



**Republic of Uganda**

**Ministry of Health**

# **INTEGRATED CHILD HEALTH DAYS IMPLEMENTATION GUIDE**

**June 2015**

## Table of contents

Foreword .....	2
<i>Vitamin A Administration</i> .....	13
<i>Administration of de-worming medications</i> .....	15
<b>Reminder on Use of Insecticide-Treated Bed Nets (ITNs)</b> .....	22
<b>Reminder on Hygiene Practices</b> .....	23

## **List of Acronyms**

<b>AEFI</b>	<b>Adverse Events Following Immunization</b>
<b>BP</b>	<b>Blood Pressure</b>
<b>DEO</b>	<b>District Education Officer</b>
<b>DHIS</b>	<b>District Health Information System</b>
<b>DHO</b>	<b>District Health Officer</b>
<b>DPU</b>	<b>District Planning Unit</b>
<b>EID</b>	<b>Early Infant Diagnosis</b>
<b>EPI</b>	<b>Expanded Program on Immunisation</b>
<b>FBOs</b>	<b>Faith Based Organisations</b>
<b>GAVI</b>	<b>Global Alliance Vaccine for Immunisation</b>
<b>HMIS</b>	<b>Health Management Information System</b>
<b>ICHDs</b>	<b>Integrated Child Health Days</b>
<b>ITNs</b>	<b>Insecticide Treated Mosquito Nets</b>
<b>IYCF</b>	<b>Infant and Young Child Feeding</b>
<b>MoH</b>	<b>Ministry of Health</b>
<b>MUAC</b>	<b>Mid-Upper Arm Circumference</b>
<b>NGOs</b>	<b>Non-Government Organisations</b>
<b>NMS</b>	<b>National Medical Stores</b>
<b>OPD</b>	<b>Out Patient Department</b>
<b>PHC</b>	<b>Primary Health Care</b>
<b>RED</b>	<b>Reach Every District</b>
<b>SAM</b>	<b>Severe Acute Malnutrition</b>
<b>UNEPI</b>	<b>Uganda National Expanded Program on Immunisation.</b>
<b>VHT</b>	<b>Village Health Team</b>

## Foreword

Child Days Plus (CDPs) was initiated by the Ministry of Health (MoH) in 2003 with support from partners to promote child survival and improve key health care practices at house hold level. This intervention was initially piloted in twelve districts on a bi-annual basis. Focus was on districts that had suboptimal immunization coverage. Subsequently, the Child Days Plus was scaled up to cover all the districts in Uganda with an ambitious package of services.

Compelled by the slow progress in attainment of the Millennium Development Goals 4 and 5 (reduction of child and maternal mortality), in July 2012, the Ministry of Health (MoH) Uganda in collaboration with UNICEF started implementing an innovative program known as Family Heath Days (FHDs) in order to accelerate progress towards the attainment of the development goals. The primary objective of FHDs was to reach those mothers and children who were not being reached through health facilities, routine and other outreaches.

Family Heath Days were implemented with the help of churches and mosques for community mobilisation and provision of operational sites. This approach was found useful to reach the unreached children because 1) there are almost three times as many churches and mosques as compared to health centres therefore communities could easily access these places of worship 2) religious organisations have longstanding relationships with communities and are able to effectively mobilize their congregations and sanctioning of the health services by religious leaders encourages uptake. Further, the places of worship and Faith Based Organisations (FBOs) provide known and permanent sites which can easily be accessible to the communities. This enabled health workers to provide an integrated package of health services to families during the days of worship.

The Ministry later reviewed the two initiatives; CDPs and FHDs and found that the two approaches had a common focus to a greater extent.

The Ministry recommended harmonisation of the two initiatives, which was then renamed Integrated Child Health Days (ICHDs) to have a package of services from both initiatives .

This guide has therefore been developed in order to harmonise the two initiatives to respond to the requirements of the Sustainable Development Goals focusing on maternal and child health.



Dr Jane Ruth Aceng  
Director General Health Services

## **1.0: Background**

The importance of maternal and child health in the well-being and development of any society cannot be underscored. In Uganda, interventions to promote health and nutrition of mothers and children have played a critical role in improving the health of mothers and children. Whereas the country made tremendous progress towards the realisation of Millennium Development Goals (MDGs) 4 and 5 which directly impact on child and maternal health, targets were not met. Infant mortality is estimated at 57/1000 live births while maternal mortality is 310/100,000 live births. The country is still ranked among the 24 countries which contribute to more than 80% of global deaths of children less than five years.

According to the Uganda Demographic Health Survey 2011, Vitamin A deficiency has doubled from 19% in 2006 to 38% in 2011, the prevalence of anemia among children is 49%, while in pregnant and lactating mothers has stagnated at 63%. The coverage for vitamin A (57%) have remained below and the recommended national target of 80%. These and more statistics show that there is still a lot to be done to improve maternal and child.

It is with the view of this background that the government of Uganda through the Ministry of Health (MoH) together with development partners has developed these guidelines for Integrated Child Health Days (ICHDs). The guidelines are to aid and strengthen the implementation of ICHDS interventions to achieve improved health outcomes with particular focus on child and maternal health.

### **1.1: General Objective of the ICHDs**

- ❖ To reach every community and provide low cost life-saving interventions.

#### **Specific objectives of the ICHDs**

- ❖ To provide immunisation and other health services at community level
- ❖ To mobilise and create awareness in communities on importance of maternal and child health.
- ❖ To provide reproductive health services to adolescents and women of child bearing age.
- ❖ To conduct health checks and referrals for Non Communicable Diseases (NCDs)

### **1.2: Interventions for ICHDs**

The ICHDs will mainly focus but not limited to the following interventions;

1. Immunisation
2. Deworming
3. Growth Monitoring and Promotion

4. Reproductive health
5. Vitamin A Supplementation
6. Health checks such as Blood pressure, blood sugar and others
7. HIV/AIDS Counselling and Testing (HCT) and Early Infant Diagnosis (EID) services
8. Birth Registration

### 1.3: Target Groups and Interventions for ICHDs

The activities for ICHDs will target missed opportunities and the due doses for the stated interventions. The table shows the target group with the corresponding intervention.

