



Advocates Coalition for Development and Environment

67TH STATE OF THE NATION PLATFORM

“Confronting the Challenge of Child Mortality in Uganda: Scale-up and Consolidation of Gains from the CODES project”



ACODE Policy Dialogue Report Series, No. 32

**Adelaine Aryaija Karemani, Barbara Ntambirweki
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ABSTRACT

Over the years, Uganda has made significant strides in reducing child mortality. Child mortality in Uganda declined from 156 per 1000 live births in 1990s, to 137 per 1000 live in 2005, 90 per 1000 live births in 2011 to the current 69 per 1000 live births¹. This was partly due to result of increased knowledge and service in the health sector. The five-year Community and District Empowerment for Scale-up (CODES) project, developed jointly by Uganda's Ministry of Health, UNICEF and Karolinska Institutet in partnership with Advocates Coalition for Development and Environment (ACODE), Child Fund International (CFI), Liverpool School of Tropical Medicine (LSTM) and Makerere University School of Public Health (MUSPH) put in place a myriad of interventions to reduce child deaths associated with diarrhea, pneumonia and malaria. It is against this background that Advocates Coalition for Development and Environment (ACODE) together with CODES partners held the 67th State of the Nation Platform (STON) for a discussion on *“Confronting the Challenge of Child Mortality in Uganda: Scale-up and Consolidation of Gains from the CODES project.”* A number of recommendations emerged key among which was the call to adopt the community dialogue model to increase demand for health services particularly for children and the need to strengthen the capacity of Health Unit Management Committees (HUMCs) through training and financial facilitation.

A. Introduction

This report focuses on the achievements

and lessons learnt from five years of CODES implementation. The dialogue brought together a cross-section of key stakeholders in child survival in Uganda including; Women MPs, District Health Officers, Chief Administrative officers of the 13 CODES implementation districts, National Medical Stores, Health Monitoring Unit, UNICEF, ACODE, CFI, MoH and Makerere University. The objectives of the 67th STON were as follows:

1. To share with participants the achievements and lessons learnt from 5 years of CODES implementation;
2. To provide a national-level platform for participants to discuss the achievements and lessons learnt from 5 years of CODES implementation;
3. To provide a national-level platform for participants to discuss policy implications for CODES exit and sustainability strategy.

B. Background

Child mortality remains a global health concern and this explains its particular locus in the global health/child survival agenda. The recent Millennium Development Goals (MDGs) and the present Sustainable Development Goals (SDGs) put emphasis on reducing child mortality². Consistent with the global child health agenda, the Government of Uganda (GOU) through the Ministry of Health (MOH), and in partnership with Development Partners and Civil Society Organizations (CSOs) has undertaken several child survival interventions under the national framework of National Minimum Health Care Package (UNMHCP), Health Sector Strategic Plans (HSSP) I, II and III (2000/1-2004/5; 2005/06-
² UNDP: http://www.undp.org/content/undp/en/home/sdgooverview/mdg_goals.html. Accessed on October 10, 2016

¹ (MFPED, 2015; MOH, 2015a; UBOS and ICF, 2011).

2009/10; 2010/11-2014/15), Health Sector Strategic Investment Plan (HSSIP) (2010/11-2014/15), and the Health Sector Development Plans (HSDP) I and II (2010/11 – 2014/15; 2015/16 – 2019/20), inter alia (MOH, 2015a³; 2015b⁴). The totality of the interventions resulted into considerable strides in reducing child mortality in the country, especially the type of mortality resulting from the top killer childhood diseases of diarrhea, pneumonia, and malaria, as well as diseases resulting from lack of or inadequate administering of timely vaccines. Consequently, contemporary reports indicate a trend of drastic decline in child mortality rate in Uganda over the last two and a half decades, an era that overlaps with the United Nations MDGs epoch. The Uganda MDG report 2015 indicates that Uganda “missed narrowly” to meet MDG 4 target of reducing child mortality to the rate of 56 per 1000 live births by 2015 (MFPED, 2015)⁵.

The CODES project put in place a myriad of interventions to reduce child deaths associated with diarrhea, pneumonia and malaria. The interventions involved activities that were supported by the Government of Uganda, CSOs, and other non-state actors all of which focused on reducing child mortality. Designed as a learning project, CODES set out to demonstrate how strengthening of district health systems management and community empowerment could be scaled-up to attain intended objectives. CODES was anticipated to help the government to boost its capacity to implement policies

and interventions that lead to an array of improvements in health outcomes, especially concerning the control of diarrhea, pneumonia, and malaria.

