


Uganda Child Health EOP Summary & Results

	Geographic Implementation Areas <i>Regions</i> <ul style="list-style-type: none"> • 2/10 (20%)—East Central and South Western regions <i>Districts</i> <ul style="list-style-type: none"> • 4/128 (3%)—Kaliro, Luuka, Sheema, Ntungamo <i>Facilities</i> <ul style="list-style-type: none"> • 134/151 (89%) 	Population <i>Country</i> <ul style="list-style-type: none"> • 40.3 million <i>MCSP-supported areas</i> <ul style="list-style-type: none"> • 1.29 million
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Technical Areas

Program Dates

January 1, 2017–March 31, 2019

Total Funding through Life of Project

\$2,400,000

Demographic and Health Indicators

Indicator	# or %
TFR (births per woman)	5.4
NMR (per 1,000 live births)	27
IMR (per 1,000 live births)	43
U5MR (per 1,000 live births)	64
Children who received all basic vaccinations	55%
Children under 5 with diarrhea who received ORS and zinc	30%
Children (6–59 months) who tested positive for malaria by rapid diagnostic test	30%

Source: Uganda DHS 2016

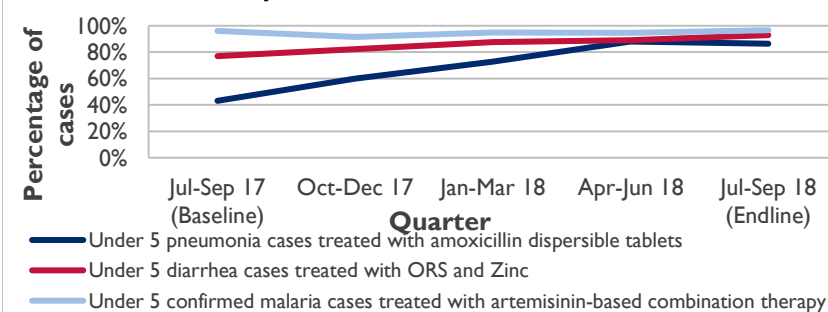
Strategic Objectives through the Life of Project

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

Highlights through the Life of Project

- Identified, costed, and demonstrated the feasibility of implementing at all levels, an essential package of low-cost, high-impact child health interventions to contribute to a reduction in child mortality in the South Western and East Central regions of Uganda.
- Facilitated the revitalization, update, and scale-up of the IMNCI strategy, training package, and delivery approaches as a vehicle for integrated delivery of the essential child health package.
- Worked with the national government to adapt and adopt pediatric quality of care standards to the Ugandan context, after an investment by USAID to assist WHO to develop and launch global pediatric quality of care standards.
- Supported the national government to pilot, document, and develop a National Guide on Using Catchment Area Mapping and Planning for Action for other child health and broader RMNCAH interventions.

Figure 1. Improved and sustained coverage of appropriate treatment for under-5 cases of pneumonia, diarrhea, and malaria



Uganda—Child Health

Background

MCSP partnered with the USAID Mission in Uganda and the Uganda MOH's national EPI to strengthen RI. This support was a continuation of USAID's commitment to strengthen immunization services, which was initiated in 2012 through technical assistance provided by MCSP's predecessor, MCHIP, which implemented the REC-QI approach and its performance improvement cycle in five districts of Uganda. In July 2014, this work was transitioned to MCSP to support the MOH and EPI to operationalize REC-QI at the national level and throughout 11 districts. In late 2016, USAID requested MCSP to provide tailored child health technical assistance to the MOH at national level and two of USAID's recently awarded RHITES projects to identify, demonstrate, cost, and document a package of essential low-cost, high-impact child health interventions in four prioritized districts (or demonstration districts), with the ultimate goal of contributing to a reduction in child mortality in the South West and East Central regions, in line with the objectives of the Uganda Sharpened Plan for RMNCAH. MCSP's RI and child health programs were implemented in Uganda alongside the Stronger Systems for RI project funded by the Bill & Melinda Gates Foundation and awarded to John Snow Inc. in 2014 as a sister project to MCSP, employing the same REC-QI methodology but in an additional 11 districts in different regions of the country.

