

MINISTRY OF HEALTH GOVERNMENT OF UGANDA

REVIEW OF THE CHILD DAYS PLUS STRATEGY

SUBMITTED BY

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EXECUTIVE SUMMARY

Introduction and Rationale

This report is based on a study conducted to review a Child Days Plus Strategy (CDPS), as a means of reaching out to more children with basic services. The review was conducted in October, 2006.

The health status of children and women in Uganda remains poor, as indicated by stagnated health indicators, making it difficult to attain the set Millennium Development Goals (MDGs). Three quarters of life years are lost due to pre-mature deaths caused by preventable diseases. Malaria, respiratory infections and diarrhea are responsible in over a half of all infant deaths. 60% of childhood deaths are associated with malnutrition where 2 out of every 5 under-five children suffer from severe chronic protein energy malnutrition and 28% of all under-five children suffer from Vitamin A deficiency. 50% of under-fives have anemia, a third of which is due to iron deficiency anemia (IDA) from multiple chronic infections of soil-transmitted helminthes.

Recognizing that child mortality in Uganda is still unacceptably high, Government with its development partners has since 2004 been implementing a Child Days Plus Strategy (CDPS), as a means of accelerated delivery of an integrated package of key interventions to reduce child mortality and morbidity. CDP targets increasing coverage of, a) Vitamin A supplementation to 100% among 6-59 months and among postpartum mothers, b) de-worming 1-14 years against soil transmitted helminthes to 100%, c) full immunization of infants to 95%, d) TT immunization in pregnant women to 95% and non-pregnant adolescent girls to 75%, and e) mass drug administration coverage of neglected endemic diseases to 95% in eligible population.

After three years of implementation, the MOH contracted Child Health and Development Centre to review the processes of CDP to inform strategic direction by documenting the strategic approaches used, identifying the critical success factors and lessons learned as well as reviewing progress made in terms of coverage.

Methodology

Employing mainly a qualitative methodology, the review collected data from almost all districts in the four regions, to get a deeper understanding of how different stakeholders, perceive CDPS so as to inform policy and program for improving process and results of the Strategy. The review process included review of existing documents to obtain a national profile on nutrition and epidemiological context and four regional-based district workshops were organized to gain understanding of CDPS implementation at the district level. In-depth interviews were carried out in ten purposely-selected districts based well performing and not performing districts from each region, to explore what works well and what does not so work well. In addition, key informant interviews were conducted with community leaders and focus group discussion with community level male and female adults, to get an understanding of the service recipients' perspectives of CDPS implementation.

Perceptions and Understanding

Understanding of the strategy

Different stakeholders understand CDPS depending on their roles and the way they benefit from the strategy. Both district managers and health service providers in all districts had apparently a good understanding of CDPS, although from different perspectives. District managers' definition mainly focused on the overall goal and purpose of CDPS, similar to what is stated in the strategy document, - "a biannual exercise adopted by government to improve the health of the children in the country".

Health providers defined the strategy in terms of its service package, where they explained the whole range of the package of services, as described in the strategy document. Nevertheless, despite the generally good understanding of what CDPS, many district managers and health workers preferred to consider CDPS as a special program or campaign, that should come with special funding and logistics support outside than that of the routine health services. On the other hand, most communities understood CDP from service utilization perspective, articulating mainly as mass immunization days.

Institutional Arrangements

Institutional arrangement and roles, responsibilities and linkage of different actors are well understood and appreciated by district managers, health providers and community resource persons. The multi-sectoral nature of the institutions involved in CDPS implementation was appreciated. For example collaboration with the education sectors, where teachers were respected in society, was acknowledged as very important for mobilizing pupils and their parents on the value of the strategy. However, while district managers appreciated the Ministry's coordination and resource mobilization roles, managers were dissatisfied with the idea of waiting for the Ministry officials before the micro planning, and they interpreted it as denied planning autonomy. They also expressed a gap in utilization of the private health providers, some political and community leaders in service provision, mobilization and advocacy for the strategy.

Integration

Integration was appreciated as a critical strategic approach for successful implementation of CDPS. Success factors for integration were mostly in the strategy delivery approach, multi-sectoral collaboration, and implementing through existing health infrastructure.

