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CHILD MORTALITY IN UGANDA: What can we do to end it?

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ABSTRACT

Each year in Uganda, approximately 200,000 children under the age of five die from illnesses such as diarrhoea, pneumonia, and malaria, which are largely preventable or treatable, and from diseases that could be eliminated through the administration of timely vaccines.[1] Although the country has made significant strides in reducing child mortality over the past several years, its current child mortality rate of 90 deaths per 1000 live births is still too high for it to meet its Millennium Development Goal (MGD) target of 56/1000 by 2015.

It is within this context that Advocates Coalition for Development and Environment (ACODE) sought to explore the current opportunities for strengthening child survival that exist within the health sector. To that end, ACODE organized the 55th State of the Nation (STON) Platform under the theme "Child Mortality in Uganda: What can we do to end it? "With a special focus on lessons learned from the Community and District Empowerment for Scale-up (CODES) project. A number of recommendations emerged from the presentations, chief among them being the need to increase the health sector's budget allocation at the national level. More specific recommendations included the need to strengthen and streamline health sector planning at the district level by reinstituting and enforcing the development of district health sector

1 Government of Uganda. Health Sector Strategic Plan III 2010/11. Kampala, Uganda. Ministry of Health, 2010

operational plans, ensuring that donor spending on health sector activities aligns with district and Ministry of Health priorities, and creating more equitable per-capita spending on health commodities at the sub-district level.

A. BACKGROUND

Globally, approximately 60 per cent of the 9.7 million children who die each year could be spared if preventative and curative interventions were delivered to those who need them most.[2] Back in 2000, the state of global child health was dire enough that the United Nations sought to include the goal of reducing child mortality in its Millennium Declaration, which gave birth to the fourth Millennium Development Goal of reducing child mortality by two-thirds over a period of 15 years.

Unfortunately, Uganda is not currently on track to meeting this goal, which comes due in 2015. However, over the past several years the country has made significant strides in reducing its under-five mortality rate, from 137 deaths per thousand live births in 2005/6 to just 90 deaths per thousand live births in 2010/11. Uganda's MGD goal is to reduce under-five mortality to 56 deaths per thousand live births—a rate that is still far too high, but one that the country seems well positioned to achieve at some point within the next few years if the current rate of change remains constant.

It is within this context that ACODE sought to explore the current opportunities that exist within the health sector when it comes to strengthening child survival. Recent improvements in health outcomes suggest that Uganda is well-placed to build on its current successes. Considerable challenges remain, however, especially in connection with the financing, management, and administration of health resources throughout the country. ACODE conceived of this STON dialogue not just to highlight the on-going challenges, but to identify concrete solutions to those challenges, and build a broad base of support for implementing the solutions among key policy-makers and political leaders within government.

This discussion of the health sector and child health took place within the framework of an innovative project currently being implemented by the Ministry of Health, in partnership with UNICEF, ACODE, and ChildFund International (CFI): the Community and District Empowerment for Scale-up project, better known as "CODES." The overall goal of the CODES project is to help the Government of Uganda reduce child mortality throughout the country by ensuring that the government has the capacity—particularly at the district level—to implement policies and interventions that lead to a wide array of improvements in health outcomes, especially concerning the control of diarrhoea, pneumonia, and malaria in children under five. The project also creates opportunities for local communities to engage and assess district health services, while hosting community dialogues that provide parents and caretakers of children under five with health education to improve child wellbeing. Given this context, the objectives of this STON platform were:

1. Promote a deeper understanding of the pressing challenges to reducing under-five mortality in Uganda, from the point of view of technical leaders, health workers, and the parents of children under-five themselves;

2. Understand the current strategies being undertaken at the national and district levels to reduce under-five mortality, and whether those strategies are sufficient or need to be strengthened;

3. Provide an opportunity for political leaders to understand what they can do tosupport those strategies

B. INVITEES AND PRESENTERS

The invitees of this particular dialogue not only included the monthly attendees of the STON platform, but also the Members of Parliament from the eight new CODES intervention districts of Apac, Arua, Bugiri, Buhweju, Buvuma, Luuka, Maracha, and Masindi.[3] The attendance of parliamentarians was designed not only to keep them abreast of the health-related interventions occurring within their districts, but alsoto help inform the policy and budgetary debates surrounding the health sector that occur within Parliament. Additional invitees included members of Uganda's Parliamentary Forum for Children, the District Health Officers of the eight CODES districts above, and CODES project partners representing the Ministry of Health, UNICEF, CFI, the Liverpool School of Tropical Medicine, Makerere University School for Public Health, and Karolinska Institutet.

