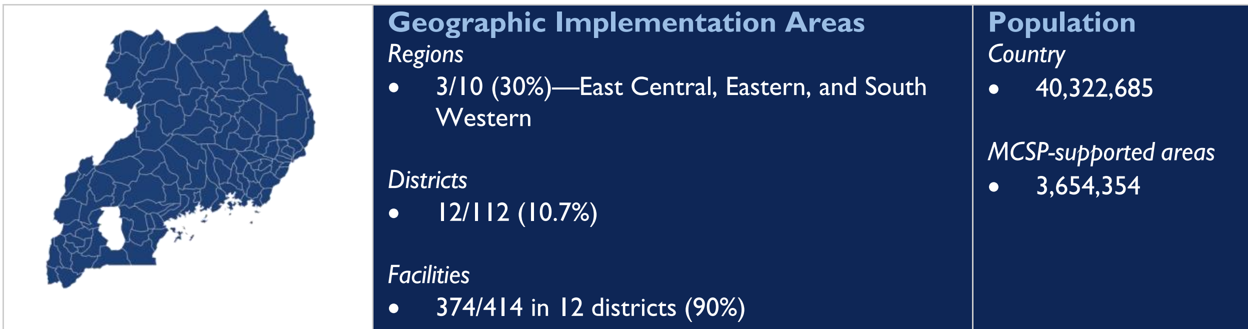
Uganda CH and RI PY4 Summary & Results



Geographic Implementation Areas

Regions
- 3/10 (30%)—East Central, Eastern, and South Western

Districts
- 12/112 (10.7%)

Facilities
- 374/414 in 12 districts (90%)

Population

Country
- 40,322,685

MCSP-supported areas
- 3,654,354

Technical Areas

Program Dates

July 1, 2014–March 31, 2019

Cumulative Spending through End of PY4

Demographic and Health Indicators

Indicator	# or %
Children 12-23 months who received the third dose DPT	79%
Children 12-23 months who received all basic vaccines	55%
U5MR (per 1,000 live births)	64
Children under 5 with diarrhea given ORS and zinc	30%
Children under 5 with fever who took antimalarial drugs	87.6%

Source: Uganda DHS 2016.

Strategic Objectives

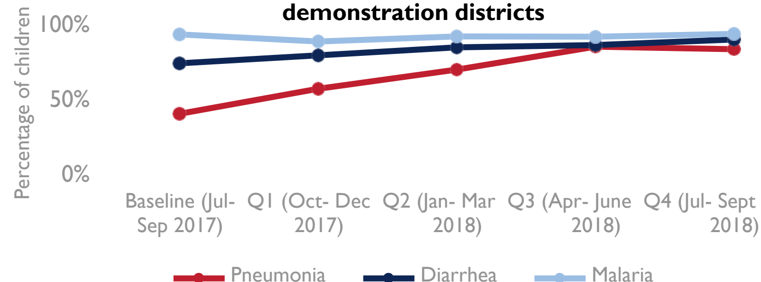
Routine Immunization
- Strengthen the Uganda National EPI's institutional/technical capacity to plan, coordinate, manage, and implement immunization activities at the national level.
- Improve district capacity to manage and coordinate the immunization program as guided by Ugandan National EPI leadership.

Child Health
- Enhance national guidelines and frameworks to support implementation of the essential child health package.
- Strengthen technical skills, competencies, and practices of the Regional Health Integration to Enhance Services partners and MCSP-supported demonstration districts to implement the essential child health package.
- Strengthen district-level management and planning to support delivery of the essential child health package using adapted REC-QI approaches.
- Conduct a cost analysis for delivery of the essential child health package.
- Improve availability of strategic knowledge and tools to scale up the essential child health package.

Key Accomplishment Highlights

- MCSP's innovative approach to facility-based microplanning was adopted by the MOH for use countrywide by all EPI stakeholders.
- Supported the national government and other USAID implementing partners to revitalize, update, and scale up an integrated newborn and child health strategy, training package, and delivery approaches.
- Supported the MOH to review and streamline national HMIS tools to improve the documentation and availability of quality data on child health service delivery.
- Engaged nonhealth stakeholders in all MCSP-supported districts to review RI and child health performance, problem-solve around bottlenecks, and commit local government resources to strengthen RI and child health services.

Figure 1. Children under 5 who received appropriate treatment (pneumonia, diarrhea, and malaria) in four demonstration districts



Uganda Child Health and Routine Immunization

Key Accomplishments

MCSP's partnership with USAID/Uganda started with the 2012 initiation of technical assistance to strengthen RI through MCSP's predecessor, MCHIP. In PY4, MCSP continued to implement two programs in Uganda. The RI program worked with the MOH and the Uganda National EPI to operationalize REC Using QI at the national level and throughout 11 districts in 2014–2019. The Child Health program provided above-site technical assistance in the area of child health to the USAID Regional Health Integration to Enhance Services projects in the South Western and East Central regions of Uganda in 2017–2019. MCSP is being implemented alongside the Stronger Systems for Routine Immunization project, which was awarded to John Snow Inc. in 2014 by the Bill & Melinda Gates Foundation and employs the same REC Using QI methodology in an additional 11 districts and will end October 31, 2019.