**Table 1: Target Groups and Interventions for ICHDs**

<b>Target group</b>	<b>Intervention</b>
Children under five (0-59 months)	<i>Birth registration</i>
<b>Immunisation for due doses and missed opportunities</b>	
At birth and missed	BCG and OPV (oral polio vaccine)
At 6 weeks/missed	DPT-HepB-Hib (a pentavalent vaccine against haemophilus influenza type-B, diphtheria, pertussis, tetanus, hepatitis-B), Rota Virus, PCV
At 10 weeks/missed	
At 14 weeks	DPT-HepB-Hib, Rota Virus, PCV, IPV
9 months	Measles
10-year old girls in the community and schools	HPV
Women of reproductive age 15-49 years	TT immunization
<b>De-worming and Vitamin A supplementation for due doses and missed opportunities</b>	
6 - 59 months	Vitamin A supplementation
1-14 years	De-worming
6 - 59 months	MUAC
45 years and above	Blood Pressure
All age groups	Blood sugar
Exposed infants	EID samples collection
Parents/caregiver and other community members	Promotion of Nutrition and Family Health care practices (Breastfeeding, sleeping under an insecticide-treated bed net, good hygiene and sanitation practices)

*\*Other services based on the district specificities and availability of drugs (NTDs), TB dots etc.*

## **2.0: Planning, Implementation and Monitoring Processes for ICHDs**

The above ICHDs interventions will be availed through health facilities, designated community outreach centres such as schools, places of worship, refugee camps and other public places. Implementation will be decentralised right from national level and scaled down to local levels i.e. facility and community levels. There will be collaboration between the Ministry of Health, partners and local governments in planning, implementation, monitoring, supervision and reporting at all levels.

### **2.1: National Level Planning**

The Ministry of Health and partners will be responsible for mobilization of resources to support ICHDs in all the districts of Uganda. In addition, MoH and partners shall play the role of quality assurance and ensure that the objectives of reaching the target groups through the ICHDs in all districts are realized.

Ministry of Health, through the nutrition unit in the Department of Community Health, shall have overall responsibility of overseeing planning, support supervision, implementation, monitoring and evaluation of ICHDs in collaboration with Ministry of Education, Science and Technology and Sports (MESTS).

The MoH through the National Medical Stores (NMS) and Uganda National Expanded Program on Immunization (UNEPI) will quantify, procure and distribute all required logistics and supplies before the commencement of the ICHDs.

### **2.2: District Level Planning**

The District Health Officer (DHO) will work with the District Education Officers and other partners in planning, coordination, monitoring and implementing ICHDs in the districts. The district will not only integrate ICHDs plans in their annual plans but will also develop specific district micro-plans for each ICHDs schedule prior to implementation. Micro plans for each district shall include:

- 1) Analysis of immunization coverage using the Reach Every District (RED) approach, categorization, mapping of health facility catchment area against target populations with emphasis on areas with low coverage, schools and hard to reach/serve communities.
- 2) Communication and community mobilization strategies with strong focus on reaching the unreached.
- 3) Specifications/location of operation sites, staffing at the sites and their contacts.
- 4) Requirements of supplies and logistics by sub-county level and a budget. The micro-plans will also include supplies required per outreach and details of stock at hand for ICHDs. The micro plans shall be a reflection of health facility micro plans

### **2.2.1: District Planning Unit (DPU)**

- The district planner who is the head of the District Planning Unit (DPU) will work closely with the DHO's office during the micro planning and implementation of ICHDs.
- The district planner or designated official from the DPU will collect all verified and signed birth notification forms from the DHOs office for data entry at the DPU.
- The district planner will oversee the entry of birth records from the forms into the Mobile VRS and the subsequent printing of birth certificates. The certificates should be printed in batches by LC1, bound and labelled in order to facilitate their delivery to the exact village where the beneficiaries live.
- The district planner will also arrange and designate one staff from the DPU to distribute printed birth certificates and Birth Registration Forms to respective Sub-county Chiefs for signing and further distribution to the health facility where registration took place, who will then deliver them to registered children.

### **2.3: Health Facility Level Planning**

The health facility will also integrate ICHDs plans in their annual plans. They too just like at district level, will also develop simplified specific micro-plans for each ICHDs schedule prior to implementation. A simplified micro plan will include: name of outreach sites, dates, responsible officers, and name of the VHTs /designated persons, required resources among others. Detailed schedules of ICHDs activities at outreach sites shall be developed and displayed at the health facilities.

### **2.4: Community Level Planning**

Planning and implementation at community level will mainly involve use of local leaders, Village Health Teams (VHTs), Faith Based Organisations and schools as detailed below.

#### **2.4.1: Sub-County Chiefs, VHTs and other local leaders shall be responsible for:**

- Community mobilisation for ICHDs
- Receiving printed short birth certificates and birth registration forms from the DPU, sign and stamp them
- Liaise with health workers to ensure timely birth registration and distribution of the certificate
- Working with Parish Chiefs, schools and Local council-1s (LC1s) to ensure that the right personnel are available during the ICHDs at all places of worship, FBOs, schools and other designated sites for purposes of verification of parentage of registered children.
- Planning for ICHDs activities in conjunction with the health facilities.