The keynote speaker at the event was Dr. Elioda Tumwesigye, the Minister of State for Health. Other speakers included Dr Flavia Mpanga of UNICEF, who provided an overview of what needs to be prioritized in terms of policy and service delivery to end under-five mortality;Elizabeth Allen of ACODE, who shared findings from a demand-side study that sought to understand how the parents of children under five themselves view the quality of health services within

2 Government of Uganda. Integrated Community Case Management of Childhood Malaria, Pneumonia and Diarrhoea. Implementation Guidelines. Kampala, Uganda. Ministry of Health 2010.

3 The CODES project targets 16 districts throughout the country, randomly divided into two groups: an intervention group and a comparison group. The eight districts listed in the text above comprise the intervention districts. The comparison districts include the following: Alebtong, Iganga, Kamuli, Kasese, Kiryandongo, Kole, Mitooma, and Sheema

their districts; Dr. Hector Tibeihaho of CFI, who discussed the kinds of quality improvement exercises being undertaken at the district level, and the ongoing data needs of districts; and Eric Ssegujja of Makerere University, who shared some lessons learned from the CODES project and their implications for policy. Dr. Elly Tumushabe, District Health Officer (DHO) for Mukono, was a discussant and made some pointed recommendations for improving district services based on his experiences in Mukono, which has been involved in the CODES project since 2011.[4] Further policy recommendations were also discussed by Members of Parliament, the District Health Officers (DHOs) from the CODES districts, and by members of civil society organizations. The dialogue itself was chaired by Mr. Hussein Kashillingi, an attorney and long-time member of the STON platform.

C. PRESENTATIONS

1. Keynote Address: Dr. Elioda Tumwesigye, Minister of State for Health

In Uganda today, the health sector has an annual budget of over UGX 1.27 trillion, which translates into approximately $13 per capita. However, global recommendations for per capita healthcare spending stand at approximately $48, which is more than three times what Uganda currently provides its citizens. Dr. Tumwesigye noted that for the Ministry of Finance to currently meet that standard, it would need to redirect funding from other sectors, depleting resources currently available for roads, electricity, and education. Dr. Tumwesigye thus expressed his gratitude to UNICEF and organizations like ACODE, whose work help fill some of the shortfalls in service provision. The Minister encouraged development partners to continue to work closely with the health sector to achieve the various goals and mandates put forward by the Ministry of Health. Preventative interventions that focus on hygiene, sanitation, immunizations, the use of malaria nets, and avoiding tobacco products and unprotected sexual encounters are paramount.

In terms of improving infrastructure within the sector, Dr. Tumwesigye discussed several hospital renovations currently on-going throughout the country. For instance, Uganda's main referral hospital, Mulago, just began a major multi-year renovation with a loan from the World Bank, while cancer and heart institutes are currently being established. Within the realm of human resources, the Minister discussed the ways in which Ministry of Health is revising its existing Village Health Team strategy to ensure that at the parish level, well-trained community extension workers are available to meet the needs of families.

2. Presentation: Dr.Flavia Mpanga, UNICEF

"Child Mortality: What must be done to end it?"

Dr. Flavia Mpanga, who serves as the principal investigator of the CODES project, provided an overview of the CODES project, highlighting the existing disease burden that drives mortality rates among children under five. In Uganda today, diarrhoea, pneumonia, and malaria account for up to 40 per cent of all deaths among children in this age bracket each year, despite the fact that such ailments can be prevented and treated through simple, effective interventions. When it comes to malaria, for instance, providing children with Artemisinin-based Combination Therapy (ACTs) within 24 hours of the onset of symptoms can go far in preventing the disease from advancing to more life-threatening stages. Similarly, administering zinc to children with diarrhoea over a ten-day period can effectively forestall the dangerous effects of diarrhoeal dehydration.