The CODES project had 3 pillars;

1. Ensuring that the best interventions were used to reduce child death and illness in each of the participating districts.
2. Helping District Health Managers to use simple tools to improve their performance on health service delivery.
3. Empowering communities to demand and receive better quality and gain more access to all health services.

C. The three pillars epitomized both the “Supply-Side” and “Demand-Side” components of the CODES project. The “Supply Side Component” interventions were intended to improve district level health systems and health facility based-continuous quality improvement (CQI) in health service delivery while the “Demand-Side Component” was intended to mobilize and galvanize citizens to demand for effective and quality health service delivery. ACODE has shouldered the mandate of implementing the third pillar/Demand-Side component of the CODES project.

D. Presentations:

**Dr. Flavia Mpanga Kaggwa,
UNICEF, Principal Investigator,
CODES project:**

Dr. Mpanga presented a brief overview of the 5-year CODES project, the policy prospects and exit/sustainability strategy. Dr. Mpanga extended appreciation to the CODES project implementers (ACODE +

³ Ministry of Health (2015a). Annual Health Sector Performance Report for Financial Year 2014/15. MOH. Kampala, Uganda.

⁴ Ministry of Health (2015b). Health Sector Development Plan (2015/16- 2019/20) .MOH. Kampala, Uganda.

⁵ Ministry of Finance, Planning and Economic Development (2015). Millennium Development Goals Report for Uganda 2015. Results, Reflections and the Way Forward. MFPED with Support from United Nations Development Programme (UNDP). Kampala, Uganda.

CFI) for their contribution towards reducing child mortality in Uganda, which further led to achieving the MDG 4. Uganda's child mortality rate was noted to stand at 55/1000 live births which was acknowledged to be a huge achievement. However, this observation was put in context and noted to be inadequate because so many children continued to die needlessly.

Dr. Mpanga shared the CODES project hypothesis which consisted of several inputs with an overall aim of reducing child mortality in the 13 implementation districts. The CODES hypothesis adapted an approach that harnesses data that the districts already had from the HMIS/DHIS2. They also obtained data from dialoguing with communities to understand their experiences and reasons for not seeking health care services. With this data, districts health teams were approached to perform evidence based planning that targeted

as to supervise and to track performance of health units. Health officials were further empowered to put in place improvement plans and continuously implement in a SMART way for the next cycle. This has resulted in strengthening all six pillars of the health system; leading to increased coverage of key health interventions. Dr. Mpanga emphasized that all this was done with very little resources—district health teams used existing resources and where resources were not available or sufficient, districts mobilized resources from other donors because the districts were now able—while using data, to tell partners where their need was and therefore influenced where resources could be allocated. With this, the hypothesis was that; all these inputs together would reduce child morbidity and mortality and help the nation get to Vision 2040 and eventually also look into the sustainable development goals.



Figure 1 Dr. Flavia Mpanga, UNICEF making her remarks at the 67th STON session

sub-counties that were performing sub-optimally as well as made sure that the little resources available were efficiently utilized.

CODES project empowered district health officials to be able to take decisions as well

Districts that participated in the CODES project included; **Wave 0 (Proof of concept)** namely: Buikwe, Bukomansimbi, Masaka, Mukono, Wakiso; **Wave 1 (Intervention districts)** of Apac, Arua, Bugiri, Buhweju, Buvuma, Luuka, Masindi and Maracha and **Control districts** of Alebtong, Kole, Kiryandongo, Kamuli, Iganga, Kasese, Mitoma and Sheema. The project started with a proof of concept phase in 5 districts. There were 8 intervention and 8 control districts. The project design deliberately intervened in 8 districts. In control districts, baseline and end-line data collection ascertain status in terms of child indices was the main activity.

Looking at key processes that were employed by the CODES project; Child Fund International (CFI) collected data using Lot Quality Assurance Sampling (LQAS) and District Health Management Information Software System version 2

– Bottleneck Analysis (DHIS2-BNA) and accordingly brought evidence to the work plan processes. ACODE was in-charge of the ‘demand side’ component of CODES through the use of community dialogues. Dr Mpanga explained that a community dialogue all about talking and holding a discussion-- and that this had power in itself. CODES showed that talking to household members reduced child mortality. Issues like talking to households about family care practices, sleeping under mosquito nets, immunizing children and washing hands with soap and clean water were small things that many people take for granted but that these had really reduced mortality.