### **2.4.2: Faith Based Organizations (FBOs)**

Faith Based Organisations (FBO's) will be used as avenues for implementation of activities for the ICHDs and will have the following responsibilities;

- Sensitize their congregation during worship about the ICHDs
- Mobilise communities to increase the uptake of services delivered through ICHDs during pastoral care visits, meetings and use of their media houses.
- Provide places of worship as venues for outreach sites.
- The religious leaders will nominate person(s) per site to work with the health workers to ensure adequate delivery of services.
- Monitor the implementation of the ICHDs at their place of worship
- Liaise with health facility to ensure that activities are implemented at their sites.

### **2.4.3: Schools**

Teachers and pupils in schools will be very instrumental in the implementation of ICHDs through:

- Mobilise school children and communities to receive ICHDs services
- Mobilise parents for required services.
- Participate in planning for appropriate ICHDs
- Provide venues for appropriate ICHDs services
- Monitor and report AEFIs

## **3.0: Schedule for ICHDs**

The ICHDs activities shall be implemented bi-annually in the months of April and October at all health facilities and designated outreaches. However, activities may also be implemented on any other day as determined by the district and facilities such as Fridays, Saturdays and Sundays at places of worship where indicated

### **3.1: Staffing Needs**

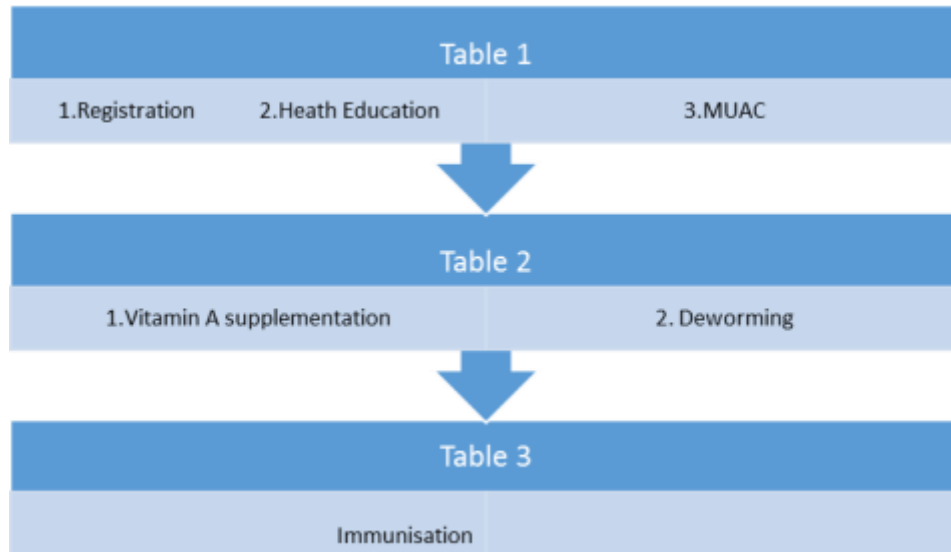
Staffing needs will depend on the approach being used either static or outreach. Each health facility will determine number of staff needed per site depending on the micro planning and interventions given. It is however advised that at least one qualified health worker whether for static or outreach implementation.

#### **3.1.1: Static**

At the health facility, the package will be implemented by the respective departments.

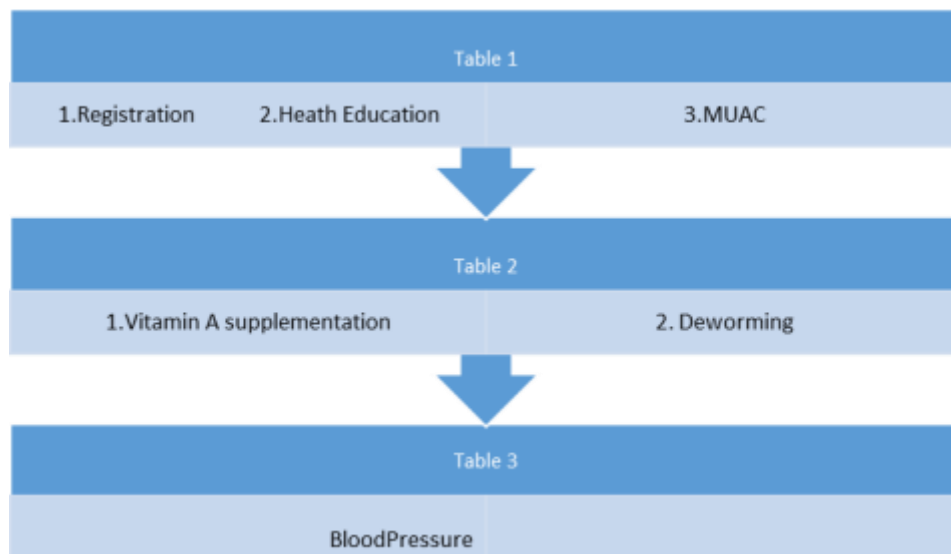
At the immunisation area, at least two health workers are required; the child should receive the scheduled antigens, deworming tablets, Vitamin A and MUAC should also be taken.

**Figure 1:Flow chart at facility level in the immunisation area**



At OPD the child should receive appropriate services due and MUAC should also be taken where appropriate. For those older than 45 years, their blood pressure should be taken by a health worker.

**Figure 2: Flow chart at facility level in the OPD**



A child due for immunisation identified at OPD shall be referred to the immunisation area

### 3.1.2: Outreach

The recommended delivery team for the ICHDs package of services includes at least a health worker and a delegate from the sub county for birth registration: in case of a faith based or any organisation outreach, a representative seconded by the organisation will be part of the outreach team.

For outreaches, a health worker shall administer Vitamin A and whenever deworming is done should be supervised by health worker.

The in-charge of the health facility of the catchment area will be responsible for data management using appropriate reporting systems (DHIS II /HMIS).