Regarding the CODES project, Dr. Mpanga stressed that the emphasis is not on delivering health inputs like commodities, but instead on strengthening and

4 The preliminary phase of the CODES project, dubbed "Wave Zero," occurred between 2011 and 2013, and included the districts of Mukono, Wakiso, Buikwe, Masaka, and Bukomansimbi. CODES-related activities have continued in all five of the districts

prioritizing the kind of evidence-based planning and community-based preventative measures that can lead to more efficient management and administration within the sector. The project employs the DIVA approach— Diagnose, Intervene, Verify, and Adjust— with the goal of addressing bottlenecks in both health service delivery on the supply side and the utilization of services by and for children under five on the demand side.

Continuous quality improvement (CQI) exercises are one method of addressing such bottlenecks, insofar as CQI focuses on cost-effective ways of tightening efficiency within the sector, especially at the health facility level. After participating in CODES CQI activities, for instance, facilities like Bukakata HC-III in Masaka were able to reduce staff absenteeism and the amount of time that patients spent waiting in queues by requiring health workers to sign an attendance book at the beginning of their shifts, and drawing a red line in the book after a certain time to signal the tardiness of those who showed up late. For midwives who arrived late because they lived far away, the facility partitioned one room to allow them to stay overnight when their shifts required it. Needless to say, the success of such interventions has hinged on the commitment of facility managers and district officials to enforce certain measures and to apply consequences to staff who break the rules.

Dr. Mpanga thus called on MPs to work with communities to realise their rights, while holding district leadership and health centres accountable for the services that they are responsible for providing. As representatives of the people, MP buy-in and support, especially when it comes to sharing information with district technical leaders and relaying complaints to the relevant authorities, is immensely important to the success of the initiative and the ultimate strengthening of the health sector as a whole.

3. Presentation: Elizabeth Allen, ACODE

"Caring for Children under Five: Why do Children Sometimes Fail to Get the Care They Need?"

Elizabeth Allen, who leads the demand-side component of the CODES project, discussed how parents and caretakers of children under five view district health services and why they make the decisions they make when seeking care on behalf of their children. This component of the project involved the collection and analysis of both qualitative data, undertaken by ACODE, and quantitative data, undertaken by ChildFund International and the Liverpool School of Tropical Medicine. Findings showed the potential effects of poor health facility management and administration on the ability and willingness of parents and caretakers to seek services from public facilities. The data also revealed the ways in which parents and caretakers respond to supply-side bottlenecks like drug stock-outs and staffing shortages.

When exploring problems related to facility management and administration, ACODE paid special attention to allegations of health worker abusive or unprofessional conduct, the solicitation of illegal fees, queue management when patients are in critical condition, and absenteeism or late reporting for duty. The CODES project is particularly interested in these metrics insofar as removing them can be done inexpensively relative to the cost of increasing supply-side inputs, and can result in increased efficiency within the sector.

That said, the findings from the study also revealed that when parents and caretakers were asked to disclose their five biggest barriers to care, the most common complaints across the districts were primarily systemic barriers that require substantial investments in the health sector to alleviate. These barriers include drug stock-outs, long distances to health facilities due to facility shortages within districts, and issues connected to household poverty such as lacking money for transport and medical care. Only one frequently mentioned barrier to care fell under the category of facility management and administration: abusive or uncaring health workers. What this suggests is that while gains in efficiency are critical to the overall functioning of the sector, the sector's structural problems—which can only be solved through increases in financing—must be rectified in order to see the kinds of improvements in health outcomes that the government has targeted.

4. Presentation: Dr. Hector Tibeihaho, ChildFund International

"Strengthening District Health Management and Improving Health Service Quality"

Dr. Hector Tibeihaho, who leads the supply-side component of the CODES project, discussed the different district-level activities that CODES is undertaking, and outlined the various policies and practices that need to change in order for districts to strengthen their oversight and management of the

sector. The role of CFI is to strengthen the capacity of district personnel to collect and analyse data on child survival indicators, while supporting district technical leaders in the development of health sector work plans and providing capacity-building for CQI through training, coaching, and mentorship. The goal of these activities is to enhance the quality of district interventions, especially concerning the control of diarrhoea, pneumonia, and malaria in children under five.