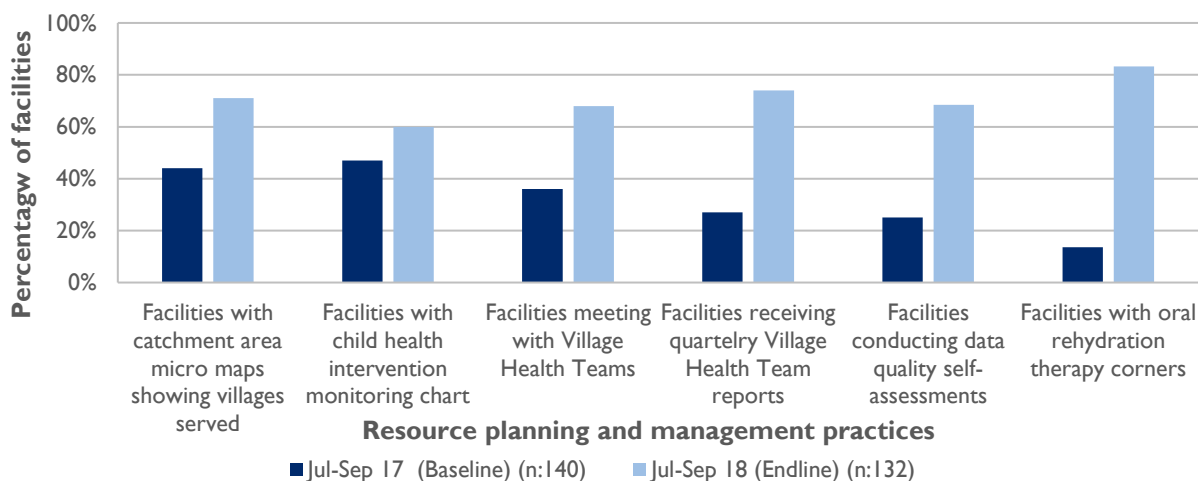
Key Accomplishments

Revitalized, Updated, and Scaled Up the Integrated Newborn and Child Health Strategy

MCSP, in collaboration with other partners, including WHO, supported the national government to revitalize, update, and scale up the IMNCI strategy, training packages, and delivery approaches. The updated strategy provided a vehicle for integrated provision of a prioritized essential child health package at all levels of care. 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. Over the life of the project, through support to USAID's RHITES projects in the East Central and South Western regions, 853 health workers and 2,427 CHWs were trained on these actions, increasing access to evidence-based holistic care to approximately 400,000 children and enabling about 80,000 children to receive appropriate treatment for diarrhea, pneumonia, and malaria in the four demonstration districts.

Additionally, MCSP worked in collaboration with WHO and the MOH to identify and pilot two alternative training approaches for implementation of the IMNCI strategy—the distance learning model developed by WHO and the short-interrupted course model developed by the MOH—as a part of the essential child health care package. The two approaches were designed to address challenges previously faced by the country and to sustain IMNCI implementation by reducing the duration of offsite face-to-face training and related training costs, in addition to minimizing the disruption of services and ensuring optimum numbers of health workers were trained within a short period of time. The pilot demonstrated the feasibility of implementing both the short-interrupted course model and the distance learning model in the Ugandan context, and generated learning—in terms of the cost, the “how,” and effect on health worker competencies and practices—to inform which model will be used for the national rollout of IMNCI, as prioritized in the Uganda Sharpened Plan for RMNCAH. The MOH has adopted both approaches in a two-pronged strategy to roll out the short-interrupted course model in the short term for building capacity of health workers when starting from very low levels of knowledge and skills while using distance learning model for continuously updating skills of health workers who already have some basic knowledge and skills in IMNCI. Additionally, the MOH has received technical support from the WHO to use experiences and learning from MCSP and from UNICEF implementing the IMCI Computerized Adaptation and Training Tool, to develop recommendations and guidelines on how to use these approaches as part of the broader IMNCI implementation strategy.

Figure 2. Increase in uptake of resource planning and management practices for improved coverage of child health interventions at health facilities



Adapted and Adopted 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, MCSP worked with the MOH to adapt and adopt these standards to the Ugandan context. The adapted standards were integrated into the 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 in 2019 and leveraging resources from the World Bank’s Global Financing Facility for Every Woman Every Child.

