REPUBLIC OF UGANDA

MINISTRY OF HEALTH

BIG CATCH UP (BCU) REPORT

Reaching children who missed routine vaccination

FEBRUARY 2025

Content

Executive summary

In Uganda, Big Catch-up vaccination was conducted through regular routine immunization service delivery (fixed, outreach, mobile, school-based), periodic intensification of routine immunization (PIRI) activities, that ensure individuals have the opportunity to receive routine immunizations for which they are overdue and eligible.

Big catch up targeted Reaching children who missed vaccination during the period 2020–2024, which was partly due to COVID pandemic, and provide all missing vaccinations

Due to the impact of COVID 19 restrictions, the Uganda noted accumulation of zero dose and under immunised children. As of 2023, the program had registered 329,359 zero dose children. Additionally, due to suboptimal performance of new vaccines especially in the second Year of Life (2YL) during the year 2023, the program had only achieved 21% MR2 coverage below the target of 95%. Subsequently, by November 2024, 44/146 districts(30%) had registered measles outbreaks

Interventions

Interventions related to;

1) planning, coordination and financing,

2) vaccine, cold chain and logistics,

3) Training of SIA for quality,

5) Monitoring and supervision and

6) Advocacy, social mobilization and communication were supported

Results

At national level, the big catchup targeted to reach 95% of the 329,359 zero-dose children, however, we vaccinated 292,907 (89%)

DPT3 was given to 288,960 out of the 413,350 targeted children thereby giving a coverage of 70%. Out of the 591,210 targets for MR1, we reached 570,189 (96%). Out of the 3,081,426 targets for MR2, we reached 1,557,831 (50%)

Conclusion

Uganda has indeed made significant strides in improving its immunization coverage, particularly through initiatives like "big catch-up". This Big catch up was designed to reach children who have missed routine vaccinations, often due to disruptions in healthcare services, geographic barriers, or other challenges including those were affected by the COVID Pandemic restrictions.

Dr Baganizi Michael

Program Manager UNEPI

BCU Overview

Big Catch-up vaccination refers to the action of vaccinating an individual who, for whatever reason, is missing or has not received doses of vaccines for which they are eligible, as per the national immunization schedule.

In Uganda, Big Catch-up vaccination was conducted through regular routine immunization service delivery (fixed, outreach, mobile, school-based), periodic intensification of routine immunization (PIRI) activities, that ensure individuals have the opportunity to receive routine immunizations for which they are overdue and eligible.

Despite efforts to ensure continuity of routine immunization services, coverage of essential childhood and adolescent vaccines lagged. Communities continued to face a range of local barriers to access, including social, financial and geographic factors, along with influences from proliferating vaccine misinformation

Big catch up targeted Reaching children who missed vaccination during the period 2020–2024, which was partly due to COVID pandemic, and provide all missing vaccinations more so New vaccines namely HepB birth dose, IPV2, Yellow fever, Rotavirus3 and MR2 that were performing sub optimally. According to WUENIC 2023, Uganda was among the top 10 countries with the highest number of zero-dose children (83,000) in the Eastern Africa region (rank=5 out of 14 countries) but with high coverage of 95%.

DTP1 coverage, by country, Eastern Africa, 2023

Source: WHO/UNICEF Estimates of National Immunization Coverage, 2023

This chart shows DTP1 coverage in countries of Eastern Africa from lowest to highest coverage, and the rank of the top 10 countries with the most zero-dose children, based on absolute numbers.