Among the most pressing concerns facing districts are the weak implementation of Integrated Management of Childhood Illness (IMCI) in health facilities, and critical information gaps in Health Management Information System (HMIS), especially data on diarrhoea and pneumonia, both of which are widely unreported and are thus not being addressed as required. Additionally, mechanisms that support stronger supervision need to be instituted within health facilities, and CQI within facilities needs to be prioritised to a far greater degree than is currently the case.

Particular policy issues that need to be raised by district councillors and Ministry of Health include reviving the creation of operational plans at the district level, a practice that has currently fallen by the wayside, in part because of failures within Ministry of Health to take a more supervisory role. Development partners must also be compelled to prioritize district priorities before their own institutional agendas, which would go far in allowing districts to mobilize and leverage the kinds of resources they need to meet the health systems requirements within their locales.

5. Presentation: Mr. Eric Ssegujja, Makerere University

"Lessons Learnt and Implications for Policy"

Eric Ssegujja, a member of the CODES evaluation team at Makerere University, noted that projects like CODES can offer a number of important insights for policy makers who are interested in strengthening the performance of the sectors they oversee. For instance, CODES evaluators have noted that District Health Management Teams (DHMTs) with well-educated and fully staffed team scan easily absorb new data-driven methodologies like those prioritized by the CODES project. While this observation is perhaps intuitive, it nevertheless bears emphasizing given the human resource gaps that most DHMTs in Uganda struggle with. That said, even well-staffed DHMTs have trouble implementing targeted interventions throughout their districts due to low funding levels. Any lobbying by Parliament that seeks to widen the decision-making and fiscal space available to DHMTs would thus go far in alleviating those roadblocks to implementation.

Findings from CODES and other projects also show how financial support from NGOs can lead to the faster adoption of various activities and interventions, it can simultaneously foster dependency. Again, proper funding and staffing within district bureaucracies is key, as are policies that better align the activities of NGOs with district priorities.

Finally, evaluators noted that political leaders are well-placed to strengthen the management and administration of health services within their individual districts by communicating the concerns of their constituencies to the relevant technical authorities. In many ways, the high visibility of political leaders makes them uniquely capable of supporting demand creation within their communities.

6. Discussant: Dr. Elly Tumushabe, District Health Officer (DHO), Mukono

Research encourages innovation, as noted by the District Health Officer of Mukono, Dr. Elly Tumushabe. Over the past three years, the support that Mukono District has received from CODES has strengthened its technical capacity to engage in data-driven planning and analysis and implement a number of activities related to quality improvement and evaluation. In

response to the keynote speaker, Dr. Elioda, who voiced concerns about the limited financial resources available to districts, Dr. Tumushabe noted that the CODES approach focuses on gains in efficiency through the use of available resources. That said, Dr. Tumushabe emphasized the key role that MPs play in lobbying the central government for more sectorial funds. Learning from the successes of other countries throughout the region is also key. The experiences of Ethiopia, where community extension workers are paid monthly stipends, and Rwanda, where health workers receive performance-based remuneration, provide key lessons about the ways funding can be used more efficiently to receive stronger returns on healthcare delivery.

In terms of policy recommendations, Dr. Tumushable noted the need for the central government to procure and supply medicine to districts according to population size instead of the number and level of health facilities that exist within a given district. Mukono Municipality, for instance, has a population of 125,000 personsand a drug budget of UGX 137 million. This translates into per capita spending of UGX 1,096. Mukono South, meanwhile, has a total population of 143,000 persons and a drug budget of UGX 230 million, which translates into UGX 1,608 per person. The current drug budget allocations, which do not take into consideration the per capita burdens of health facilities, create unnecessary disparities in resource spending that can and should be alleviated through better policies. Similarly, staffing shortages could be addressed by allocating posts for health workers in health facilities using a standardized government health worker to population ratio.