### 3.2: Logistics and Supplies for Implementation

A detailed list of the equipment and commodities required for implementation of the ICHDs-package of services has been developed. By April and October, each health facility should have the following equipment and logistics. The list also provides minimum preparation for outreach services

**Table 2: List of supplies for ICHDs at Facility and Outreach level**

Vitamin A Capsule
Albendazole/ Mebendazole
MUAC tapes
All antigens
BP machines, BP register and referral forms
Birth registration forms
Weighing scales and pants, Hand washing facility
Appropriate data collection tools such as Tally sheets, child registers, Child Health Cards, Mother Child passport and other appropriate register
IYCF Counselling cards
ICHDs IEC materials
EID sample collection Kits

Each district is responsible for ensuring that adequate supplies are available in every sub-county, health facilities and at the designated outreach sites as well as places of worship (when indicated) at the time of service delivery.

Facilities will forecast the requirements for ICHDs at the beginning of the financial year and forward the forecasts to the DHO who will later forward them to the centre. The supplies for ICHDs will then be delivered by National Medical Stores (NMS) through the normal supply chain.

### **3.3: Budgeting**

The ICHDs will be budgeted in the normal Government of Uganda (GoU) budgeting cycle. The funding for ICHDs is drawn from PHC vote, and external funding from partners and other stakeholders. Budgeting for support supervision should be done during the routine GoU budgeting cycle.

### **3.4: ICHDs Communication and Community Mobilization**

Various channels to be used for communication and community mobilisation shall include:

- Mass media including print and electronic
- Information Education and Communication materials (e.g. brochures, flyers)
- Faith Based Organisations at pulpit to the congregation
- Messages passed through school children to their parents and community members
- Music, skits and Drama
- Interpersonal communication
- House to house
- Development functionaries of government departments
- Communication and participation of leaders such as opinion, Religious and cultural leaders
- Non-Government Organisations

### **4.0: Monitoring and Evaluation**

This will be at national, regional, district, health facility/static and designated outreach posts. At national level the MoH will collaborate with departments involving health, education and other key stakeholders. District Health Teams (DHTs) will be responsible for supervising the ICHDs activities that are conducted in their respective districts.

### **4.1: Reporting**

Health Management Information System (HMIS) forms will be used for data collection and reporting. District health officers will be responsible for ensuring that adequate HMIS tools are available in their districts and at each service delivery site. All data from designated outreaches will be filled in the summary report forms (HMIS 075 and 076) and reported in the Health Facility Monthly Forms (HMIS 105) and submitted to the Health Sub-District office by the 7<sup>th</sup> of the following month (May or November). Health sub-districts will report the compiled data from facilities to the District Health

Office by 14<sup>th</sup> of May/November and from the district to the centre by the 28<sup>th</sup> of May/November. The DHOs shall be responsible to complete reporting by all health facilities in the district through DHIS II.

## **4.2. Key Indicators**

The following are the key indicators for monitoring the ICHDs for the different target groups.

### **4.2.1. Children**

#### **EPI**

- Number and % of targeted children < 1 year received DPT3
- Number and % of targeted children < 1 year received measles vaccine
- Number and % of targeted children < 1 year received PCV vaccine
- Number and % of targeted children < 1 year received HPV 2doses
- Dropout rates (DPT1-DPT3) (acceptable levels <10%)

#### **Vitamin A / De-worming/ Nutrition Screening**

- Number and % of targeted children 6-59 months who have received Vitamin A supplementation
- Number and % of targeted children between 1 – 14 years received de-worming treatment
- Number of children 6-59 months who are screened with Mid- Upper Arm Circumference (MUAC) indicators
- % of children with Severe Acute Malnutrition(SAM) (assessed using MUAC)
- % of children with Low Weight/Height for Age

#### **Birth Registration**

- Number of children under 5 years registered
- Percentage (%) of registered children under 5 years issued with short birth certificates from previous round

### **4.2.2: Men and Women**

- Number and % of women of reproductive age (between 15 and 45 years of age) who have received TT vaccine
- Number of men/women above 45 years that received Blood Pressure and blood sugar measurements
- % of the men and women who were screened and referred for care

### **.4.3: Steps in Provision of Specific Services**

#### **A. Birth Registration**

A birth certificate is the basis for the issuance of other identity documents and is particularly important in helping determine one's age and knowledge of oneself as an individual. After registration of a birth, a child is entitled to a birth certificate. The parents of all children under 5 years of age, whose births have never been registered and who don't have a birth certificate, should be directed to take their children to the birth registration desk (or tent) at the site. We recommend that the birth registration table should be close to the Vitamin A table considering that both are targeting children less than 5 years. The health worker delivering Vitamin A services should also ask if the child's birth was registered and direct those whose birth has never been registered to the birth registration table.

#### ***Birth Registration Steps***

1. The Health Worker, or Parish Chief or any other assigned notifier on site will ask the mother, father, or guardian of the child, "Is your child less than 5 years old?", "Has your child's birth been registered and does he or she have birth certificate?"
2. If the child has never been registered, then they will direct the parent or guardian of the child to the birth registration table.
3. At the birth registration table, the parent or guardian of the child will be received by a notifier (health worker or Parish Chief or any other assigned registrar on site) and shown where to sit.
4. The notifier will then ask the parent/guardian of the child the birth details of the child and enter these records into the Birth Registration Form booklet.
5. At the end of the day, the notifier will submit the Birth Registration Form booklet to the health worker in charge of that site, who will then submit it to the district along with other supplies.
6. The District planning Unit will then pick all the birth registration forms from the DHOs office, and ensure that birth records in the Birth Registration Form booklets are entered into online Mobile VRS, verified, and short birth certificates are printed.
7. The District Planner will then send back all printed short birth certificates to the sub-county headquarters to be signed and stamped by the Sub-county chief.
8. All signed and stamped short birth certificates will be collected by the ACDO or Parish Chief and distributed to respective health facilities where ICHDs services including birth registration were delivered.
9. Upon receipt of the signed and stamped birth certificates, the respective health facility or outreach site will distribute the certificates to the registered children during the subsequent round of ICHDs.