Adopted Catchment Area Mapping for RMNCAH

MCSP supported the [application of the RED/REC approach to other child health interventions beyond immunization](#) in the four demonstration districts, which was associated with increased uptake of child health interventions delivered through community- and facility-based services. It was found that the application of RED/REC practices to other child health interventions helped health managers at the district and health facility levels to appreciate and use their data, recognize and address gaps in coverage, and identify underserved communities and strategies for reaching them. As a result, 33,000 more children under 5 were reached with deworming treatment, and approximately 30,000 were reached with vitamin A supplementation across the four districts in 1 year.

Building on MCSP’s experiences adapting RED/REC to other child health interventions, the MOH pursued adoption of 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, the guide will serve to improve prioritization, planning, equitable access, and community participation for RMNCAH services, thereby facilitating implementation of the Uganda Sharpened Plan for RMNCAH. The MOH plans to roll out the National Guide on Using Catchment Area Mapping and Planning for Action in 75 out of 128 districts (59%), with support from the World Bank’s Global Financing Facility for Every Woman Every Child.

Completed a Cost Analysis of the Essential Child Health Package

MCSP completed a [cost analysis](#) estimating the resources needed to roll out the essential child health package through IMNCI training, mentorship, and the REC approach, as well as the costs to deliver the package in public facilities and to scale it up to other districts. Across all sampled facilities, the annual per capita and per child under-5 cost was UGX 4,266 and UGX 19,184 (USD 1.15 and USD 5.18), respectively. Per capita and per child under-5 costs decreased from lower-level Health Center IIs to higher-level Health Center IVs, given the relatively larger catchment populations of the higher-level facilities, which spread the costs over a larger population. With the rollout and delivery of the essential child health package in the four demonstration

districts, the costing analysis produced an important piece of evidence to inform the Government of Uganda and implementing partners' planning for the expansion of training and service delivery approaches both regionally and nationally. The costs to deliver the essential child health package showed that the package was a relatively affordable set of integrated interventions with the potential to contribute to under-5 mortality reductions through improved case management.

Improved Quality of Child Health Data

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. The limited availability of quality data to inform planning and improvement of child health services was identified at the start of MCSP as one of the major challenges affecting the delivery of child health services. MCSP collaborated with the MOH to conduct orientation and support targeted onsite mentorship of the RHITES partners and health service providers in the four demonstration districts to:

- Generate baseline data on child health for each of the districts.
- Develop a [child health scorecard](#) to monitor implementation of the essential child health package at facility and community levels.
- Understand and correctly use the national MOH registers for child health service delivery, including child health, outpatient, and community registers.
- Use routine data quality audits at the health facility level to improve and validate the quality of child health data generated and reported.

A total of 311 health workers and 2,527 village health teams were oriented on the use of health management information tools, and the percentage of health facilities conducting data quality self-assessments doubled from 28% to over 60%. MCSP support contributed to an overall improvement in the accuracy of child health data reported through the national HMIS when compared to registers at the facility level.

Experiences from the short period of implementation showed that the child health scorecard was a useful QI tool for health facility- and district-level health managers. It provided a mechanism to visually present and easily communicate service delivery performance to stakeholder groups, and helped stakeholders to identify and prioritize support for poorly performing child health interventions and facilities. It also helped district level managers to identify and scale up at district-level good practices, such as the allocation by health facilities of primary health care funds to support community engagement activities for child health. The child health scorecard has now been adopted by the District Health Offices in the four demonstration districts. At the national level, MCSP's implementation experiences were shared and have been used with experiences from using other performance tracking tools to revise and improve on the MOH integrated RMNCAH scorecard.

Recommendations for the Future

In light of the project's achievements and lessons learned in Uganda, MCSP would like to recommend the following:

- **Adopt a “light” essential child health package and scale up the updated IMNCI guidelines.** Based on MCSP's experiences and learning from program implementation in the four demonstration districts, it is recommended that the MOH and its implementing partners adopt the MCSP “light” essential child health package. Individual interventions in the package may be given more weight during implementation depending on the disease profile of a district or region. The updated IMNCI guidelines should be scaled up as an approach for integrated delivery of the essential child health package using the alternate cost-saving training approaches piloted by MCSP. The selection of which of the two models to scale should take into consideration other lessons learned beyond cost implications; for whichever model is selected, further refinement should be done using feedback provided during the MCSP pilot implementation. For both models, there should be engagement and empowerment of focal staff on the

district health management team and the health facility managers to provide leadership and oversight for the rollout, and to ensure that the acquired learning contributes to the transformation of health worker practices in the day-to-day management of children.