A Tanahashi model was employed as a backbone for the CODES project to assess the health system across the six determinants of coverage on the supply and demand side including (i) availability of commodities, (ii) HR availability—*health workers and VHTs*, (iii) physical access to services—*are these health centers in reasonable reach?, are the VHTs close enough and do they have drugs in their medicine boxes?* The demand side which could many times be complex was simplified and looked at; (iv) initial utilization—*if you have made available all supply side services, will the services be utilized? Do they come for their 1st immunization when a child is born and what is their experience when they do come that will make them come again?*, (v) continuous utilization and (vi) quality coverage. Dr Mpanga further illustrated that when a child is suffering from pneumonia, the desire is to see whether there are antibiotics, whether there are health workers in the facility to prescribe the antibiotics and if they are there, whether they are accessible enough. For this particular case, the CODES project saw that there were gaps among health workers with antibiotics and hence showed that children did not get their antibiotics within 24 hours of onset of illness. The

health workers were put to task to develop solutions. This process enabled the analysis of system gaps by subjecting them to a root cause analysis to identify solutions and strategies for districts.

Some of the achievements on the supply side were;

- Evidence based work-plans in 13 districts increased funding for child health from **4%** to **6%** in 2 years
- Improved reporting through DHIS from **23.5%** in 2013 to over **80%** in 2016 across the 487 facilities in the 13 districts
- Testing/assessment before treatment for malaria and pneumonia improved from **23%** to **69%** at facility level in 2 years
- Decreased health workers absenteeism from **44%** to **29%** in 2 years
- Increased male involvement: ANC with spouses. Giving men a service has increased their involvement.

Dr Mpanga concluded by sharing policy prospects that would sustain the gains from Codes and these included;

- **Data:** suggested that there should be a shift from expensive surveys to the use of routine data: from LQAS to DHIS2 for planning at district level.
- The national planning guidelines recently revised to include the use of Reproductive Maternal New-born Child Adolescent Health (RMNCAH) score cards which they have digitalized into DHIS2—it has 24 indicators and at a glance the different colors direct interrogation of performance, digitalized the bottleneck analysis, and causal analysis and community aspects to inform evidence based planning at district level and that

scale up of developing action trackers for all districts and national planners was expected to start in November 2016.

Dr. Agnes Kobusingye, Child Fund International/ Liverpool School of Tropical Medicine, Team leader CODES project

Dr. Kobusingye presented about the supply-side interventions. Lessons learned; challenges and prospects. She reiterated the processes of the CODES supply side intervention by listing the steps undertaken as schematically presented below.

Step 1: In identifying bottlenecks, a quantitative household survey in conducted by employing an LQAS. This was conducted every 2 years. A health facility assessment which was conducted annually, a village health team survey conducted every 2 years and the Health Management Information System (HMIS) was used for mid-term

check-up every year. This data is analyzed using a bottleneck assessment tool on an annual basis.

Step 2: A causal analysis using the management analysis and 5 WHYs model was also conducted. Here a qualitative survey of community and health providers was conducted using a management check list as well as results from the bottleneck analysis. Managerial short comings, decision space, resources, capacity and motivation are identified through a forum with district health teams and if a response I was No, it was subjected to the 5 whys model.

Step 3: This process was done in fora with district health teams. For each identified cause (factor responsible for the observed gap in coverage), the district teams suggested possible solutions. Potential solutions were prioritized using a rank-scoring approach that took into account effectiveness of the suggested intervention, feasibility, affordability and acceptability.

