# SUPPORTING PROGRESS TOWARDS MDGs 4 AND 5 IN EAST AFRICA: IMPROVING MATERNAL AND CHILD HEALTH IN SHINYANGA REGION IN TANZANIA, AND GULU, KITGUM AND PADER DISTRICTS IN NORTHERN UGANDA

REVISED APPLICATION TO AUSTRALIAN INTERNATIONAL DEVELOPMENT AGENCY (AusAID)

BY

AFRICAN MEDICAL AND RESEARCH FOUNDATION (AMREF)
HEADQUARTERS, NAIROBI, KENYA

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**LIST OF ACRONYMS**

AMREF – African Medical and Research Foundation

AusAID – Australian Agency for International Development

DANIDA – Danish International Development Agency

IMCI – Integrated Management of Childhood Illness

MCH – Maternal and Child Health

MNCH – Maternal, Newborn and Child Health

SRH – Sexual and Reproductive Health

SRHR – Sexual Reproductive Health and Rights

## INTRODUCTION

In January 2011AMREF commenced implementation of a 4 year Sexual and Reproductive Health and Rights (SRHR) program in three countries of East Africa: Tanzania, Uganda and Kenya. This program was fully funded by DANIDA.

In July 2011, funding of $2m over 2 years (July 2011 – June 2013) was committed by AusAID to jointly fund the program to allow expansion both geographically and in terms of objectives. In summary, the program was expanded to improve child health in the original target locations as well as two additional districts.

AMREF is now in discussion with AusAID about further possible financing to extend the additional funding period by 1.5 years for a continued focus on IMCI aligned with the overall project timeframe (DANIDA funding is for 4 years up to Dec 2014). AMREF also wishes to respond to the need for improved access to emergency obstetric care and skilled birth attendance to achieve the existing broader program aim of reducing reproductive morbidity and mortality. It plans to address this by expanding inputs/activities under objectives 1 and 2 (to be refined in discussion with AusAID and DANIDA).

**Objective 1:** To increase the capacity of frontline health services to provide reproductive and maternal health services with a focus on youth, women and girls, by 2014

**Objective 2:** To build community capacity to support the reproductive health rights of girls and women, including strong male involvement and gender awareness and adoption of practices, by 2014.

There is a need for extensive consultation with program teams in different countries for in-depth and needs based planning to develop one coherent extended and expanded plan. It is therefore proposed that AusAID approve additional funding in advance of a final revised implementation plan which will be made available to AusAID for comment in August.

It is proposed that a planning exercise be undertaken in July 2012 to a) review the overall implementation plan to adjust for the extended timeframe and b) to plan in detail the expanded activities to address MCH, specifically in relation to improving access to emergency obstetric care and increased skilled attendance at birth.

The output of this planning exercise will be a matrix indicating the specific activities, timing of completion and revised detailed budget for each location.

The planning exercise will also address the need for the development of an exit strategy/plan.

At the same time the existing M&E framework will be **revisited and revised** to:

- Refine the objectives;
- Clarify outcomes, outputs and inputs with

- Defined targets and annual milestones based on baseline data for each outcomes and output
- Specify data source and timing of availability to both on-going monitoring and final evaluation

This will be developed consistent with the new AMREF M&E framework and with AusAIDs new performance monitoring requirements.

A supplementary budget amounting to $1,060,000 Australian dollars is attached as year three and four (6 months) extensions. This includes support to improve M&E capacity, systems and processes across the program within the 18 months beginning July 2013. This support will allow AMREF to respond to AusAID's recommendation to improve M&E following a review of its first six month report. An M&E position will be supported fully for the third year then on a reducing basis until the end of the project period in December 2014.

The July planning meeting will be arranged to include attendance by the AusAID technical adviser who will provide additional support to ensure that the intended products are achieved. A specialist M&E adviser/consultant will facilitate the M&E component of the meeting. The meeting will result in

- A reviewed logical framework for the whole project including more sharply stated objective
- A monitoring and evaluation framework that defines outputs and outcomes better and focuses on a limited number of important indicators to ensure feasibility of data collection to measure outcomes and its use to strengthen overall AMREF monitoring and evaluation
- A revised implementation plan and exit strategy

## Background

In January 2011AMREF commenced implementation of a 4 year Sexual and Reproductive Health and Rights (SRHR) program in three countries of East Africa: Tanzania, Uganda and Kenya. This program was fully funded by DANIDA. The specific initial program locations in each country were:

Tanzania - 4 districts in Shinyanga Region – Kahama, Shinyanga Urban, Shinyanga Rural and Kishapu.

Northern Uganda – 2 districts in Acholi Region – Gulu and Kitgum

Kenya – Turkana district

The overall aim of the program is to: reduce reproductive morbidity and mortality and increase enjoyment of sexual and reproductive health rights among hard to reach marginalized communities who live in these areas.