- **Expand catchment area mapping and planning, as well as other aspects of the RED/REC approach.** MCSP recommends that the MOH and its implementing partners expand the use of the RED/REC approach, especially catchment area mapping and planning, as a system strengthening approach for child health and potentially other RMNCAH interventions for which population coverage is a goal. Use of catchment area mapping and planning will improve prioritization, planning, equitable access, and community participation for RMNCAH services, thereby facilitating full implementation of the Uganda Sharpened Plan for RMNCAH.
- **Prioritize and support data documentation, ownership, use, and regular reporting.** MCSP recommends that the MOH and its implementing partners prioritize and continue to provide support for quality documentation, ownership, use, and regular reporting of child health service delivery data, which is necessary for the full realization of results from IMNCI; catchment area-based micromapping, planning, and action; and other approaches that have been used to roll out the essential child health package. Access to and availability of essential medicines and supplies needed for the implementation of the essential child health package should be prioritized and is another critical challenge that has constrained results from the rollout of the essential child health package.
- **Gather and disseminate learning from USAID’s RHITES project.** In less than 2 years of implementation, MCSP successfully gathered many lessons learned that informed MOH national guidelines, in addition to implementation of the World Bank’s Global Financing Facility for Every Woman Every Child. MCSP recommends that USAID’s RHITES partners continue to gather and disseminate their learning from implementing the work over the next several years and with a wider geographical scope.

Selected Performance Indicators for Life of Project	
Global or Country Performance Monitoring Plan Indicators	Achievement (Target)
Number of national-level guidelines, tools, manuals, reports, and briefs developed or revised for child health with MCSP support	9 (target: 8; target exceeded)
Percentage of health facilities with job aids for case management of childhood illnesses in MCSP demonstration districts	90% (target: 100%)
Percentage of cases of children under 5 with diarrhea seeking care at health facilities who received ORS and zinc in the last quarter	92% (target: 85%; target exceeded) ¹
Percentage of cases of children under 5 with pneumonia seeking care at health facilities who received appropriate treatment with antibiotics in the last quarter	88% (target: 85%; target exceeded) ¹
Percentage of children under 5 years of age diagnosed with malaria through routine diagnostic testing and/or microscopy testing who received artemisinin-based combination therapy treatment in the last quarter	96% (target: 85%; target exceeded) ¹

¹ Achievements per the program endline for the period of July–September 2018.

For a list of technical products developed by MCSP related to this country, please click [here](#).

Uganda Routine Immunization EOP Summary & Results



Geographic Implementation Areas

Regions

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

Districts

- 11/112 (10%)—Kanungu, Mitooma, Mbarara, Butebo, Pallisa, Bulambuli, Mayuge, Bushenyi, Ntungamo, Butaleja, and Kibuku

Facilities

- 403/403 (100%)

Population

Country

- 40.3 million

MCSP-supported areas

- 3.65 million

Technical Areas



Program Dates

July 1, 2014–March 31, 2019

Total Funding through Life of Project

\$4,600,000

Demographic and Health Indicators

Indicator	# or %
IMR (per 1,000 live births)	43
U5MR (per 1,000 live births)	64
Children (12–23 months) who received three doses of DPT-HepB-Hib	79%
Children (12–23 months) who received three doses of pneumococcal vaccine	64%
Children under 5 who had symptoms of acute respiratory infection in the 2 weeks preceding the survey	9%
Children under 5 who had diarrhea in the 2 weeks preceding the survey	20%