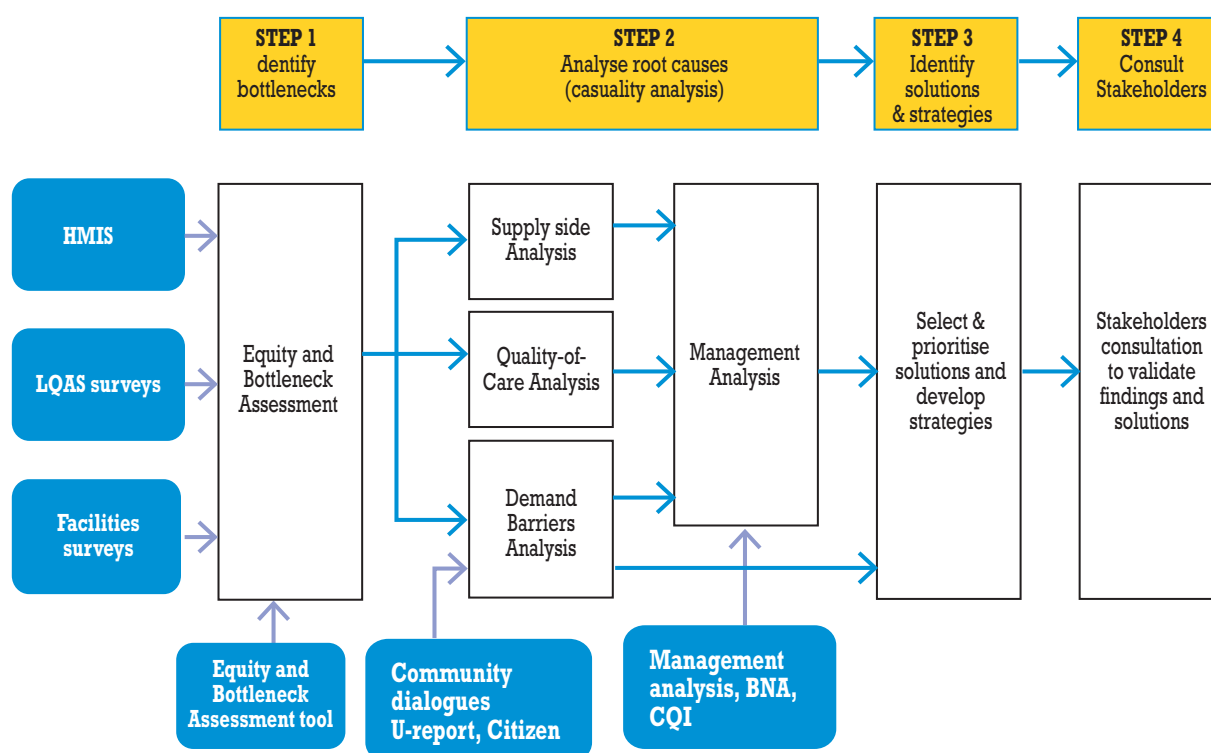




Figure 2: Dr. Agnes Kobusingye, CFI, making her presentation

Sample findings from Bugiri district were presented. For all the indicators under antibiotics for pneumonia for instance, an improvement was realized and in several other districts, they hoped to see a lot of these improvements from the endline findings as virtually all the determinants in the Tanahashi model at the health facility and district have shown an upward trend but commodities. This was because factors influencing the availability of drugs and commodities are usually beyond the districts control.

Another example was at the health facility in Masaka which was working on the client waiting time in the laboratory. By the time CFI intervened, the average client waiting time was 3 hours to pick results from the laboratory and they worked it out using the continuously quality assessment approach—the In-charge warned the lab person about late coming and absenteeism, introduced an attendance register and a group approach to testing. As a result all, these approaches put together reduced on the client waiting time to less than 30 minutes.

CFI has further worked with health facilities and trained personnel on how to score themselves as well as ably work with those scores. All the health facilities in the

13 districts had color coded canvas charts. The red meant that they did not meet the standard and the green meant that they met the standard. The aim was to turn all the reds into green.

Dr. Kobusingye went on to share some findings from the supply-side component of the CODES project such as;

- Health facility score cards:
 - She said that health facility staffs had been trained to score themselves with an aim to turn all the reds into green.
- District score cards:
 - These were simple tools that leaders could use to understand the status of events in health facilities.
- Aligning CODES project with already existing cycles. If there was data for use in a bottleneck analysis shortly before the national budget framework, then one would see a lot of the output of analysis of problems being transferred into the budget framework.
- *Leadership and Governance from MoH and the district managers* were very crucial: Support supervision reports:
 - there was a book to guide health workers on how to improve performance at the health facility. However, some reports do not indicate the gaps and actions to be taken by the health facility following the supervision. Some supervisors only made comments like “good work” “struggle continues”... etc and this still needed to improve. More still, health facilities were conducting staff and departmental meetings as required. However, the frequency of meetings was not regular, minutes were not available

in some facilities and they didn't show a review of progress on action points from previous meetings. One of the reasons was that, health In-charges were not trained to be administrators and performance would improve if they were trained.

