**BULAMBULI MEASLES RUBELLA bOPV SUPPLEMENTATION IMMUNIZATION ACTIVITIES; TRAINING, COORDINATION AND THE IMPLEMETATION REPORT OCTOBER 2019**

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| Region: Eastern District: BulambuliName of District Supervisor: Dr Gidale Muiri MupalyaDates in the district:  |

**A: MEASLES-RUBELLA-bOPV IMMUNIZATION CAMPAIGN**

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| **Training:**Bulambuli district joined the rest of the districts to implementation of the Measles rubella and Polio national Immunization Days (NIDS) campaign from 16th to 20th 2019.In a bid to make the program a success, very many activities took place to prepare for the activity prior to the implementation processThe district training took place at chief administrative officer`s boardroom from 8th to 9th of October 2019 that attracted 36 participants who included one representative of the sub-county as a district supervisor for that sub-county and ten 7DHT and 3DET members.The Sensitization of district leaders, sub-county leaders, teachers, mobilizers, health workers and LC1s were conducted from the district up to all sub-counties. The process started with stakeholders coordination meeting on 29th of September followed by second coordination meeting on 14th October 2019 and third coordination meeting on 21st October 2019 to review the achievements. Trainings started with teachers from 1st to 5th October followed by district trainings from 8th to 9th October which proceeded with the sub-county trainings from 11th to 13th October 2019 |
| **Objectives:*** Prepare a pool of supervisors to support implementation of the district level measles/Rubella and Polio vaccination campaign
* Equip supervisors with knowledge and skills to ensure quality implementation of the campaign
* Provide technical support and coordination in the respective districts

Expected outputs:* Management capacity established for supervisors to support districts to work within the allocated budgets and mobilize local resources to fill any existing gap
* Set up a command centre for the district
* Capacity built for supervisors to support sub-counties to;
	+ Mobilize and sensitize communities about MR campaign
	+ Develop and implement team allocation plans per school and posts
	+ Register and report all children under 15 years through ODK
	+ Submit to National command centre the lists of all posts through ODK
	+ Supervise the training at sub-counties and submit daily performance data through ODK
	+ Quantify and distribute vaccines and related supplies at sub-county, designated storage points and at the posts
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| **Training proceedings****A: at district level:**The district trainers were trained by the central supervisor together with the team of DHT that had been trained at regional level who included the DHO, ADHOMCH, Biostatician, DHE and DCCA. A total of 36 participants were trained as indicated by cadre

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|  | **Cadre of participants** | **Total number-day 1** | **Total number-day 2**  |
|  | Clinical Officers | 9 | 9 |
|  | Nurses | 11 | 11 |
|  | Midwives | 1 | 1 |
|  | Medical officers | 3 | 3 |
|  | Education officer | 3 | 3 |
|  | Cold chain technician | 1 | 1 |
|  | Environmental staffs | 6 | 6 |
|  | biostatician | 1 | 1 |
|  | Health Educator | 1 | 1 |
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|  | Total | 36 | 36 |

**Training proceedings at sub-county level:**The sub-county workshops took place from 11th to 13th in 16 training sites that included Buluganya SC which handled two subcounties with Sotti, Bulago had Nabiwutulu SCs, Lusha alone, Buginyanya and Bumugibole at Buginyanya SC Masira and Bufumbo at Masira Sc, Kamu and Bulegeni TC at Bulegeni HC, Simu and Bulegeni SC at Bulegeni SC HQRs, Buyaga and Buwanyanga at Buyaga Town council HQRs, Bunalwere and Bukhalu at Bunalwere SC HQRs, Bulambuli TC and Muyembe SC at Muyembe HC, Bwikhonge and Nabbongo SCs at Bunanghaka HC and finally Bumufuni and Bunambutye at Bunambutye SC HQRs. This was done because the district trainers were not enough to be distributed to all the sub-counties. Summary of participants at the district level training