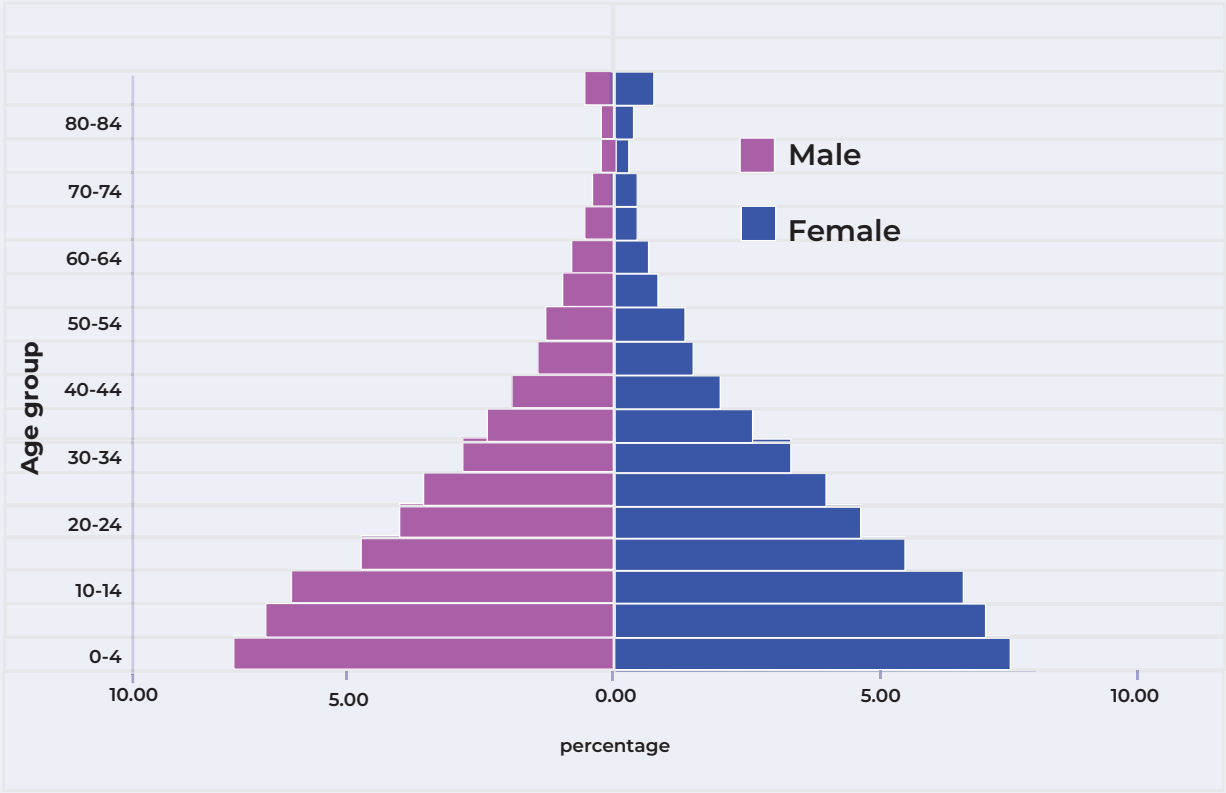
Uganda had high numbers of zero-dose children (83,000) despite high vaccine coverage (95%).

Uganda Demographic Characteristics

Uganda's total population was 45.9 million people as at May 2024 with 21.6 million males and 24.3 million females. Buganda sub-region had the largest population of 13.0 million persons, followed by Busoga (4.4 million persons). Karamoja sub-region had the smallest population of 1.4 million persons.

The NPHC 2024 results indicate that the younger population constitutes a high percentage of both males and females and the age has relatively followed a declining trend. Uganda has a largely young population as shown by the broad base of the pyramid as shown below.