**NOTE:** It is important to tell the parents/guardians of all registered children, that they will receive their birth certificates at the same health facility or outreach site premises and will be informed when to pick them.

### **A. Vitamin A Supplementation**

During the April and October rounds of ICHDs, vitamin A supplementation shall be offered to children 6-59 months of age who would have missed the routine supplementation and any child who has not received Vitamin A in any 6 months.

#### Benefits

- Vitamin A supplementation helps to decrease the severity of many infections such as diarrhoea and measles through enhancing the immune system and deficiency can lead to an impaired response to infection
- Bi-annual administration of Vitamin A also improves and saves a child’s vision
- Fetal growth and development - development of the heart, lungs, kidneys, eyes, and bones, and the circulatory, respiratory, and central nervous systems
- Vitamin A in the form of retinoic acid is essential for gene transcription
- Retinoic acid also maintains skin health by activating genes that cause immature skin cells to develop into mature epidermal cells
- Vitamin A is particularly essential for women who are about to give birth, because it helps with postpartum tissue repair
- Influence is particularly critical during periods when cells proliferate rapidly and differentiate, such as during pregnancy and early childhood

#### *Vitamin A Administration*

1. Check the age of the child (only children age 6 to 59 months should receive Vitamin A capsules).

Age (months)	Dosage
Infants below 6 months (non-breastfed infants only)	50,000IU (1/2 Blue capsule or 2 drops red capsule)
6-11	1 Blue capsule (100,000 IU) or 4 drops red capsule
12-59	1 Red Capsule (200,000 IU) or 2 blue capsules

2. Review the Child Health Card, if available. If the child has received Vitamin A within the past three months, do not administer.
3. When the Child Health Card is not available, ask the caretaker if the child has received Vitamin A capsule in the last three months. If the answer is “yes”, do not administer.
4. If the answer is “no”, select the appropriate dose of Vitamin A to the child as follows:
5. Administer the Vitamin A as appropriate:

Blue

Red

6. Ask the caretaker to hold the child firmly, make sure the child is calm.

**Figure 3: Illustration of cutting the narrow end of the Capsule**



7. Check if the child is comfortable after swallowing the drops/ Capsule,
8. Put all used casings/ shells of the capsules into a bag for disposal.
9. Tally the child's dose on the Vitamin A part of the tally sheet / Form 076
10. Record the child's dose in the Child Health Card

### **Take home messages on Vitamin A**

*Vitamin A is available in the daily foods we take but because of the way we handle our foods, it is lost.*

*It is important to bring your children 6-59 months for vitamin A supplementation every after 6 months.*

*The signs and symptoms for Vitamin A deficiency are not easily seen with naked eyes and by the time they are detected, it is too late to reverse the condition.*



## De-Worming

Albendazole (400 mg ) is the drug of choice for de-worming however, Mebendazole (250 mg and 500 mg) can be a substitute but caution should be given for safety of water and dose basing on the weight. Children 1 – 14 years of age should receive routine de-worming treatment once every six months.

### Benefits

Worms compete with humans for nutrients in the body leading to micronutrient deficiencies and iron deficiency being the most common which leads to anaemia.

- Deworming prevents worm infestation of children, which would otherwise lead to anaemia.
- Increases growth and weight gain
- Improves nutrition
- Increases resistance to other infections

### Administration of de-worming medications

1. Check the age of the child (only children age 1 to 14 years should receive de-worming treatment).

Age	Dosage
1-2 years	Single dose every 6 months (200mg Albendazole or 250mg Mebendazole). Crush the tablet between 2 spoons and dissolve by adding a small amount of clean boiled water and give to take.
2-14 years	Single dose every 6 months (400mg Albendazole or 500mg Mebendazole). Give a tablet to chew (DOT)

2. Ensure your hands are washed before touching the de-worming tablets.
3. Ensure the child is calm and is not chewing anything at that moment
4. Put the tablet into child's mouth and ask him / her to chew/swallow it.
5. Give the child boiled water to drink.
6. Record the child on the de-worming section of the tally sheet /Form 076
7. Record the de-worming treatment in the Child Health Card

### Take home messages for de-worming

*Worms are in the environment we live in, especially in the soils and dirty water. When we eat foods and fruits that are not properly washed or cooked, worms can enter our bodies. These worms compete with us for the nutrients, and then we suffer devastating consequences which are usually fatal. The removal of these worms from our bodies is very easy and cheap. It is important that everybody is de-wormed minimally twice a year.*

## **B. Screening for Malnutrition**

It is very important to identify children with malnutrition and to refer them for healthcare service as quickly as possible. During the ICHDs outreaches, screening of children aged 6 to 59 months will take place in those districts, which have referral (i.e. therapeutic feeding centre / TFC) available.

Children below 6 months should be weighed and their weight plotted on the child health card to determine how the child is growing.

Children between 6 month to 5 years should be weighed, length/height and MUAC taken.

All children screened for malnutrition using MUAC, their results should be recorded in the OPD registers. Results will then be summarised at the end of the months in HMIS 105. During outreach sessions health workers should carry a register and register all children screened for malnutrition.