The specific objectives of the program were defined as follows:

1. To increase the capacity of frontline health services to provide reproductive and maternal health services with a focus on youth, women and girls, and a special focus on family planning uptake
2. To build community capacity to support the reproductive health rights of girls and women, including strong male involvement and gender awareness and adoption of practices
3. To increase organizational capacity for gender mainstreaming and rights based programming for AMREF, community organizations and other collaborators in the project
4. To generate evidence of effectiveness of these approaches to reduce reproductive health morbidity and mortality through operations research and monitoring and evaluation to enhance replication in similar settings elsewhere

In July 2011, funding of $2m over 2 years (July 2011 – June 2013) was committed by AusAID to jointly fund the program to allow expansion both geographically and in terms of objectives as detailed in the supplementary proposal below. In summary, the program has been expanded to improve child health in both the original target locations and two other districts.

The additional aim of the expanded program funded by AusAID is **To improve child health through** increased access to integrated management of childhood illnesses and treatment of micronutrient deficiencies in children under five years old.

The specific outputs targets are:

1. To increase by 40% the proportion of children receiving appropriate treatment in the community and health facilities for malaria, pneumonia and diarrhea by 2013
2. To reduce the proportion of children with micronutrient deficiencies by 15% in target districts by 2013

Key Performance Indicators are:

1. Proportion of children with fever appropriately identified at family level and, managed appropriately
2. Proportion of very sick children referred immediately to health facilities by community health workers (also known as Village Health Teams in Uganda)
3. Proportion of children with pneumonia correctly diagnosed and treated with amoxicillin
4. Proportion of children with fever who receive malaria treatment within 24 hours of onset of fever
5. Proportion of children with diarrhea correctly treated with ORS and zinc
6. Proportion of children who receive at least two doses of vitamin A per year
7. Proportion of children who are dewormed at least once per year
8. Proportion babies born at home who are seen in a health facility within 2 days

9. Proportion of children completing OPV 4 and DPT 4 in monitored villages

Geographical Expansion:

The additional districts are **Ushetu,** Shinyanga Tanzania, and **Pader** District, Uganda.

AMREF is now in discussion with AusAID about further possible financing to extend the additional funding period by 1.5 years for a continued focus on IMCI aligned with the overall project timeframe up to Dec 2014 (DANIDA funding is for 4 years up to Dec 2014).

AMREF also wishes to respond to the need for improved access to emergency obstetric care and skilled birth attendance to achieve the existing broader program aim of reducing reproductive morbidity and mortality. It plans to address this by expanding inputs/activities under objectives 1 and 2.

**Objective 1:** To increase the capacity of frontline health services to provide reproductive and maternal health services with a focus on youth, women and girls, by 2014

**Objective 2:** To build community capacity to support the reproductive health rights of girls and women, including strong male involvement and gender awareness and adoption of practices, by 2014

Additional funding requested will allow for an extension of the approved interventions set out below (final proposal submitted to AusAID in April 2011) up until December 2014. It will also build upon this to expand activities to address maternal health specifically in relation to access to emergency obstetric care and skilled birth attendance (SBA).

**Supplementary Background Analysis**

Maternal and Child Health are intricately tied to economic and social development as shown by the report of the Commission on Macroeconomics and Health which links improved health to poverty reduction and economic development in poor societies. It is an established fact that maternal & child health indicators are good predictors of the overall health of a country. Apart from the direct consequences of child mortality and morbidity, ill health in mothers and children causes incalculable burden on nations' budgets and household incomes with negative impact on economic and social development. There has been some progress in reduction of child mortality in high burden countries in Asia and Africa, but the decline has been very slow in sub-Saharan Africa, Eastern Africa included. Africa accounted for 41% of the global child deaths total of 10.8 million in the year 2000. Although the global total may have declined since, the relative share for which Africa accounts continued to rise

The areas targeted by this intervention were selected because they suffer many disadvantages including extreme poverty and little access to information and reproductive health services, including family planning. Girls and women are the most marginalized due to gross gender inequities and exposure to conflict and sexual and gender based violence. The background analysis of the populations in the project areas is presented in the annexed project document for the main DANIDA project, and is not repeated here other than elements of child health not covered in the DANIDA proposal. Indicators of maternal, reproductive and child health in these areas are extremely poor and are characterised by high morbidity and mortality among mothers and children, and poor coverage with basic health services. Maternal complications including obstetric fistula are common among women who survive child birth, and the program focuses strongly on prevention although it does not include surgery for fistula. It is intended that this will be addressed in possible following phases of this work