Uganda Population Pyramid



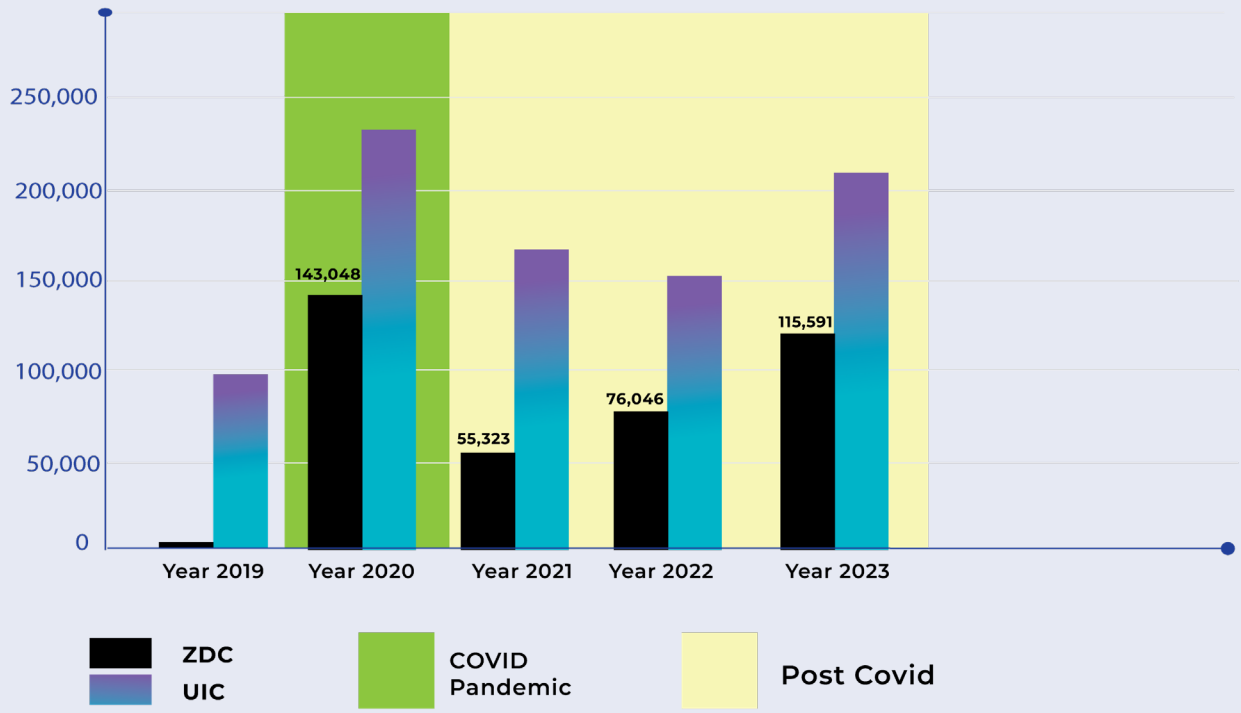
50% of the population are below the age of 17 years, 24% youth and 5% elderly. The population growth is 2.9%.

Wakiso district was the most populated with over 3.4 million people followed by Kampala with over 1.9 million people whereas Moroto and Kalangala districts were the least populated with 103,344 and 70,589 people respectively.

Rationale/Justification

The Big Catch-Up is a global initiative launched in April 2023 to close immunization gaps caused by the COVID-19 pandemic, restore global immunization levels, and strengthen immunization systems so that catch-up activities become an integral part of immunization programs. Decades of progress in immunization were reversed during the pandemic when, in 2021, coverage dropped to levels not seen since 2005, resulting in an alarming number of zero-dose children globally.

Due to the impact of COVID-19 restrictions, Uganda noted accumulation of zero dose and under immunised children. As of 2023, the program had registered 329,359 zero dose children.



The graph above shows how The COVID-19 pandemic has had a significant impact on routine immunization programs in Uganda, leading to an increase in the number of zero-dose children and under immunized children

DPT1 and DPT 3 performance over time (2010-2023) according to WUENIC

The charts above show the coverage of DTP1 and DPT3 in Uganda for 2010-2023. Notable there was an increasing coverage until 2020 where there was a slight decline hence increasing the zero dose and under immunised children

Additionally, due to suboptimal performance of new vaccines especially in the second Year of Life (2YL) during the year 2023, the program had only achieved 21% MR2 coverage below the target of 95%. Subsequently, by November 2024, 44/146 districts(30%) had registered measles outbreaks.