### **For Child and Maternal Nutrition Counselling and Advice (Refer to IYCF Guidelines for Uganda)**

**MUAC screening** (see illustration in Figure 4 below)

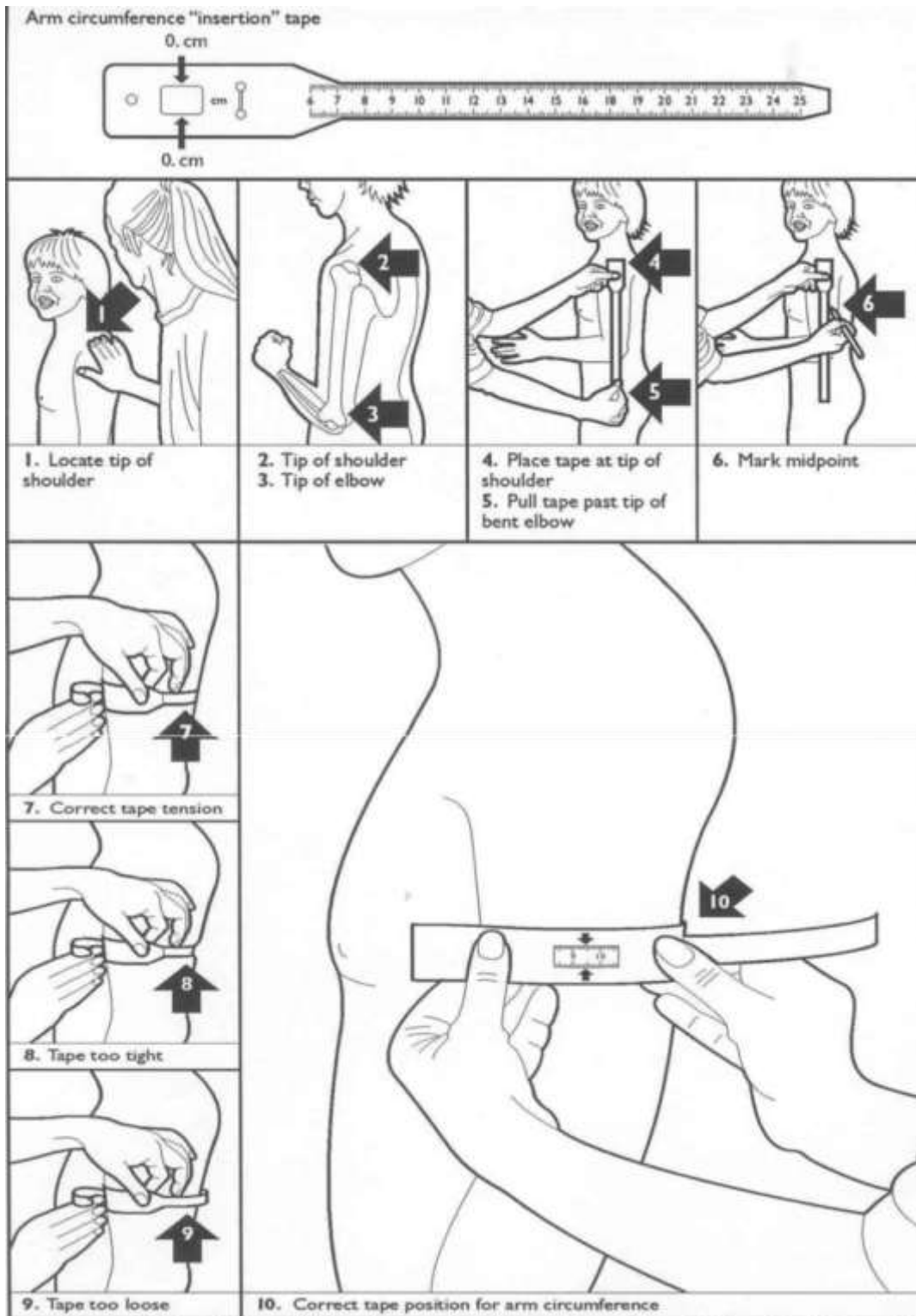
Determining the age of the child by asking the mother/caregiver to tell you the age of the child.

1. If the child is less than 6 months old, do not measure his or her upper arm with the MUAC strip.
2. If the child is 6 months of age or older, you may use the MUAC strip to measure the upper arm.
  - a. Calculate the midpoint of the child's left upper arm by first locating the tip of the child's shoulder (arrows 1 and 2) with your fingertips. Bend the child's elbow to make a right angle (arrow 3).
  - b. Place the tape at "zero" (which is indicated by two black arrows on the tape) on the tip of the shoulder (arrow 4) and pull the tape straight down, past the tip of the elbow (arrow 5). Read the number at the tip of the elbow to the nearest centimetre. Divide this number by two to estimate the midpoint. Mark the midpoint with a pen on the arm (arrow 6).
  - c. Straighten the child's arm and wrap the tape around the arm at the midpoint. Make sure the numbers are right side up. Make sure the tape is flat around the skin (arrow 7) and is not too tight or too loose (arrows 8 and 9).
  - d. Read and call-out the measurement to the nearest 0.1cm (arrow 10).

### Interpreting MUAC Results

- If MUAC is **equal or more than 12.5 cm** (green zone on the tape) it means that the child is properly nourished - record it in the tally sheet (form 076) and congratulate the mother for her well-fed child;
- If MUAC is **between 11.5 and 12.5 cm** (yellow zone on the tape) it means that the child is at risk of malnutrition - record it in the tally sheet and refer to the nearest supplementary feeding program if available;
- If MUAC is **less than 11.5 cm** (red zone on the tape) it means that the child is severely malnourished - record it in the tally sheet and refer him to the nearest hospital and/or therapeutic feeding center for immediate medical assistance.

**Figure 4: Measuring arm circumference using MUAC tape**



Source: How to Weigh and Measure Children: Assessing the Nutritional Status of Young Children, United Nations, 1986.