Source: Ugandan DHS 2016

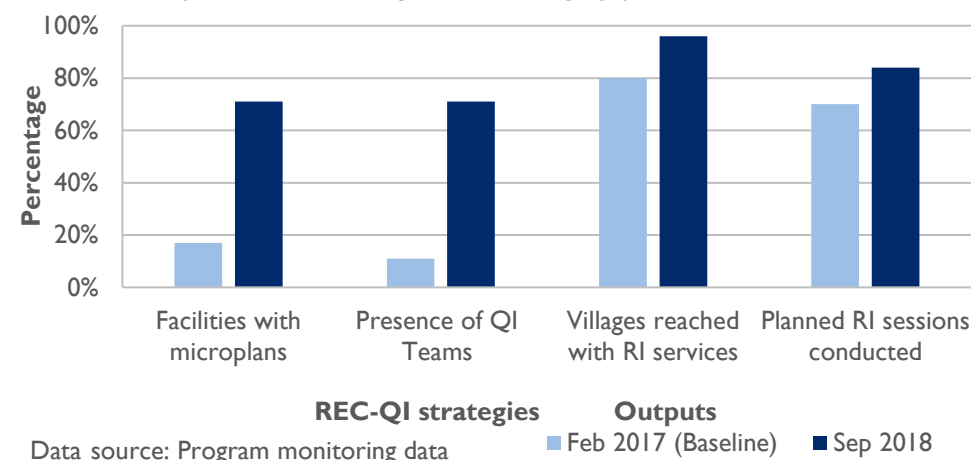
Strategic Objectives through the Life of Project

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

Highlights through the Life of Project

- Supported the MOH EPI to develop the first-ever national immunization policy in Uganda.
- Institutionalized key REC Using QI (REC-QI) approach concepts and lessons into eight national level guidelines, manuals, and/or tools.
- MCSP's participatory approach to mapping and facility-based microplanning was adopted by the national government for use countrywide by all EPI stakeholders.
- Engaged nonhealth stakeholders in all MCSP-supported districts to review RI performance, problem-solve around key bottlenecks, and commit local government resources while also promoting peer learning.
- Convened national meetings at which health officials and nonhealth stakeholders from 18 districts committed to specific actions to regularly support RI; these were captured and disseminated in an MOH-issued document.
- Strengthened the quality of RI data and promoted its use for decision-making.
- Collaborated with the MCSP Uganda Child Health team to adapt REC-QI tools for subnational planning of other RMNCAH interventions.

Figure 1: Improvement in MCSP-supported REC-QI strategies and outputs in four districts (Mbarara, Bushenyi, Pallisa, Mayuge)



Uganda—Routine Immunization

Background

MCSP partnered with the Mission in Uganda and the MOH's National EPI to strengthen RI. This support was a continuation of USAID's commitment to strengthen immunization services initiated in 2012 through technical assistance provided by MCHIP, which implemented the REC-QI approach in five districts of Uganda. In July 2014, this work was transitioned to MCSP to support the EPI to introduce REC-QI throughout 11 districts and at the national level. In late 2016, USAID requested that MCSP provide tailored child health technical assistance to the MOH at the national level and two of USAID's recently awarded RHITES projects to identify, demonstrate, cost, and document a package of "essential" low-cost, high-impact child health interventions in four prioritized districts (or demonstration districts), with the ultimate goal of contributing to a reduction in child mortality in South West and East Central regions. Since 2014, these MCSP RI activities have been supplemented with support from the Bill & Melinda Gates Foundation through Stronger Systems for RI, which enabled doubling of the number of districts in which the REC-QI approach was introduced.

Key Accomplishments

Supported Development of National Immunization Policy

In 2014, MCSP supported the MOH's EPI in collaboration with other partners to develop the first-ever Uganda immunization policy and printed over 600 copies to facilitate its official dissemination in 2015. Enacting a national immunization policy was instrumental in ensuring that immunization is streamlined in the national development agenda and provides the basis for sustainable financing of the MOH's EPI.

Institutionalized REC-QI Lessons Learned

MCSP supported incorporation of REC-QI [concepts](#) and [lessons learned](#) into the following six national guidelines, manuals, and/or tools, and their dissemination:

