusters of cases, and community transmission) [1]. Despite these efforts, the COVID-19 response largely focused on government tertiary and intensive care facilities. At primary care level, no re-organisation was done to effectively maintain essential health services and respond to the pandemic [3]. Views within the medical fraternity indicated that the response should have included primary health care (PHC) providers, given that "they see the most patients, particularly those in private practice" [3].

Emergency response measures precluded access to essential services. These were both demand and supply driven, and most acute during periods of lockdown, when major movement restrictions were

imposed [3, 4]. Movement restrictions curtailed health worker and patient access to facilities [4-6]. Some facilities reduced provision of essential services, by rationing appointments and curtailing outpatient services [5, 7, 8]. Preventive services and outreach programs were also suspended while public sector health workers were redeployed to designated COVID-19 facilities [7].

Foster relations

This behaviour considered coordination arrangements and sectoral engagement for the continuation of essential health services during the COVID-19 response

The Government of Uganda designated a Ministry of Health (MoH) focal point, the Director Clinical Services, to oversee continuation of essential health services. This role was mirrored at district level under the District Health Officer. The guidelines further provided for a coordination mechanism at national and district level.

The private sector organised itself due to concerns with coordination that existed before the pandemic. Pre-existing coordination arrangements included a Health Policy Advisory Committee (HPAC) and the Public-Private Partnership in Health technical working group (PPP/H TWG). In lieu of these platforms, the private sector "initiated data collection on resource availability across private facilities"[1]. Dialogue with the MoH ensued, led by the Uganda Healthcare Federation (UHF) which resulted in private sector representation on the National Taskforce (NTF) for COVID-19 [1].

The NTF and sub-national mechanisms have remained intact, however, based on the 2021 Resurgence Plan, there is limited "linkages" between the central response structure and the districts while some of the response pillars have coordination, communication and consensus challenges [9]. Within the resurgence plan, there is no explicit mention of the for-profit private sector (in relation to continuity of essential services) while the faith-based medical bureaus are mentioned but only in relation to risk communication as part of the COVID-19 response [9].

Build understanding

This behaviour considered private sector data capture and information exchange for the continuation of essential health services during the COVID-19 response

The literature suggested that lockdown measures in Uganda had an immediate impact on access to essential services. For example, the Kampala National Referral Hospital saw a dramatic decrease in antenatal care (ANC) attendance during the initial lockdown (April 2020) as well as a rise in adverse pregnancy outcomes, inclusive of low-birthweight and premature infant births [8]. The Kampala study referenced similar findings for rural facilities. Utilisation of immunisation clinics was also affected, while, in contrast, there was an increase in childhood malnutrition clinic attendance [8].

There was reported to be greater "resiliency" in sexual health and contraceptive services [8], likely shored up by non-governmental organisations. This was also observed for the utilisation of HIV services, which "bounced back quickly" in part due to international support [8] and adaptation of service delivery approaches [6]. Malaria services were also resilient and showed only a modest decrease in the use of diagnostics and prescribing practices (as reported for the period April 2020-March 2021), while other malaria indicators reportedly remained stable [10].

A MoH report based on routine information indicated a "rebound" in the use of essential services by August 2020, but acknowledged poor data quality and uneven reporting across districts [11]. Issues with data quality pre-existed COVID-19 and may have been exacerbated due to reporting demands

and surveillance of COVID-19 cases [5]. Interest in the use of data from routine information may have improved. For example, one research study on HIV dispensing practices, reported that the COVID-19 lockdown necessitated health workers to use routine services statistics in "an unprecedented way" to reduce patients being lost-to-follow-up [6]. The degree to which the private sector was included in routine systems and the use of data for information exchange was not addressed in the literature.

The literature indicated changes in the availability in medicines and supplies for essential services during the initial phase of COVID-19. The Kampala study noted shortages in some medications and vaccine availability both pre- and post-lockdown, due to import restrictions and reallocation of finances to the pandemic [8]. Another study highlighted the use of self-medication particularly amongst women [12]. While this was widely practiced before the pandemic, the reasons cited for self-medication during the pandemic included fear of being diagnosed COVID-19 positive at a health facility. Adaptations to HIV dispensing practice through longer supply of refills may have contributed to stock-outs at some facilities due to limitations in the government supply chain capacity [6]. Private sector providers using alternative distribution channels to government, such as the Joint Medical Stores (JMS), were reportedly more flexible in their supply chain strategies and able to place longer-term orders [6].