### C. Routine and Catch-up Immunizations

All Ugandan children should complete their vaccinations before their first birthday. Older children who are found not to have been vaccinated should receive the missed doses except for BCG vaccine that should be given up to two years only. Vaccinating children during ICHDs visits helps them catch up with any vaccinations he or she might have missed during routine health check-ups at the healthcare facility.

**No illness or mild suffering (fever, allergy, diarrhoea or cough) is a contraindication to the child's vaccination.** For schedule of vaccinations see Tables 3 and 4 below.

**Table 3: Uganda Child Immunization Schedule for children under**

AGE OF CHILD	VACCINE	DISEASES PREVENTED
At birth or soon after birth	Oral Polio, BCG	Polio and Tuberculosis
6 weeks old	Oral Polio, DPT-HepB+ Hib	Polio, Diphtheria, Whooping Cough, Tetanus, Hepatitis B & Haemophilus influenzae type b illnesses
10 weeks old	Oral Polio, DPT-HepB+ Hib	Polio, Diphtheria, Whooping Cough, Tetanus, Hepatitis B & Haemophilus influenzae type b illnesses
14 weeks old	Oral Polio, DPT-HepB+ Hib	Polio, Diphtheria, Whooping Cough, Tetanus, Hepatitis B & Haemophilus influenzae type b illnesses
9 months old	Measles	Measles

**Table 4: Uganda immunization schedule for girls and women of reproductive age for tetanus toxoid (TT)**

Girls and women 15-45 years old and pregnant women	VACCINE	DISEASE PREVENTED
First visit	TT1	Tetanus
At least 4 weeks after TT1	TT2	Tetanus
At least 6 months after TT2	TT3	Tetanus
At least 1 year after TT3	TT4	Tetanus
At least 1 year after TT4	TT5	Tetanus

**NOTE:** Always check the safety of vaccines before administering (Refer to Immunisation in Practice IIP Reference Manual, 2007)

### Take home messages on immunisation

*Immunisable diseases are still common in our communities; they are very common in children under the age 5 years. Vaccines have been made free in all facilities in Uganda. It is your responsibility to take your child for immunisation at a Health facility. All children should have completed their immunisation schedule by their first birth day.*

### D. Growth monitoring

This is where infants and children 2 years and below have their weights taken every month in order to monitor their growth. Infants and young children should gain weight every month and therefore, parents, communities and caregivers are advised to undertake growth monitoring and promotion interventions seriously.



### Take home messages on Growth monitoring

*Care givers, parents and communities are advised to regularly measure their children's growth by plotting the weights on the Child Health card. In case the child is not growing well (is not gaining weight appropriately), then he/she should be referred to the health facility.*

## E. Hypertension Screening

All adult males accompanying pregnant women and their children and females above 45 years shall be assessed for hypertension. Two measurements taken at least with five minutes interval shall be conducted when client is seated.

Classification of blood pressure is indicated as below;

Category	SBP mmHg	DBP mmHg
Normal	<120	> 80
Pre-hypertension	120-139	80-89
Hypertension, stage 1	140-159	90-99
Hypertension, stage 2	≥ 160	≥ 100

*Key: SBP= systolic blood pressure. DBP= diastolic blood pressure*

Those with Blood Pressure reading above 140/90 mmHg should be referred to a health facility for further checkup using a referral slip for Blood Pressure and Blood Sugar.

All adults screened for blood pressure and their results will be recorded in the OPD registers. Results will then be summarised at the end of the months in HMIS 105. During outreach sessions health workers are advised to carry a register and register all screened adults.

### Take home messages on BP

Hypertension or raised blood pressure is a very big problem in Uganda. Unfortunately 80% of those with high blood pressure don't know they have it. High blood pressure and indeed other non-communicable diseases (NCDs) like diabetes and cancer may have no symptoms and therefore one has to make sure his/her blood pressure is checked/screened regularly at least once a year, even when he/she feels healthy. High blood pressure and other NCDs if not treated can result in serious complications like stroke, heart failure, kidney failure, blindness, impotence and death. Avoid high blood pressure and other NCDs by living health lifestyles, by doing the following

1. **Avoid tobacco use:** tobacco is dangerous in all forms, be it smoking, chewing or even exposure to second hand smoke.
2. **Eat health diets:** avoid excessive fats, sugars and salt. Eat lots of fresh vegetables and fruits. Eat a balance diet

3. **Do physical exercises:** be physically active, do exercises that you enjoy like sports, dancing. Digging and riding a bicycle are also good exercises. Make sure you exercise at least 30 minutes every day
4. **Avoid obesity:** control your size. Ask your health worker your ideal size depending on your height/age and work towards maintaining that weight
5. **Avoid alcohol abuse:** excessive alcohol intake is detrimental to your health, a male should not exceed 2 common beers and a female one a day.

## **F. Referrals**

Any client seen during outreach services who has danger signs, problems or issues that the service provider cannot handle should be referred to a higher functional unit without delay according to guidelines for referral.

- A referral note describing the patient's condition and any treatment provided should always be completed and given to the patient or his/her family.
- The partner or relatives of the patient should be informed, counselled and encouraged to accompany the patient;
- Feedback to the referring provider from the referral unit should be ensured;
- All referrals should be handled professionally and ethically.
- Those with high blood pressure will be referred to appropriate facilities where such patients can be screened and managed.

**All relevant documents, Child Health card, immunization and treatment records, etc. should accompany mothers or babies when they are referred.**

**Newborn babies should be kept warm during transport and should be breastfed, if possible.**

### **4.4: Health Messages to be given to all Clients**

#### **Reminder on Use of Insecticide-Treated Bed Nets (ITNs)**

All children, pregnant women, lactating mothers and men should sleep under insecticide treated bed nets. Sleeping under the nets prevents mosquito bites during the sleep and therefore, prevents contracting the life-threatening malaria disease.