Integration of personnel from different sectors, departments and communities, as well putting together different child survival interventions that are provided as a package during the conducting of CDPS, was valued for maximizing outputs from resources. However, integration was said to be challenged by sometimes inadequate technical competences, time constraints, delay of distribution of supplies/logistics, and problems of integrating human resources.

Implementation Process

Implementation of CDPS is a multi-sectoral activity involving several stakeholders at national, district and community level, therefore it requires proper coordination, planning and logistical support.

Coordination

District health managers had a good understanding of the coordination process and aware that coordination of CDPS took place at several levels. The arrangement of the Ministry of Health to lead the coordination was considered appropriate by health managers, because improving the health of the population is its mandate. While the strategy document is silent on the district level coordination, the CAO's office was acknowledged as appropriate for coordination as head of civil service activities at that level. A good inter-sectoral collaboration both at the center and within the district, and the presence of the National Coordination Teams backup from the Ministry of Health was reported to enhance coordination process in districts. However, district managers were concerned that the coordination process is greatly hampered by financial resources and recommended additional funding to districts so as to apply special strategies for effective coordination in hard to reach areas.

Planning

Prior actual implementation of CDPS, a planning process is vital, and it takes place at various levels, but always starts at the National level. The overall strategies to improve implementation are designed at national level, guided by the HSSP II, by the Ministry of in association with relevant line ministries and development partners. The multi-sectoral planning process was appreciated for easing implementation, but there was a general concern that at district level some people are left out, which affects the implementation process, particularly mobilization. The main planning challenges that were mentioned were, delay in release of PHC funds for planning, failure to mobilize for all relevant partners' participation, changes in activity implementation dates, inappropriate approach in planning and lack of updated demographic data in primary service areas. Respondents recommended a change of approach in planning, to a bottom-up so as to cater for the specific differences within districts and involve stakeholders at lower levels.

Resources, Funding and Logistics

Adequate funding was a prerequisite for successful implementation of CDP. The strategy document points out sharing and or pooling of resources as crucial for the successful implementation of CDPS, that are supposed to ride on routine activities, and districts are expected to incorporate this activity in their annual budgets. Districts acknowledged using PHC funds allocation from the centre and credit line facilities, to procure drugs such as Albendazole. However, the PHC grant was reported to be usually inadequate and in some places released late. Many districts reported obtaining funds for additional support from development partners, and NGOs support for CDPS was acknowledged in some districts, such as World Vision and Minesota in Rakai, and Masaka and Sembabule districts. However, many districts without such support, for example Kapchorwa, Manafa and Mbale, have to entirely depend on PHC. Only few districts like Wakiso used district-generated funds for the CDPS activities.

As a challenge, most districts reported insufficient funds to cater for allowances for the health providers, and other stakeholders implementers particularly during mobilization. In some cases development partners who had withdrawn from districts created funding gap in meeting these allowances. Transport difficulties were also reported in districts

were due to lack or presence of old vehicles that were expensive to maintain and needed to be boded off. District managers recommended that essential supplies should also be provided and distribution system should be improved, particularly transport at all levels.

Social Mobilization

Social mobilization a core activity, which influences participation and uptake of the services provided under the CDPS. Mobilization by the MOH through the mass media strategy was highly appreciated by district respondents. In addition, printed IEC materials supplied by the Ministry and distributed by districts was also accepted as an important mobilization tool. Use of innovative community mobilization methods were applied in some district to reach out to more people. For example, in Pader drama was used, while in some districts of central and eastern regions parish mobilizers used door to door for social mobilisation and sensitisation. However, under funding of the health sector, late commencement of mobilization activities and poor transport facilities to reach villages limit effective mobilization.

Community Participation

CDPS is supposed to be a participatory exercise and social mobilization is in part intended to enhance community participation. There was a general feeling of collective responsibilities by communities in the implementation of CDPS. Health managers and providers appreciated caretakers' bringing of children to receive services provided, as key for the success of the CDPS activities. Conversely, communities were acknowledged for their mobilization role, particularly through their leadership, which is significant for encouraging uptake of services. However, there was a concern that communities do not participate in the planning process, and some community resource person persons such as traditional healers and private clinic operators are often left out, yet they are influential in the community. Similarly, low male participation was reported, perhaps a result of the cultural gender division of roles, where the care for children is traditionally female responsibility.