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| **Sub-County** | **Cadre of participants** | **Total no-day 1** | **Total no-day 2**  | **Total no****Day 3** |
| **26**  | **Nurses** | **86** | **86** | **86** |
|  | Midwives | 54 | 54 | 54 |
|  | Clinical Officers | 6 | 6 | 6 |
|  | Nursing Assistants | 34 | 34 | 34 |
|  | Total | 186 | 186 | 186 |

The first day had the VHTs one from every village in all the sub-counties giving a total of 1299 VHTs having a sensitization at the respective venues |

**B: Status of District preparation for the campaign (Pre campaign)**

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| * 1. Coordination:
* There were three coordination meetings that were chaired by the RDC and attended by the DISO, DHT, DET, Sub-county chiefs for all sub-counties in the district, District Chairperson, Secretary Health, DPC, Planner and DCDO.
* The first meeting was to orient the stakeholders and seek for political will and involvement of stakeholders so that they can in the end continue coordinating the activities at their respective areas of jurisdictions. It also discussed the budget and identified the loop holes and discussed the sources of alternative funding.
* The second meeting established and discussed the preparedness of the campaign. The issues identified included the cults that had been talked to and had assured the RDC that they were not going immunize their children and the soliciting of extra transport from the partners and other sources outside government vehicles
* The third meeting discussed the performance of the activity and what challenges were faced and how best they would handle it in the coming campaigns
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| * 1. Personnel and training:

Given that the district had been allocated 93 posts, 186 health workers were identified and trained for three days in management of both MR and polio vaccines. On top of that there were 186 post mobilizers two per post. During school immunization, two teachers were identified to help in the school arrangements and updating of school registers to ensure that all pupils had been vaccinated. All these staffs were adequately imparted with knowledge and the demonstrations at their practical times indicated readiness to do the work. The two days training at district level were not adequate given the fact that there was an element of the new garget the Open Data Kit (ODK). This was also continued by DHT throughout the sub-county training that ensured the grasping of the concept on consecutive use of it. The district did not have enough employed qualified staffs so they did open sourcing from the communities of the already qualified but unemployed health workers which attracted many staffs from the community who were screened using their papers and the right numbers were picked from the many that had submitted in their applications. During implementation there were some failures in many areas in that most reports were not successfully sent coupled with weak network strength and lack of network in other places therefore it was not effectively used throughout the program. Charging of phone was also another big issue. There is need to have backup power and setting the system so that the DHT are able to view the reports as they are sent to the serverThe program was as laid; |
| * 1. Planning:

The district participated in the macro mapping using the population figures from UBO up to parish levels and the sub-counties worked together with the VHTs and generated the village lists. During the planning the hard to reach and hard to convince populations were catered for but there was no budget set aside from the releases hence the district tasked DHO to set aside some funds from other sources so that the security organs can be catered for. All schools were mapped out and the populations identified and adequately planned for. Challenges encountered was that there were 19 parishes that were left out hence we had to ensure that there was a combination of some parishes for some teams. During microplanning it was also identified that some communities were not adequately accessed by routine immunization services |
| * 1. partner/inter-sectoral collaboration:

there was a cordial collaborative relationship with the RHITE-E partner in that they supported the district with one vehicle to assist in district coordination and command centre. Education played a key role of supporting and monitoring the schools, the politicians, police and internal security played different roles during the implementation like district social mobilization teams moved in all public areas to broadcast the information outside. Parish chiefs were used as mobilizers.  |
| * 1. Availability of funds:

Funds were received from the centre timely but were not adequate to cater for all activities for example there was no budget set aside for security during the implementation. The social mobilization teams were provide with SDA for many days but the teams were not facilitated with fuel and facilitation for the drivers hence making life difficult for implementation of the activity by the teams however it was offset in the planning by DHO setting some facilitation for the pending budgetsApart from funds sent from MOH and the locally solicited funding, there was no any other source of funding |
| * 1. Social Mobilization:

A social mobilization plan was developed by the district stakeholders to avoid duplication of information and colliding in the same villages. Key messages were developed and presented to the teams that were used throughout the campaign. IEC materials were brought in time and distributed to communities, schools and other public places such as churches, mosques and burial places. All this was effectively handled by the District Health Educator together with the District Inspector of Schools. The RDC, District chairperson and DPC organized meetings with resistant communities where they assured them that they were not ready to take children for immunization come what may. |
| * 1. Logistics including transport:

Logistics and vaccines were delivered timely and distributed to the sub-county centres prior to implementation day and were adequate in most posts throughout the five days apart from Bunambutye SC that suffered a stock out during the fourth day because there was a newly created refugee camp that had not been budgeted for however it was catered for using the buffer stock that was included in the planning. The district stakeholders collectively assisted in arranging for transport means especially the Chief administrative Officer ordered the release of all the vehicles to ensure that they perform the activity.There was no stock out of vaccines in the district throughout the exercise indicating good planning1. Bundling is a very good principle in that it effectively clears doubts of the package for the items needed and avoids wastage and misuse of the supplies
2. Proper planning especially at micro level is very good in that it considers the actual populations not estimates that usually ends up in either being high or low
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| * 1. Injection safety:

Facilities had disposal pits that had been constructed in preparation for the campaign and the district had an incinerator however there was the element of the heavy rains during transporting of the safety boxes for incineration |
| * 1. Storage/cold chain facilities:

The district was supplied with enough cold boxes that worked as reservoirs in all sub-counties throughout the district. Refilling with icepacks was done on the third day and it was based on demand during the exercise |

2. intra campaign implementation

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| 2.1 were te human resources for schools adequate | No. only two teachers were not enough to handle all the pupil and besides that there seven classes in primary schools |
| 2.2 Did you have enough supplies | yes |
| 2.3 was the cold chain temperature monitored and maintained | Partially because at the DVS and facilities were there were refrigerators, the thermometers and fridge tags were doing the service however at sub-counties with no facilities and during implementation at posts, there was no monitoring of temperature though other precautions were being taken of discarding a vial after six hours for MR and the sponge method |
| 2.4 Health workers skills | Given the fact that we used qualified health workers coupled with strict monitoring the skills were ensured to maximum safety precautions were taken during practical so that the proper route of administration and site were put in consideration. |
| 2.5 Data management | The staffs really knew and taken the training standards of tallying after immunization to avoid the errors so there were few anomalies |
| 2.6 injection safety and waste management | Safety boxes were enough. Filled boxes were being collected and disposed of at the district incinerator in Muyembe HCIV. On top of that the facilities had dug standard pits for disposing off the wastes. Hygiene had been ensure and all the surroundings of the rubbish pits had been made tidy |
| 2.7 AEFI surveillance | There were no AEFI cases detected in the area throughout the program |
| 2.8 Social mobilization | Communities used so many channels for getting information about MR; radios, TV telecasts, church sensitizations, at burial places |
| 2.9 Surveillance  | There were no reported cases for measles and AFP cases for investigation |
| Mentorship follow up for routine MR introduction | Since the MR is replacing the measles that has been available hence there is no much to be put in as knew ideas hence it will be incorporated into the system  |

Summary of Key challenges

The budget had a lot of loopholes in the following areas

1. No budget allocation for the drivers and fuel for the district stakeholders social mobilization to communities
2. Number of parishes budgeted for were 93 compared to existing 112 in the district
3. District training only catered for one trainer per sub-county yet training at each sub-county was conducted by two trainers
4. No budget for the security for the resistant communities and hard to reach communities yet the distict had many of such
5. Only one VHT had been budgeted for and yet every village had two VHTs
6. Parish chiefs who are the chief mobilizers had not been budgeted for
7. Poor road network coupled with heavy rains that made movement and frequent breakdown of vehicles
8. Big stone that fell off from the hills and blocked birtanyi road to Buginyanya making moving to Buginyanya, Bulago, Lusha, Bumugibole, Masira and Bufumbo Difficult

COVERAGE