- **Immunization in Practice Manual:** MCSP supported the review, updating, printing, and countrywide dissemination of a more than 12-year-old version of the *Immunization in Practice Manual*, which is a reference manual for pre- and in-service EPI training. A total of 2,000 copies were printed and distributed to all health facilities in the country.
- **National EPI standards:** MCSP supported the review and updating of the national EPI standards, which provide benchmarks for uniformity of services countrywide and work as standard operating procedures for the national RI program. The updates supported by MCSP incorporated newly introduced vaccines, technologies, and approaches to align with international standards.
- **WHO EPI prototype curriculum for pre-service training:** MCSP played a leading role in the adaptation of the WHO EPI prototype curriculum for pre-service training to streamline and standardize EPI pre-service training and examinations, and minimize the skills gaps previously found with newly qualified health workers. The new curriculum was reviewed and approved by the MOH Senior Management Committee and the Ministry of Education and Sports. At the end of the project, it was awaiting MOH presentation to the interministerial committee to officially endorse its use in health worker training institutions countrywide.
- **Enhanced RED Categorization Tool:** Supported MOH's EPI and the MOH Department of Health Information to incorporate the Enhanced RED Categorization Tool into the MOH DHIS2, which is accessible online, to allow managers at all levels to instantly access information about their health facilities/districts for decision-making purposes.
- **National Guide on Using Catchment Area Mapping and Planning for Action:** MCSP supported the adaptation of REC into RMNCAH by developing a *National Guide on Using Catchment Area Mapping and Planning for Action* for other interventions that incorporates lessons from the use of REC for RI. The guide supports government-led planning and local resource mobilization for self-reliance.
- **Documentation of MCSP's experiences and lessons learned:** MCSP documented experiences and lessons learned from supporting districts with the REC-QI health facility microplanning process to create

user-friendly microplanning tools and a guide on how to prepare them. These were reviewed by staff from the MOH's EPI, national EPI partners, and selected districts, and adopted by the MOH's EPI for countrywide use.

Supported Adoption of Microplanning and Catchment Area Mapping

MCSP's innovative approach to [facility-based microplanning](#) that applied QI tools to systematically identify, analyze, and prioritize problems and test solutions was adopted by the MOH's EPI for use countrywide by all EPI stakeholders. MCSP's support to staff in over 400 health facilities in 11 districts built facility capacity to carry out detailed, facility-level microplanning to improve access and quality of RI services. This helped advance equity and increase the number of children vaccinated, with an additional 644 villages reached with RI services in four districts and approximately 323,000 children receiving a third dose of pentavalent vaccine 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 by the MOH, this document will serve to improve prioritization, planning, equitable access, and community participation for RMNCAH services, thereby facilitating implementation of the Uganda RMNCAH Sharpened Plan. The MOH plans to roll out the National Guide on Using Catchment Area Mapping and Planning for Action process in 75 out of 112 districts (67%), with support from the World Bank's Global Financing Facility for Every Woman Every Child.

Promoted Mobilization of Local Resources and Peer Learning

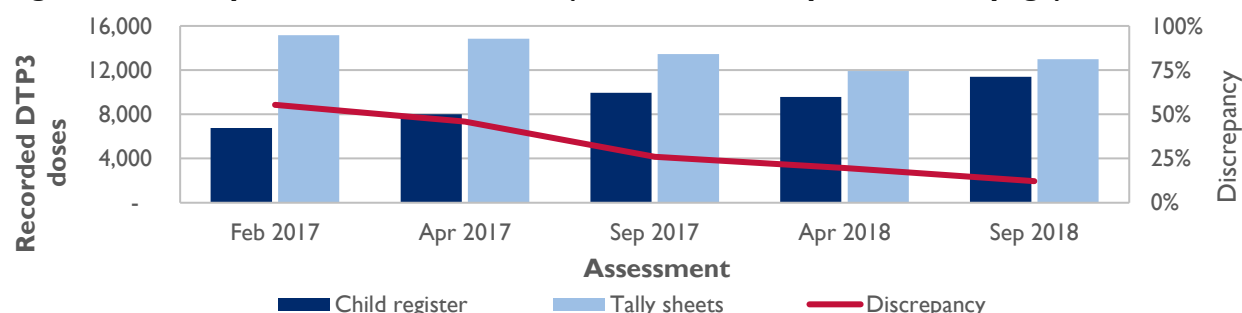
MCSP, together with Stronger Systems for RI, recognized a gap in involving district and sub-district non-health stakeholders, including civil authorities, political representatives, and community leaders, in immunization efforts and recognized their potential to greatly influence the allocation of local resources for RI. MCSP engaged such non-health stakeholders in all 11 MCSP-supported districts (and an additional 11 Stronger Systems for RI-supported districts) to review RI performance, problem-solve around key bottlenecks, and mobilize local government funds and resources to strengthen RI services. MCSP and Stronger Systems for RI's work with non-health stakeholders led to the gathering of key leaders from 18 districts to endorse a series of commitments regarding their role in supporting RI in their respective districts. These district leaders' commitments have been widely disseminated in all 22 districts supported by MCSP and Stronger Systems for RI, and draws attention to the important role of non-health stakeholders, stipulating specific actions for them to take to raise the priority of RI and mobilize local resources to address RI challenges in their districts.