In addition to the quantity of health workers, the quality of workers must be improved. Dr. Tumushabe recommended a new remuneration policy tied to performance as a mechanism to address absenteeism and complacency. He also suggested that the management staff in health facilities earn additional remuneration, as is currently the case for head teachers in the education sector. Dr. Tumushabe also noted the necessity of appointing high calibre community health workers who are paid a monthly incentive, similar to the incentives received by extension workers in Ethiopia, as a way to improve health indicators and reduce the unnecessarily large workloads of staff at health facilities. Supporting and facilitating community health workers can also mobilize communities themselves to increase and improve their health-seeking behavior.

Finally, Dr. Tumushabe noted that the sustainability of the CODES intervention after the project phases out will depend on government leadership, specifically within Ministry of Health, and by MPs, who must lobby the central government for policy shifts in key areas. Countries with better health indicators than Uganda, for instance, have sub-national structures for continuously monitoring district health systems through the use of LQAS tools and the application of CQI. The Ministry of Local Government (MoLG) and MoH should consider using these assessment tools in the development of effective monitoring structures for district health systems.

D. POLICY RECOMMENDATIONS

A lively discussion and debate followed the speakers' presentations, out of which the following policy recommendations emerged.

CATEGORY	PROBLEMS	PRIORITIES / RECOMMENDATIONS
1. Health Facility Management and Administration	• *Poor management and administration within health facilities* • *Laxity in the supervision of health centres among district technical and political leaders* • *Poorly prioritised Continuous Quality Improvement exercises* • *District-level health sector operational plans that are not being drafted or used*	• *Parliament and the Ministry of Health (MoH) should consider a new remuneration policy for health workers tied to performance to address absenteeism and complacency.* • *Parliament and MoH should create performance-based remuneration for health facility management, similar to policies that exist for head teachers in the education sector. In-charge remuneration should be tied to metrics related to the quality of supervision, appraisal, and reporting of the staff they oversee.* • *MoH, through district health officials, should better enable facility in-charges to carry out their managerial tasks by providing management skills training.* • *MoH, through district health officials, needs to provide funding for CQI within all health facilities.* • *MoH needs to take a supervisory lead in reviving the culture of drafting district health sector operational plans to guide yearly activities and sector priorities.*
2. Budgetary Allocations	• *District budgetary allocations for health that don't account for the different population sizes that exist within health facility catchment areas, and therefore result in unequal per capita spending both within and across districts* • *Districts that can easily prioritize high-impact interventions with the support of high-quality data, but that continue to have difficulty identifying sources of funding to implement the interventions*	• *MoH and the National Medical Stores should allocate commodities based on the populations that exist within a given health facility's catchment area to ensure equity in per-capita commodity spending.* • *MoH must ensure that the allocation of health workers within facilities is determined by the size of the population within a given health facility's catchment area using a standardized government health worker population ratio.* • *MPs and MoH must lobby the central government to widen the decision and fiscal space of district technical leaders. Most of the money that districts receive to finance their health sectors comes in the form of conditional grants, which leaves little money available to finance other priorities identified through data assessments.* • *Donors and NGOs working within districts need to be compelled to focus more on supporting and implementing district health priorities than is currently the case. (Frequently, donors and NGOs prioritize their own activities and goals before the needs of the cash-strapped district health systems in which they operate.)*
3. Data Management and Planning	• *Weak implementation of Integrated Management of Childhood Illnesses (IMCI) within health facilities* • *Data gaps in Health Management Information System (HMIS), especially for diarrhoea and pneumonia, which make data-driven interventions difficult*	• *Members of Parliament and MoH must lobby for funding to fully implement IMCI within health facilities, and to strengthen the collection of data for HMIS.*
4. Village Health Teams (VHTs) / Community Extension Workers	• *VHTs that aren't properly facilitated to do their work, which affects their performance and effectiveness*	• *MoH's VHT policy—which is currently being revised—should prioritise the facilitation of VHTs through budgetary allocations that provide monthly remuneration, while providing mechanisms to strengthen VHT supervision and support by health workers at nearby facilities.*