Mr. Moses Mukundane, ACODE CODES project Team leader

Mr. Mukundane presented about the demand-side of the CODES intervention, lessons learnt, challenges and prospects. In the demand-side component, ACODE set out to mobilize and galvanize citizens to demand and receive better quality of health services. A multitude of activities were conducted to achieve this goal. These included; (i) a baseline study, (ii) developing citizen report cards (CRC) and, (iii) conducting two day robust community dialogues. Community dialogues involved: (a) Day one where there was a discussion of CRC findings in separate breakout session of caretakers of children U5 years, VHTs, community leaders and health workers and; (b) Day two where there was an interface session combining breakout groups and sub-county/district leaders to dialogue which climaxed with the creation of joint action plans (community contracts). Other activities included; (iv) Post-dialogue follow up/ monitoring visits 3-6 months after the date of dialogue, (v) media campaigns/advocacy which involved airing of public health messages on radio stations in 13 CODES districts, U-report SMS platform for both survey questions and health promotion/education messages and mTrac 8200 to capture community compliments and complaints about health services delivery issues. The last activity was of conducting a demand-side end-line study.



Figure 3: Moses Mukundane ACODE, presenting demand side of CODES Intervention at the 67th STON

Highlights of Achievement of the demand side

Highlights of achievements that the demand side registered were:

- The robust awareness creation in communities on basic health issues and collective action for child health survival through for example;
 - Establishment of community-initiated health outposts - i.e., Buwenda, Satellite of Butenga HC-IV, Bukomansimbi district and Kimi island, Satellite of Koome HC-III, Mukono district and Increased latrine coverage and other sanitary facilities in most homesteads in communities that hosted the dialogues- Role of LCs, VHTs, and community-based 'CODES' committees.
 - Enhanced participatory planning for community health/ child survival; Creation of Joint Action Plans to address challenges of healthcare

A snapshot of accomplished activities:

ACTIVITY	RESULTS
<input type="checkbox"/> Baseline study and development of citizen report card <input type="checkbox"/> Community dialogues <input type="checkbox"/> Media and advocacy <input type="checkbox"/> Capacity building of CODES district-based NGOs/ CBOS <input type="checkbox"/> Capacity building of DHTs <input type="checkbox"/> Post-dialogue monitoring <input type="checkbox"/> Endline studies	<input type="checkbox"/> 2 baseline study reports (Wave Zero and Wave One). <input type="checkbox"/> 25,800 Citizen Report Cards. <input type="checkbox"/> 151 Community dialogues in 13 districts <input type="checkbox"/> 13,355 participants (Caretakers of children under five years, VHTs, Parish-level community leaders, sub-county and district leaders); 60% caretakers of children under five years <input type="checkbox"/> 151 community contracts ("Joint Action Plans"); 60% implemented. <input type="checkbox"/> 151 Community-initiated 'CODES' Committees <input type="checkbox"/> 6,807 U-report enrolees; 30% are caretakers of children <input type="checkbox"/> 8 Radio adverts / public health messages on most popular radio stations in 13 CODES districts <input type="checkbox"/> 122 Key staff from 43 NGOs / CBOs <input type="checkbox"/> 13 DHTs (DHEs) <input type="checkbox"/> 161 Visits – health facility and community <input type="checkbox"/> 2 Endline study reports (Wave zero and Wave one)

service delivery and utilization.

- Prompt response from sub-county and district leadership towards critical issues emerging from community dialogues
- Creation of new health facility outreach posts for immunization and ANC
- Increased knowledge among the caretakers of children under five about prevention and treatment of Malaria, Pneumonia, and Diarrhea.

There were a number of implementation challenges experienced by the demand side of CODES project;

- Discrepancy between created knowledge through community dialogues and actual practice due to both demand and supply barriers.
- Unbalanced demand and supply-side interventions where demand was increased for health services but could not be met with health/medical supplies

stock outs.

- Constrained civic competencies to enforce meaningful social accountability due to vulnerability syndrome. For example, community members fear to send complaints using mTrac 8200.