In Uganda and Tanzania, Children under 5years die mainly from preventable and treatable conditions such as malaria (30%), vaccine preventable diseases particularly measles (22%), diarrhoea (19%), acute respiratory infections (16%) with malnutrition underlying about 60% of these childhood deaths. Micronutrient deficiencies (e.g. iron, vitamin A and Zinc are particularly prevalent among children in Tanzanian and Ugandan marginalized and poverty stricken rural communities and worsen mortality from diarrhoea and measles. Mortality in the newborn contributes to about 40% of infant mortality but receives the least attention in child survival strategies including integrated management of childhood illnesses (IMCI). The major conditions that cause deaths in the newborns are low birth weight, neonatal jaundice and neonatal tetanus. These diseases also cause considerable morbidity and in some cases, long-term disability. The HIV pandemic is further worsening the situation. Under-five mortality rates (U5MR) stand and 201 and 132 per 1000 live births respectively for Uganda and Tanzania. In Uganda, IMR and U5MR stand at 76 per 1,000 live births and 137 per 1,000 live births respectively (UDHS 2006). The Neonatal Mortality Rate is 48 per 1000 live births.

Uganda and Tanzania have national child survival strategies and programs but implementation of global initiatives like the integrated management of childhood illness

(IMCI) is patchy in outlying areas like Shinyanga and Gulu, Kitgum and Pader districts and largely limited to the health facility component. The DANIDA intervention focuses on reproductive health for youth and adults, including a strong safe motherhood component, but misses to address issues of child health in the Uganda and Tanzania sites. This reduces the potential impact in overall health improvement for mothers and children; this proposed intervention will address that gap in the next two years, and extend the reproductive health interventions to additional beneficiaries in two new districts, being Pader district in Uganda and Ushetu district in the Shinyanga Region of Tanzania (excluding Turkana in Kenya which has an adequate child health intervention).

**The New Districts for Comprehensive Intervention**

The additional district in Tanzania is **Ushetu,** which was hived off the larger Kahama district. Kahama was a very large district and was only partially covered by the DANIDA project (10 out of 55 wards). The new district which is in the process of being set up will have its own Council Health Management team (CHMTs), in addition to the Kahama urban and Kahama rural district CHMTs who for purposes of the project are treated as Kahama district. Maswa district which was in the project has moved to Mwanza region in the administrative reorganization.

Ushetu district has 40 health facilities. In the new set up, the proposed intervention will address training and supportive activities to health personnel to expand IMCI which is now only in the hospitals. The potential target population in the district is 263,000, of whom about 59,000 are children under 5 years of age. The target beneficiary population is 50% of the total and 40% children under five years in the two year period. In the whole Shinyanga region, less than 5% of health facilities have capacity (trained personnel) for IMCI, and there is no community intervention (cIMCI)

In Uganda **Pader** District which neighbours Kitgum will be added to the project to receive comprehensive SRHR and child health intervention. Pader district has a population of 210,000 with an estimated population of 43,071 of under-five year's old children and a similar population of women in the reproductive age bracket of 15 – 49 years. Most of the population is still in the process of re-establishing themselves in their old villages after massive displacements during the many years of war in the north of the country that ended 4 years ago. Pader district has 26 health centres, and one district hospital which is locally known as HC IV. The situation of staffing is only slowly returning to normal, and service provision is weak and beset with many problems of supplies and management. Approximately only 42% of health facilities provide comprehensive maternal and child health services. A few health personnel have been trained in IMCI when most of the population was in camps but there has been a high turnover and it is difficult to estimate which facilities have capacity for IMCI without an assessment. There is no cIMCI in the area. The assumption is made that capacity for both IMCI and cIMCI is neglible at this time. The district's population will benefit immensely from this intervention in terms of access to services and health improvement.

## The Supplementary Intervention

The proposed supplementary intervention will target four main causes of child morbidity and mortality in the project areas – acute respiratory infections, diarrhoea, malaria and micronutrient deficiencies. It will employ the IMCI approach focusing on the community and building its skills to link effectively with the frontline health services for early detection and management of these childhood problems. It will also work to enhance the capacity of health facilities to deliver care effectively to ill children, including support to simple diagnostic tests in the health facility laboratories and updating of laboratory staff. Health promotive and preventive services will be supported as well (immunization, nutrition education) as well and be closely linked to extensive community mobilization.

## Objectives of the Supplementary Intervention

The proposed intervention will become an integral and supporting part of the DANIDA project. The DANIDA project will therefore be fully implemented in the additional district, but coverage with the child health objectives will be applied in all the project districts at 40% of the target population of children at this time to coincide with the scaled down duration of the project and funding. 127 health facilities (57 in Uganda, 70 in Tanzania, distributed reasonably by sub-county and ward administrative units) will be covered with IMCI more to perfect the approaches and prepare for scale up to all facilities should it become possible. This practical approach has been taken to avoid spreading the intervention too thin and fail to achieve the desired results. This will be adjusted accordingly should an opportunity to continue arise. In both Uganda and Tanzania, IMCI is a priority intervention in the country child health strategies.