Remind her that windows and ventilators in the house must be screened

The stagnating water around the house should be drained.



## **Reminder on Hygiene Practices**

Mothers and caregivers should ensure that everyone in the family washes hands with running water and soap at three critical times: (1) before cooking, (2) before eating, and (3) after using the latrine or cleaning baby's faeces.

Advise mothers/care givers that they **SHOULD NOT** use bottles, teats or spouted cups, as they are difficult to clean and may cause baby to get diarrhoea.

Foods must be kept in covered containers in a clean, cool and dry place within the household.

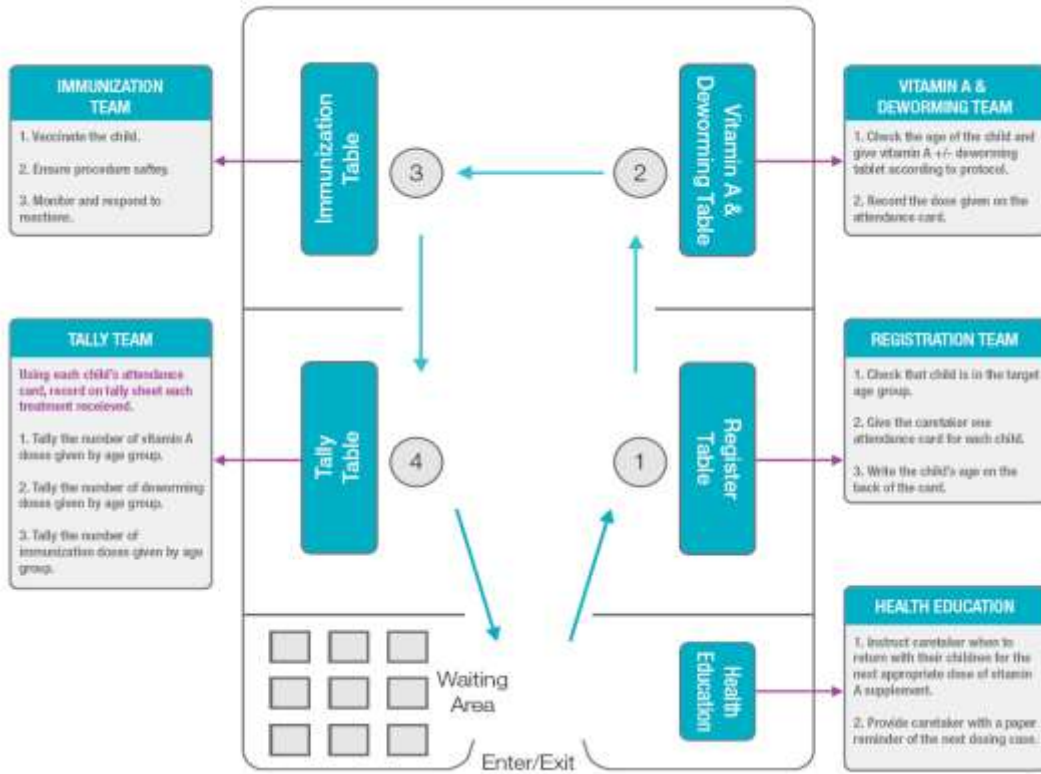
Emphasise that hot food should be eaten when it is hot.

Emphasise the need to construct and use latrines in the households to ensure that human waste is not exposed and contaminating the soil and water around the house.

All schools should have sanitary materials and sensitizing of children should be intensified during April and October when ICHDs services are being provided

## Annex 1

### Flow Chart of General Activities in an outreach area



## ANNEX 2

### Immunisation Schedule for Uganda.

Vaccine/ Antigen	Dosage	Doses Required	Minimum Interval Between Doses	Minimum Age to start	Mode and site of Administration
BCG	Infants (0-11 months)-0.05ml.  11 months and above-0.1ml	1	None	At birth(or first contact)	Intradermal right Upper Arm
Polio	2 drops	0+3	One month  (4 weeks)	At birth or within the first 2 weeks(Polio 0) and six weeks or first contact after 6 weeks(Polio 1)	Oral,
DPT- HepB+Hib	0.5ml	3	One Month  (4 weeks)	At 6 weeks(or first contact after that age)	Intramuscular, Outer Upper Aspect of Left Thigh
PCV	0.5 ml	3	One Month  (4 weeks)	At 6 weeks(or first contact after that age)	Intramuscular,  Outer Upper Aspect of Right Thigh
Rota	drops	2	One Month  (4 weeks)	At 6 weeks(or first contact after age) weeks	Orally
Measles	0.5ml	1	None	At 9 months(or first contact after that age)	Subcutaneous  Left Upper Arm
<b>Tetanus Toxoid</b>	<b>0.5ml</b>	<b>5</b>	<ul style="list-style-type: none"> <li>• TT1&amp;TT2:One month</li> <li>• TT2&amp;TT3:Six months</li> <li>• TT3&amp;TT4:One Year</li> <li>• TT4&amp;TT5:One Year</li> </ul>	<b>At first contact with a pregnant woman or women of childbearing age(15-45 years)</b>	Intramuscular, Upper Arm
HPV	0.5ml	3	<ul style="list-style-type: none"> <li>• HPV1 given at first contact with a girl in primary 4 or a girl aged 10 years for those out of school</li> <li>• HPV2:given 2 months after HPV1</li> <li>• HPV3 given 4 months after HPV2</li> </ul>	Girls in primary 4 or 10 year old girls who are out of school	Intramuscular Left upper arm

**Note: Rota virus Vaccine schedule should be completed by 32 weeks of age**