Improved Quality of RI Data and Their Use for Decision-Making

MCSP supported the MOH's EPI to develop and print biannual newspaper pullout sections that shared district-specific immunization program performance data with districts, policymakers, other key MOH stakeholders, and the lay public. The newspaper pullouts included information about the new national immunization policy and guidance for districts on how to respond to measles outbreaks. These newspaper pullouts elicited swift and appropriate action from policymakers when poor performance was reported.

MCSP supported all 11 districts to introduce practices to improve data quality, including data quality self-assessments, reconciliation of data at the end of each RI session, and reorganizing name-based child registers by village and encouraging their use to track and follow up with children. MCSP built the capacity of health personnel in these districts to continuously analyze and use their data for action, including the utilization of facility-level monitoring charts on vaccine doses administered and the enhanced RED Categorization Tool to determine RI performance at all levels. Due to these efforts, discrepancies in the data reported in the different data collection tools at health facility level (e.g., the child register and tally sheets) declined across all 11 districts (see Figure 2 with data from four districts supported in PY3). The improvements in the quality and visualization of data enabled health workers and village health teams to better identify and locate children who require follow-up so that they can complete the vaccination schedule.

Figure 2. Reductions in the discrepancies between doses administered as reported in child registers and tally sheets in four districts (Mbarara, Bushenyi, Pallisa, Mayuge)



Recommendations for the Future

Based on its experience strengthening RI in Uganda, MCSP has developed the following recommendations for the MOH and future programs.

- Scale the RI intervention nationally.** MCSP recommends the scale up beyond the 11 intervention districts of key REC-QI innovations, including health facility catchment area mapping and microplanning; non-health stakeholder engagement; and data QI using data quality self-assessment and daily data harmonization. Each of these practices has been incorporated into Uganda’s national guidelines, manuals, and/or tools. Additionally, MCSP recommends broad sharing of MCSP’s REC-QI innovations through the RMNCAH platforms that already exist at the MOH, such as the MNCH Cluster, to promote their adaptation to RMNCAH services beyond RI.
- Utilize the REC-QI approach to continue to strengthen the RI system.** MCSP found that the REC-QI approach strengthened several key aspects of the RI system, including the reach and equity of RI services, the quality and use of immunization data, the capability of health personnel at multiple levels to plan and problem-solve, the building of partnerships with community members, and health workers’ ability to engage effectively with non-health stakeholders to increase support for RI. MCSP recommends the following actions for future work with REC-QI interventions, some of which have already been initiated by MCSP:
 - Simplify and streamline some REC-QI tools so that they are less complex and labor-intensive.
 - Invest in leadership, teamwork, and on-the-job mentorship at the facility level.
 - Reinforce new skills and practices introduced through REC-QI.
 - Institutionalize key aspects of REC-QI.
 - Strengthen the capacity of health personnel to interact with non-health stakeholders.
 - Nurture a culture of data quality and use that encourages decision-making based on local data.
- Advocate and act at higher levels to address the broad health systems problems such as human resource management, last-mile vaccine distribution, and financing of operational costs.** All of these issues affect RI performance but are beyond the direct control of districts and health facilities.

Selected Performance Indicators for Life of Project	
Global or Country Performance Monitoring Plan Indicators	Achievement (Target)
Number and percentage of children who at 12 months have received three doses of DTP3/Penta vaccination from a USG-supported immunization program	282,693 PY1: 81%; PY2: 72%; PY3: 73%; PY4: 65% (target: 90%; target not achieved) ¹
Percentage of planned RI sessions that were conducted in the year ²	84% (target: 91%; target 92% achieved) ³
Percentage of health facilities with complete REC microplans ²	71% (target: 44%; target exceeded)

¹ During the program implementation period, districts faced challenges with the cold chain and vaccine stock-outs, delayed release of primary health care funds, and improvements in data quality that may have impacted immunization coverage.

² Includes Mbarara, Bushenyi, Pallisa, and Mayuge districts.

³ Delays in receiving primary health care funds on time affected implementation of outreach sessions.

For a list of technical products developed by MCSP related to this country, please click [here](#).