Integrated Management of Childhood Illness (IMCI) is a package of care that looks at the wellness of the entire child rather than looking at one condition, especially in terms of assessing the ill child. It has been show to be very effective in improving the skills of health workers to look after sick children effectively in the health facility setting (Health facility IMCI) where it aims to:

1. Improve case management skills of health-care staff
2. Improve overall health system performance for the benefit of children

The IMCI approach facilitates effective detection of childhood illessisn in outpatient clinics and appropriate management of major illnesses including timely referral to appropriate levels for very sick children.

To support these care objectives, there is an important role for the family and community which needs to adopt practices that support promotion of the child's health and nutrition and early detection and management of illness, as well as appropriate care seeking behaviour. This has evolved to be called Community IMCI (cIMCI) and now incorporates lay workers like community health workers and drug distributors who are trained to detect early illness, advise caretakers and when necessary provide preliminary and advise referral.

Tanzania was one of the earliest countries to accept IMCI and its program was part of a multicoutry evaluation of the approach, but remoter regions like Shinyanga have not fully implemented IMCI. Implementation has been generally weak even when funds seem not to be the issue. Potential reasons include inadequate planning for and financing of the intervention, as well as human resource constraints. There is high mobility of especially middle level technical support staff and therefore poor support for the intervention in the field, which has yet to include the vital community elements. AMREF's experience is that this intervention produces quick results for children where it involves the right partnerships including community participation, and AMREF holds the view that implementation will improve as both countries move to implement the community strategy, which will enhance early referral of children to health facilities besides early treatment by community health workers. The necessary experience will also be developed regarding partnership between health facilities and communities.
I think you need to add a few lines on the MOH policy in IMCI and why MOH is not doing this expensive intervention in these districts themselves.

**Intervention Purpose:**

To increase access to integrated management of childhood illnesses and treatment of micronutrient deficiencies in children under five years old

**Additional Specific Objectives**

3. To increase by 40% the proportion of children receiving appropriate treatment in the community and health facilities for malaria, pneumonia and diarrhea by 2013
4. To reduce the proportion of children with micronutrient deficiencies by 15% in target districts by 2013

**Key Performance Indicators**

10. Proportion of children with fever appropriately identified at family level and, managed appropriately
11. Proportion of very sick children referred immediately to health facilities by community health workers (also known as Village Health Teams in Uganda)
12. Proportion of children with pneumonia correctly diagnosed and treated with amoxicillin
13. Proportion of children with fever who receive malaria treatment with 24 hours of onset of fever
14. Proportion of children with diarrhea correctly treated with ORS and zinc
15. Proportion of children who receive at least two doses of vitamin A per year
16. Proportion of children who are dewormed at least once per year
17. Proportion babies born at home who are seen in a health facility within 2 days
18. Proportion of children completing OPV 4 and DPT 4 in monitored villages

The last two indicators are included to assess the health system support element of this intervention, including the ability of the health service to take advantage of the opportunities it will provide for contact with children to increase

immunization coverage. Data for their evaluation will be easy to obtain from routine immunization records

**Major Activities**

1. Preparation of detailed implementation plans with reviewed specific outputs
2. Training of District and Council health management teams
3. Training of health workers on IMCI and laboratory staff
4. Training of village health teams and community health workers on community IMCI
5. Supplies of prepackaged artemisinin based malaria treatment, rectal artesunate, Zinc and ORS, and Amoxycillin to community health workers including adequate monitoring of use as per national guidelines
6. Support to health facility essential supplies (gap filling) to avoid stock outs
7. SRHR activities as per DANIDA project for the new districts
8. Monitoring using health facility and community based health information systems
9. Evaluation at the end of two years and re-planning the intervention as necessary

**Implementation Mechanisms**

1. Detailed start-up planning with stakeholders and carrying out joint baseline assessment together with the DANIDA project (in Pader district). (the DANIDA project baseline survey was planned for May 2011 and may be delayed slightly if there is indication that this application will be approved so that the exercise is done once).
2. Training and working closely with District and Council Health Management Teams to mobilize, train, support and supervise health workers and community actors in F-IMCI and C-IMCI
3. Identifying and strengthening community leadership for health
4. Supporting health facilities through effective logistics and supervision
5. Documenting and sharing project lessons for practice and policy influencing

**Reporting**

Internally, AMREF project management guidelines require quarterly, half yearly and then annual reporting. Externally, reporting will be half yearly when a joint DANIDA/AuAID report will be compiled and submitted for comment by the donors

Revised Summary Budget - Attached.