Child Days Plus in Uganda: Best practices and challenges

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Dr. Possy Mugyenyi, MOH Uganda
Dr William Mbabazi, WHO Uganda
Dr Eva Kabwongera, UNICEF Uganda
Outline

- Historical background
- What is child days
- Observed Effect of CHDs
- Good practices/lessons learnt
- Constraints/Challenges
- Next Steps
### Relevant socio-economic indicators in Uganda

<table>
<thead>
<tr>
<th>Indicators and source</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population 2009 (UBOS)</td>
<td>30.1 million</td>
</tr>
<tr>
<td>Child population (56% of total population – UBOS)</td>
<td>15.3 million</td>
</tr>
<tr>
<td>Under five mortality rate (DHS 2006)</td>
<td>137</td>
</tr>
<tr>
<td>Infant mortality rate (DHS 2006)</td>
<td>76</td>
</tr>
<tr>
<td>Maternal mortality (DHS 2006)</td>
<td>435</td>
</tr>
<tr>
<td>Children 12–23 months fully immunized (DHS 2006)</td>
<td>46%</td>
</tr>
<tr>
<td>Children 12–23 months immunized against measles (DHS 2006)</td>
<td>68%</td>
</tr>
<tr>
<td>Vitamin A deficiency (% children &lt;5) (DHS 2006)</td>
<td>20%</td>
</tr>
<tr>
<td>% children &lt; 5yrs sleeping under mosquito net (DHS 2006)</td>
<td>9.7</td>
</tr>
<tr>
<td>Primary school attendance rate (DHS 2006)</td>
<td>82%</td>
</tr>
</tbody>
</table>
Historical background

- 1998 – initiated Vit. A supplementation (VACS) in Polio NIDS
- 1999 – 2001–VACS in polio SNIDs in 22 districts
- 2000 – piloted the bi–annual VACS in 2 districts
- 2001 – Biannual VACS guidelines development
- 2002 – Child Health Days in May and November
- 2003 – Child Health Days Strategy revisited and renamed Child Days Plus (to include NTDs)
  - 2003 – Integrated measles catch campaign (6 months – 14yrs)
    VACs (6 – 59 months); TT campaign in 5 HRD (WCBA)
- 2004 – Child Days Plus Strategy launched by MOH April 29th
- 2006 – Main streaming CHD into District Health Plans & PHC funding – districts expected to include CD and allocate funding,
- 2006 Integrated measles follow–up campaign (9 – 59 months), VACS, TT campaign in 11 districts
The CHD Package
Observed peaks during child days

Monthly Measles Vaccinations, 2002-2007
Where are the Un–immunised Children?

DPT–3 unvaccinated by District, Jan–Sept 2008

- Arua, 12.85%
- Bugiri, 10.35%
- Kibaale, 9.68%
- Bundibugyo, 8.50%
- Moyo, 7.79%
- All Others, 50.83%
Opportunity provided by CHD in poorly performing districts

<table>
<thead>
<tr>
<th>District</th>
<th>Nov-07 CHD Effect</th>
<th>May-08 CHD Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arua</td>
<td>340</td>
<td>NR</td>
</tr>
<tr>
<td>Bugiri</td>
<td>75</td>
<td>658</td>
</tr>
<tr>
<td>Kibaale</td>
<td>85</td>
<td>1,375</td>
</tr>
<tr>
<td>Bundibugyo</td>
<td>149</td>
<td>83</td>
</tr>
<tr>
<td>Moyo</td>
<td>443</td>
<td>1,018</td>
</tr>
<tr>
<td>Total Contribution of CHD in 5 districts</td>
<td>1,092</td>
<td>3,134</td>
</tr>
<tr>
<td>Total CHD Gain on measles Vaccination</td>
<td>14,820</td>
<td>21,360</td>
</tr>
<tr>
<td>% contribution of 5 districts</td>
<td>7%</td>
<td>15%</td>
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</tbody>
</table>
Good practices and opportunities available to increase and sustain coverage

- High level advocacy is vital for success
- Prioritization and support to poorly performing districts
- Catalytic funding for critical activities e.g. mobilization, drop out tracking, IPC
- Partnerships & Leveraging resources – PHC, NTD
- Crowd puller–Interventions e.g. de-worming
- Integrated Supervision during Area Teams
- Community & district ownership
- League table–based on district performance and Recognition of Best performers
Impact of decentralization on coverage and district reporting

- CHD planning and financing started as a centrally driven activity
- Role has been devolved to the districts since 2006
- Effects:
  - Reduction in reporting rates
  - Institutionalization of CHD had a cost – stagnation
Constraints/Challenges

- Health workers
  - Inadequate with limited skills, negatively affecting district capacity for planning, implementation, data management
- Overloading the package without ensuring necessary inputs (human resource, micro planning) may compromise the effectiveness
- HMIS data management
  - Tools often lacking or inappropriately used at operational level
  - Declining completeness and timeliness of reporting as CHD data is integrated into HMIS
  - Limited use of data for action at point of generation
- Poor Child Health Card retention
- Inadequate Supervision & monitoring of Child Days
Constraints/Challenges

- Logistics and supplies for the integrated package
  - Availability, timely and coordinated distribution
  - Lack of transport facilities at district and operational levels

- Intervention package
  - Overloading
  - Different target groups
  - Attractive interventions (ITNs) overshadowing others

- Funding
  - Sustained adequate & timely release of GoU PHC funds
  - Some districts still expect vertical funding for Child Days
  - District commitment to prioritize child days for allocation of PHC funds
  - Shift in thinking from a campaign-approach to a more sustainable routine approach by districts
  - Shift from donor funding – sustainability?, availability?, preparedness?
Next steps / Way forwards

- Improve planning (joint and timely)
- Improving the quality of training
- Improve monitoring and supervision
- Improve reporting to include outputs by age groups
- Mobilize more resources locally;
- External funds and technical support required.
Thank you