Monitoring

The CDP Strategy recommends monitoring and reporting to be done at all levels of implementation, focusing both on the process as well as the outcome. As means of providing technical support and standardizing routinely collected data for monitoring, the MoH developed supervision guidelines and data collection tools, and data collection was reviewed in 2005 to enable integration with the HMIS to gather both Vitamin A supplementation (VAS) and de-worming. The actual monitoring process is predominantly a district-based and led activity. However, managers were concerned that HIMS has not been fully harmonized with CDPS collected data. Reported on monitoring and supervision, were the challenges related to delayed micro planning in districts, inadequate level of funding for this activity and inadequate technical support from the center to districts.

Achievements

In general, all the stakeholders appreciated and ranked the strategy highly both in terms of quality and quantity, and found as valid and important for service provision in the

districts. The strategy was acknowledged to have improved coverage by giving opportunity most children who had missed immunization during routine services in addition to providing treatment for neglected diseases. Health managers and providers confirmed that in many areas they had been able to meet their targets for all antigens and service provision.

Coverage and Trends

In terms of coverage, there have been positive trends in many service coverage areas since implementation of CDP. There were regional variations in coverage and trends of Vitamin A supplementation, but national coverage increased from 51% in May 2003 to 78% in November 2005, with 61% of the districts meeting the national targets. There was no mass de-worming national program before the CDP, but de-worming against soil-transmitted worms nationally has increased from 30% (May 2004) to 83% (November 2005), with two thirds of the districts meeting national targets for albendazole.

On the other hand, immunization coverage trends have been positive for antigen covered since 2001. National DPT 3 (Pentavalent) coverage proxy for overall immunization performance, doubled from 41% in FY 1999/00 to 83% in FY 2003/04. The introduction of CDP further raised DPT3 to 89% in FY 2004/2005, above target for the HSSP1 period (85%), though there is wide variations district coverage.

Ownership and Sustainability

There was a general feeling that ownership of CDPS was good and acceptable. District managers felt that implementing the strategy through the existing routine service infrastructure and the strategy incorporation in district and HSD work-plans as well as political will to implement are key indicators of ownership. However, for financial sustainability, it was universally felt that without facilitation from the Centre, districts cannot sustain activities of CDPS because of the poor revenue base especially after the scrapping of graduated tax.

Good practices and Lessons Learnt

Good practices were evident in three major strategic areas, those related to a) multi-sectoral collaboration, b) integration of services delivery and c) active involvement and participation of beneficiary communities.

The multi-sectoral collaboration between government, development partners and private sector has allowed pooling resources, maximizing use and minimizing duplication of effort, thus enhancing national capacity to meet logistics for intensified activities. Conversely, advocacy for political commitment and district ownership for CDPS and integration of the package and human resources is strategic and cost effective in delivering basic health services. The use of the existing infrastructure (District, HSD, health facilities, schools) maximizes resources use and enhances capacities for implementation, sustainability and subsequently district ownership of CDPS. On the other hand, intensified community mobilization, effectively conveys messages for community participation and utilization of service. However, social mobilization was

constrained where infrastructure was poor especially in difficult terrain during the rainy season and inadequate facilitation (allowances).

RECOMMENDATIONS

Recommendations were made for the center were on advocacy and conducting a more aggressive promotion of the strategy from national to community level, integration of services, funding levels for CDPS, planning, communication modalities and harmonization of CDP reporting into HMIS.

Coordination

- A Child Days Plus strategy conference should be convened to build consensus and develop an advocacy policy for the Strategy. The same forum should clarify roles more clearly for different stakeholders to facilitate building of stronger partnership required for up scaling of CDPS.
- MoH should strengthen its coordination role, clarify roles of coordination from center to district and develop policy guidelines for integration of CDP in district and HSD annual plans.
- The MoH and MoEdS should jointly fix CDP activity implementation months; adhere to these dates to facilitate smooth implementation in districts.

Integration

- Implementation should be as an integrated service and not a parallel programme and that all staff at all levels should be trained on skills and value of integration.
- To strengthen integration of services there is a need for the Ministry of Health to ensure timely and adequate availability of core supplies and logistics.
- There is need for the center to facilitate the shift in thinking from campaign-approach to more sustainable routine approach for districts, by engaging districts in further district dialogue to explain that the strategy is built on routine service delivery to accelerate maternal and child survival interventions.
- Integrating campaign approaches such as measles mass campaign with routine CDP activities creates confusion in district understanding of CDP and should be avoided.