**Associate Prof. Peter Waiswa
Makerere University School
of Public Health/ Karolinska
Institute, Team Leader CODES
project**

Assoc. Prof. Waiswa presented about what worked and perspectives from project monitoring and evaluation (Quality Assurance). He said that the CODES hypothesis assumed that areas receiving CODES intervention will perform “better” and show accelerated “improvements” on the key protective, preventive and curative quality coverage indicators for pneumonia, diarrhea and malaria compared to those that have not received CODES intervention.

The role of Makerere University was to monitor, learn and evaluate effective coverage and cost-effectiveness of the CODES project. It recognized the importance of using data within limited resource districts to plan and manage health services better based on identified gaps. He said that when you have data and you use the data to plan better and understand which areas are doing well and which areas have gaps. You then use the gaps to allocate resources for better implementation. Prof. Waiswa continued to say, projects brought to district need to align with the planning cycle, when the government is planning so that they can leverage the resources of government and other partners. He urged planners and stakeholders to endeavor to align with the planning process.

He acknowledged the gap in health systems financing. Money noted that is often spent centrally (Kampala) and not distributed to districts. Resources are earmarked and not reallocated according to need/gaps and this was because of the limited decision space that planners and managers experience. Accordingly, discussions needed to be around the expansion of fiscal and decision space within the district.

He re-echoed Dr. Mpanga and Dr. Kobusingye’s recommendation to move away from conducting expensive surveys but utilize the readily available data from HMIS. This data is available and can be used for dashboard planning. Community dialogues are also effective for community engagement as they help to explain survey findings and guide planning/prioritization. However to ensure their sustainability, dialogues should be aligned to already existing community structures.

District planners need to plan exit/sustainability strategies learned from the CODES project while a consideration of expanding the CODES project nationwide should be considered. He noted that there was need to build the capacities of district health managers in order to improve the prioritization process towards targeted child survival interventions. Community dialogues should be integrated into existing community structures and lead by CSOs, cultural groups etc.

The combined cost of CODES per district per annum amount to UGX 149,247,391 (or US\$ 44,065). Scale up of CODES interventions to all the current 112 districts would require about UGX 16.7 billion (or US\$ 4.94 million) per annum [Adjusted for inflation UGX 18.2 Billion (or US\$ 5.4 million)]. These estimates reflected the annual costs to be incurred after the initial year when set



Figure 4: A cross section of participants at the 67th STON session

up activities have been undertaken.

Prof Waiswa concluded by saying that this was a complex intervention that was able to bring tools together at scale in many districts and communities. It introduced systematic evidence based planning for child health to districts. However, despite the capacity built, limited district resources and decision space remain bottlenecks for sustainability.

Conclusion:

The plenary provided more evidence on the achievements/successes of the CODES project. Participants recognized the shortcoming within the health systems financing as well as capacitating district health managers and health facility In-charges to plan and implement better for child health in districts. Participants also highlighted the limited roles played

by men in communities and that they needed to be involved more. In Buvuma district, health facilities were inaccessible due to islands and poor and/or expensive transport means. Health facilities continued to be understaffed with limited resources allocated to districts and limited decision space for managers to reallocate resources.

E. Policy Recommendations:

Districts /DHTs and MoH

- **Need to adopt community dialogue model** in hard to reach and peculiar communities to increase demand for health services particularly for children. Ownership and accountability was an important avenue for demand creation – but getting an effective model for scale up could be a challenge.

- **Need to prioritize quick wins amidst financial constraints;** for instance, regular supervision of health facilities to crackdown of errant behavior of some health workers, especially those that charge illegal fees, suffer from habitual absenteeism, and/or use of abusive language, etc.).
- **Need to strengthen the capacity of Health Unit Management Committees (HUMCs)** through trainings and adequate financial facilitation.
- **Need to sustain CODES gains** through supporting local NGOs and CBOs involved in child health engagements at district and community levels. It is further important for implementing partners to develop exit strategies early on to allow for district ownership of intervention
- **Build capacity of district health managers'** to plan and prioritize better, as well as, ensure that interventions are more targeted and not determined haphazardly
- **Change resource allocation strategies:** Despite the capacity built, limited district resources and decision space remain a bottleneck for sustainability.
- **Data utilisation to foster targeted interventions:** District planners should use Bottleneck, causal and management analysis tools in service areas beyond Child data to guide resource allocations and interventions.



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