IMNCI Revitalization and National HMIS Tools Update in Uganda

MCSP supported the national government to revitalize, update, and scale up the IMNCI strategy, training packages, and delivery approaches. The strategy outlined integrated management for the most common causes of child deaths (pneumonia, malaria, diarrhea, malnutrition, and measles) along with key preventive and promotive actions at the facility, community, and household levels. Through support to USAID's Regional Health Integration to Enhance Services East Central and South Western projects, 676 health workers were trained in these standards and about 80,000 children received appropriate treatment for diarrhea, pneumonia, and malaria in four demonstration districts in PY4. Additionally, MCSP supported the MOH to review and streamline national HMIS tools to improve the documentation and availability of quality data on child health service delivery.

Adaptation and Adoption of Pediatric Quality of Care Standards

After a significant investment at the global level by MCSP and USAID to assist WHO with the development and launch of global pediatric quality of care standards, the MCSP team in Uganda worked with the MOH to adapt and adopt these standards to the Ugandan context. The adapted standards have been integrated into the recently developed national Maternal and Newborn Standards Assessment Tool, which will be used to assess and launch MNCH QI Initiatives in Uganda, starting with 16 learning districts, and leveraging financial and resource support from the World Bank's Global Financing Facility-funded RMNCAH program.

Institutionalization of REC Using QI into National Immunization Reference Materials

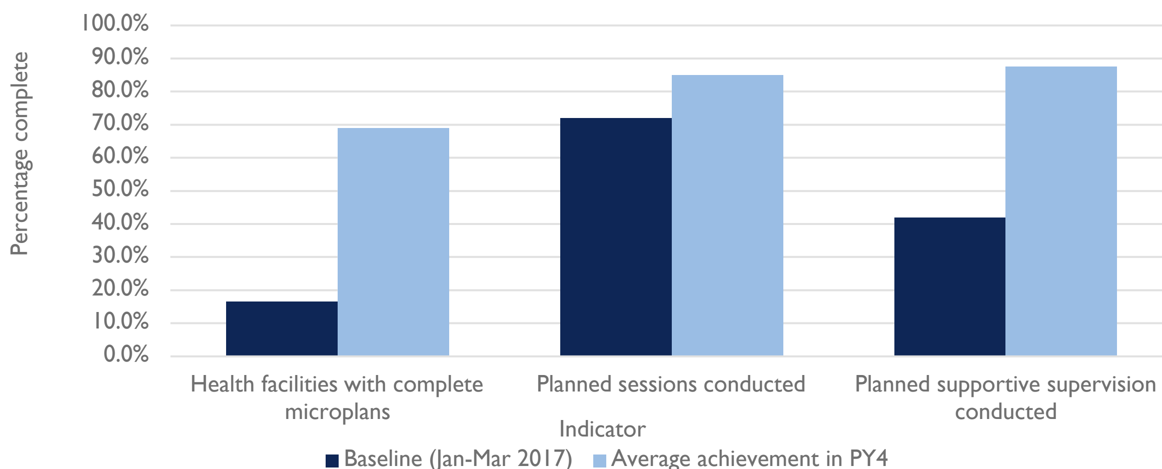
The MOH has incorporated MCSP's approaches to improving the quality and reach of immunization services into key national immunization reference materials used nationwide. In PY4, these materials included Uganda's national EPI standards; the in-service training materials for frontline health workers to introduce the REC approach; the immunization pre-service curriculum for training institutions; and the enhanced RED categorization tool that was incorporated into the DHIS2 to provide EPI managers with program data for decision-making.

Microplanning and Catchment Area Mapping

MCSP's innovative approach to facility-based microplanning that applies QI tools to systematically identify, analyze, and prioritize problems and test solutions has been adopted by the MOH/Uganda National EPI for countrywide use by all EPI stakeholders. MCSP's support to staff in over 400 health facilities in nine districts during PY4 has built their capacity to carry out detailed, facility-level microplanning to improve access and quality of RI services. This has helped advance equity and increase the number of children vaccinated, with an additional 274 villages in four districts reached in PY4 with RI services and approximately 49,779 children receiving Penta3 in four districts. The MOH also expressed interest in adopting MCSP's approach for mapping catchment populations to strengthen the broader scope of RMNCAH. MCSP provided technical assistance to the MOH to develop a National Guide on Using Catchment-Area Mapping and Planning for

Action for other RMNCAH interventions. Once finalized, this document will serve to improve prioritization, planning, equitable access, and community participation for RMNCAH services, thereby facilitating implementation of the government of Uganda's Sharpened Plan for RMNCAH services. The MOH plans to rollout Catchment-Area Mapping and Planning for Action in 75 of 112 districts (67%), with support from the World Bank's Global Financing Facility.