Enable stakeholders

This behaviour considered the development and implementation of financing mechanisms and regulations, to authorize and incentivize health system stakeholders for the continuation of essential health services during the COVID-19 response

Uganda's health sector is highly reliant on external sources of financing, derived from development aid and private health expenditure. Private sector expenditure places an enormous burden on households, which contribute 40% of current health expenditure [1]. The COVID-19 response did not redress the imbalance between external and public sources of finance. The health sector was given a smaller proportion of total funding for the COVID-19 response than expected; of this amount, most was directed to treatment capacity of referral hospitals [1] while a 79 per cent funding gap was estimated for the continuation of essential services [13]. While this situation may have prompted a "political re-awakening on health financing" and universal health coverage [3] no concrete steps were outlined in the literature.

The private sector, specifically not-for-profit hospitals, were approached to operate as COVID-19 centres but declined "due to earlier challenges engaging with the MoH as a health purchaser" [1]. These facilities comprise 41 per cent of all hospitals in Uganda and fall within the purview of faith-based medical bureaus, specifically Catholic, Muslim and Protestant [14]. While the Government of Uganda has a long history of engaging with the faith-based sector, there is limited experience on public funds used to purchase services from private for-profit facilities [15].

Nurture trust

This behaviour considered recognition of competing and conflictive interests for continuation of essential health services during the COVID-19 response

The MoH report on essential services, included a local newspaper quote (August 2020), *"It is not enough to say we are managing COVID-19 when people are dying from other conditions [in Uganda]. We need to give equal attention to other health emergencies.*" [11] Indeed, the secondary impacts of

the COVID-19 response were predicted early in the pandemic to be far greater than the primary impact of the Coronavirus disease, given Uganda's young population [16]. The modelling study further predicted that "hard-won gains" in women and children's health could be reversed, and underlined "the importance of tailoring COVID-19 responses according to population structure and local disease vulnerabilities"[16]. This was not done.

Uganda's response to COVID-19 enforced some of the strictest lockdown measures on the African continent. Community participation was low, "as most of the measures were dictated and enforced by security and military personnel" [3]. Measures coincided with political campaigning and rioting in late 2020, related to the presidential elections, and subjected the population to further control measures. Combined, these are likely to have resulted in economic, social and health consequences through loss of income, loss of access to essential services and increased isolation. These consequences were ill afforded given underlying systemic and population vulnerabilities [1, 4]. This contextual backdrop serves to highlight the susceptibility of essential health services to wider events, and further reinforces the importance of resilience within health systems [8]. It warrants reflection of response measures on public confidence in healthcare [8] as well as the ethics of such measures [4].

Deliver strategy

This behaviour considered organisational learning and innovation to improve engagement of the private sector for the delivery of essential health services during the COVID-19 response

The MoH, through its guidelines, recognised that attention to COVID-19 could be at the expense of routine essential health services [2]. This was likely the case in Uganda. Diversion of attention and resources, combined with movement restrictions, has necessitated adaptation and innovation in health service delivery. Within the Uganda literature, a number of practices were cited. Notably, there was a 'revival' in interest by health care providers and demand by patients for community-based delivery models [6]. The pandemic was seen as opportunity to "re-imagine health-systems" and leverage "health systems strengthening which may emerge out of the COVID-19 response" [5].

Adaptive strategies cited in the Ugandan literature drew from disease programs. Within HIV, these included home-based delivery of antiretrovirals; extending multi-month dispensing for stable patients; the use of community distribution points for ART refills; the use of routine health information systems; geospatial technologies for distribution of ART refills in unmapped rural settings; and the establishment of telephone hotlines at some tertiary hospitals [6]. The cancer program tested IVR technology demonstrating that this was an acceptable and accessible method for providing cancer information to patients and the general public in Uganda [17]. Within reproductive health, less sophisticated means of adaptation included text messaging and phone calls by midwives to their clients [18].

It was acknowledged that more effort is needed to gather evidence on "experiential local knowledge", on adaptations and their effects on access to essential services [5]. There is also need to develop locally-sensitive or responsive frameworks that integrate ethics and human rights considerations within public health measures [4]. Furthermore, there is need to learn from the COVID-19 experience to better leverage the untapped capacity of the private sector for the continuity of essential services and optimization of pathways to care [1].

Next steps

The Uganda literature review is part of a sequential process (Figure 1) to facilitate progressive and diverse engagement of country stakeholders in public policy and the role of the private sector in maintaining and delivering essential health services.