Planning

- Early and timely planning, mobilization and release of adequate resources and logistics are required for successful mobilization of communities.
- National Medical Stores and Joint Medical Stores should stock sufficient quantities of single dose Albendazole/mebendazole tablets for CDP

Funding

- Efforts should be taken to increase funding for CDP by the MoH harmonizing partner support, MoFEDP increasing PHC funding and districts mobilizing resources at their own level. PHC funds should be released in time at all levels and efforts should focus on strategies that sustain adequate government funding.
- Center should increase funding for CDP to districts so that they can procure Albendazole as a pull (demand-driven) process and special strategy should be

adopted to offer additional resources for hard to reach and high-risk populations, e.g. conflict affected districts.

Package of CDP

- Packaging of Vitamin A capsules should be in smaller quantities to avoid overstocking or shortages in other places.
- Distribution of subsidized ITNs should be included in CDP service package.

Social Mobilization

- To make social mobilization more effective, MoH should develop a communication strategy with targeted simple messages to meet the different needs of beneficiaries, taking into account the existing capabilities to deliver the message.
- Development of IEC materials in more local languages that are timely delivery is strongly recommended to improve social mobilization process and results.

Monitoring and reporting

- The process of harmonizing CDPS data with HMIS should be finalized, and the various levels should submit reports with feedback. Trends of coverage for the neglected tropical diseases should be documented to integrate as part of CDP.

District level

Recommendations were made for the district levels were on ensuring more effective implementation of CDPS and offering support to communities to sustain care practices adopted.

CDP Ownership and Implementation of CDP

- District should take full responsibility to implement CDP, with DDHS being the focal person to coordinate CDP activities, involve other relevant partners and clarify coordination roles of different key actors within the district.
- District should work hard on ownership of the CDPS by causing an effective demand service approach for CDP implementation, demanding resources required and enforcing more effective implementation including monitoring of the process.

Planning

- Districts and HSDs should follow planning guidelines provided by center to ensure Child Days Plus issues are well addressed and included in their annual plans.
- District micro planning should be timely (2 months before); approach should be changed to bottom-up to ensure more effective participation of beneficiaries. An effective mechanism of involving CDP service beneficiaries and lower structures in planning should be developed by ensuring that planning guidelines are clear on the bottom-up approach.
- Districts should use correctly projected population data from Uganda Bureau of Statistics as a basis for planning for CDP activities.

- Districts should work in partnership and fully involve the education system/schools in CDP planning and implementation.
- Community level registers for children and women, and school children should be enforced to provide data for planning and monitoring.

Funding

- Adequate funds, supplies and logistics should be released on time. Districts should allocate some district-generated revenues for CDP activities as away of increase funding but also in taking on ownership for strategy.

Capacity for CDP Service Provision

- Districts supported by center should strengthen service provision at HC II to build necessary capacities for service delivery at primary CDP posts.
- Districts need to enhance capacity for required skills at the primary site through recruitment at health facilities, CDP training of new staff and organizing refresher courses.

Social Mobilization

- Districts should develop framework to unify and streamline support to volunteers (allowances). Districts should mobilize more resources from district sources to support CDPS implementation.
- Community mobilization, sensitization and education should be done well and early enough and should be continuous especially at grass root levels. Activation and formation of Village Health Teams should expedited to help with grass root social mobilization.
- IEC should be strengthened to support community mobilization and sensitization using a language understood by the beneficiaries.
- To improve support to communities for sustaining health practices adopted, it is recommended that districts need to develop some mechanism (guidelines) for community resource persons and structures like VHT to provide continuous support in between CDP months.

Monitoring, Supervision and Reporting

- Districts should give more support for supervision at the HSD to improve the quality of data and enable timelier reporting and build capabilities for management and utilization of data to improves implementation process and results.

Community

- Community structures such as VHT and resource persons should be mobilized for a more active role in planning, implementation and reporting on CDP activities.
- Community registers should be compiled for use and a proactive feedback mechanism should be established for communities to improve their participation in CDPS.

- Communities should intensify environmental sanitation efforts within CDPS to reduce worms reservoir within communities.
- Community innovative methods should be developed for more effective CDP coverage for out-of- school children.
- Innovative methods should be adopted in communities for utilization of CDP data improves implementation process and results.