Figure 2. Selected indicators demonstrating strengthening of routine immunization system in four districts (Mbarara, Bushenyi, Pallisa, Mayuge) in PY4



Cost Analysis of the Essential Child Health Package

MCSP completed data collection and generated preliminary findings for a cost analysis estimating the resources needed to roll out the essential child health package through IMNCI training, mentorship, and REC, as well as the costs to deliver the package in public facilities. The full analysis—to be completed and disseminated in PY5—will also model the costs of scaling up the package to other districts. The cost analysis will ultimately provide Government of Uganda decision-makers and other key stakeholders with evidence to advocate for both the expansion of the lifesaving package and increased domestic spending to help strengthen the capacity of public health workers to deliver the essential child health package, thereby reducing under-5 mortality.

Engagement of Nonhealth Stakeholders

MCSP engaged nonhealth stakeholders (e.g., civil authorities, political representatives, and community leaders) in all 12 MCSP-supported districts to review RI and child health performance, problem-solve around key bottlenecks, and mobilize local government funds and resources to strengthen RI and child health services. MCSP's work with these stakeholders led to the creation of a MOH-issued national statement that draws attention to the importance of the nonhealth stakeholder, raises the priority of RI in these districts, and clarifies the important roles of these stakeholders in addressing RI challenges.

Way Forward

MCSP will complete sustainability forum meetings in nine districts and will close out its RI technical support at the district level. At the national level, MCSP will finalize technical inputs from key stakeholders on the Uganda EPI prototype curriculum for pre-service health worker training institutions and finalize the step-by-step microplanning guide in collaboration with other partners so that it can be used for microplanning by MOH and other EPI partners countrywide.

For the Child Health program, MCSP will complete closeout meetings with the three remaining districts and Regional Health Integration to Enhance Services partners in the East Central and South Western regions. MCSP will complete all remaining national-level above-site technical assistance including finalization of

recommendations for updating the National Child Survival Strategy; support to MOH to finalize the Catchment-Area Mapping and Planning for Action Guide for RMNCAH services; and production of the updated IMNCI and other essential child health package materials. MCSP will also refine the preliminary results of the costing analysis and complete the modeling exercise on the costs associated with rolling out and delivering the child health package to other facilities and districts. Finally, MCSP will complete the technical review and refinement of all learning documents and hold a final joint dissemination meeting for both the RI and child health programs in January 2019.

Selected Performance Indicators for PY4	
MCSP Global or Country PMP Indicators	**PY4 Achievement**
Four districts where MCSP's RI program was implemented for full reporting period (i.e., Mbarara, Bushenyi, Pallisa, and Mayuge Districts).	
Number and percent of children who at 12 months have received three doses of diphtheria-pertussis-tetanus/pentavalent vaccination from a US government-supported immunization program in four districts	49,779/67,808 (73%, target: 90%, 82% achieved)[1]
Percent of planned RI sessions that were conducted in the year	14,851/17,458 (85%, target: 91%, 93% achieved)[2]
Percent of health facilities with complete REC microplans	116/168 (69%, target 44%, >100% achieved)
Four districts where MCSP's Child Health program was implemented for full reporting period (i.e., Luuka, Kaliro, Ntungamo, and Sheema Districts).	
Number of national-level guidelines, tools and manuals, reports, and briefs developed or revised for child health with MCSP support	9 (target: 8, >100% achieved)[3]
Proportion of health facilities with job aids for case management of childhood illnesses in MCSP demonstration districts[5]	90% (target: 100%, 90% achieved)[4]
Proportion of cases of children under 5 with diarrhea seeking care at health facilities who received oral rehydration salt and zinc in the last quarter[5]	92% (target: 85%, >100% achieved)
Proportion of cases of children under 5 with pneumonia seeking care at health facilities who received appropriate treatment with antibiotics in the last quarter[5]	88% (target: 85%, >100% achieved)
Proportion of children under 5 years of age diagnosed with malaria through routine diagnostic testing and/or microscopy testing who received ACT treatment in the last quarter[5]	96% (target: 85%, >100% achieved)

[1] Improvement in data quality: The quality of immunization data among other factors affect the immunization coverage indicator. MCSP and other partners have been working with the government to address data quality issues, which likely have contributed toward bringing down the coverage. There were also district specific differences: Mbarara experienced vaccine stock-out, which affected implementation of planned RI sessions. In Mayuge, delays in release of primary health care funds coupled with vaccine stock-out affected implementation of RI sessions. In Pallisa, delayed release and reductions in primary health care funds to 50% of the expected in some HFs and vaccine stock-outs have affected implementation of RI.

[2] Limited primary health care funds to conduct outreaches, cold chain breakdown, vaccine stock-outs and the rainy seasons affected implementation of planned RI sessions in the districts.

[3] National IMNCI training guidelines including: IMNCI Chart Booklet, IMNCI Wall Charts, IMNCI Facilitator's Manual for Short Interrupted Course and Distance Learning Course, IMNCI Desk Charts, IMNCI Participants Modules (Short Interrupted Course and Distance Learning Course), IMNCI Mother's Counselling Card, District level Child Health Scorecard, National HMIS Form 105, Community Health Management Information System Form 031

[4] The indicator required verification of the presence of the documents. Due to staff transfers that took place towards the end of the project, some health facility in-charges were unaware of the presence of these guides at their new facilities if they were not found in the clinic rooms.

[5] Reported only for PY4 Q4 because consistent quarterly improvements would be masked by averaging all four quarters.