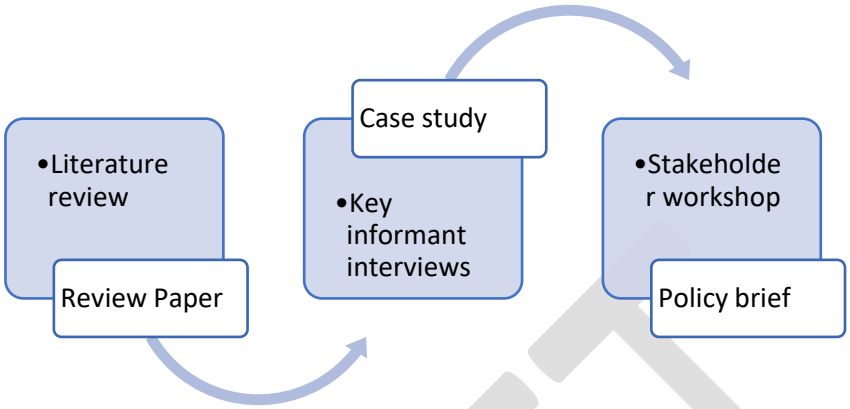

Figure 1. Policy engagement process

The literature review will inform qualitative interviews with public and private sector stakeholders as well as community-based health user representatives in Uganda. This work commenced in October 2021. This will form the basis of a case study. A multi-stakeholder workshop will be held to validate findings from the literature review and case study, distil insights and policy recommendations. The output of the workshop will be the formulation of a policy brief to improve engagement of the private sector for the delivery of essential health services. Finally, country literature reviews and case studies will be used to prepare a manuscript for peer-review publication.

References

1. Margini, F., Anooj Pattnaik, Tapley Jordanwood, Angellah Nakyanzi, and Sarah Byakika, *Case Study: The Initial COVID-19 Response in Uganda*. 2020, Washington, DC: ThinkWell and Ministry of Health Uganda.
2. Government of Uganda, Ministry of Health, *Guidance on Continuity of Essential Health Services during the COVID-19 outbreak*. 2020, Ministry of Health: Kampala, Uganda.
3. Besigye, I.K., M. Mulowooza, and J. Namatovu, *Coronavirus disease-2019 epidemic response in Uganda: The need to strengthen and engage primary healthcare.* Afr J Prim Health Care Fam Med, 2020. **12**(1): p. e1-e3.
4. Barugahare, J. and F.N. Nakwagala, *Ethical and human rights considerations in public health in low and middle-income countries: an assessment using the case of Uganda's responses to COVID ….* BMC …, 2020.
5. Graham, W.J., et al., *Protecting hard-won gains for mothers and newborns in low-income and middle-income countries in the face of COVID-19: call for a service safety net.* BMJ Global …, 2020.
6. Zakumumpa, H., et al., *Dispensing antiretrovirals during Covid-19 lockdown: re-discovering community-based ART delivery models in Uganda.* BMC Health Serv Res, 2021. **21**(1): p. 692-692.
7. Abila, D.B., P. Ainembabazi, and H. Wabinga, *COVID-19 pandemic and the widening gap to access cancer services in Uganda.* Pan Afr Med J, 2020. **35**(Suppl 2): p. 140-140.
8. Jessica Florence Burt, M., et al., *Indirect Effects of COVID-19 on Maternal, Neonatal, Child, Sexual and Reproductive Health Services in Kampala, Uganda*. 2021.
9. Government of Uganda, *COVID-19 Resurgence Plan, June 2021 to June 2022*. 2021: Kampala, Uganda.
10. Namuganga, J.F., et al., *Impact of COVID-19 on routine malaria indicators in Uganda: An interrupted time series analysis.* Research …, 2021.
11. Government of Uganda, Ministry of Health, *The effects of the COVID 19 pandemic on the continuity of essential health services delivery, access, and uptake in Uganda. Immunization, Gender based Violence, Maternal Newborn and Child Health, Nutrition, Tuberculosis*. 2020 (August).
12. Dare, S.S., et al., *Covid-19 Pandemic and Behavioural Response To Self-Medication Practice In Western Uganda.* medRxiv, 2021.
13. Global, T., *COVID 19: Summary Update for Uganda*. 2020 (December), ThinkWell Global, Kampala, Uganda.
14. Madsen, E., Bergeson-Lockwood, J Bernstein, *Maternal Health Supplies in Uganda*. n.d., Population Action International.
15. Pattnaik, A., Jordanwood, T, Nakyanzi, A, Margini, F and N. Ravishankar, *A necessity, not a choice: the case for purchasing COVID-19 services from the private sector in Uganda*. 2020 (May).
16. Bell, D., et al., *Predicting the Impact of COVID-19 and the Potential Impact of the Public Health Response on Disease Burden in Uganda.* Am J Trop Med Hyg, 2020. **103**(3): p. 1191-1197.
17. Kabukye, J.K., O. Ilozumba, and J.E.W. Broerse, *Implementation of an Interactive Voice Response System for Cancer Awareness in Uganda: Mixed Methods Study.* JMIR mHealth and …, 2021.
18. Pallangyo, E., et al., *The impact of covid-19 on midwives' practice in Kenya, Uganda and Tanzania: A reflective account.* Midwifery, 2020. **89**: p. 102775-102775.