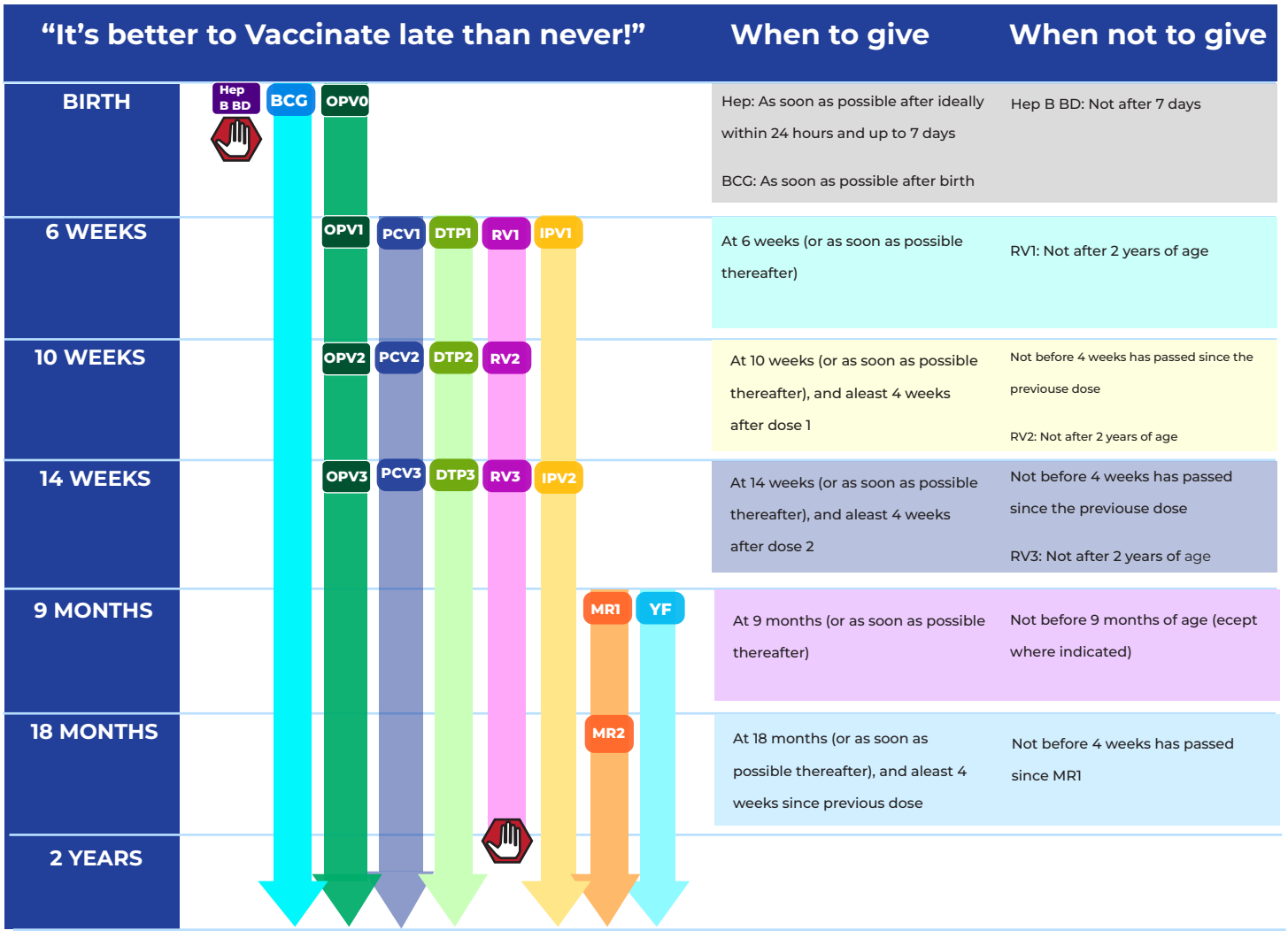
To address this gap, intensified vaccination activities are necessary to ensure that all eligible children are reached and protected against vaccine preventable diseases. The Big Catch Up intended to intensify immunisation services both at static, School and outreach posts to enable the country attain its desired EPI targets, effectively control and mitigate protracted Measles outbreaks

In order to bridge the immunity gap, Uganda conducted the Big Catch Up in November 2024. The Big catch up was integrated with administration of praziquantel, child survival interventions such as deworming and vitamin A supplementation

Methodology

A catch-up vaccination schedule was designed in line with the national immunization schedule, that adhere to upper or lower age requirements as determined by the national immunization policy.

Big catch up schedule



Even If along time has passed between doses, there's no need to start the sries from the beginig.

There is no Upper age limit for Vaccines (except rotavirus < 2years and Hepatitis B BD < 7 days

Big Catch Up package

A big catch-up immunization package was a comprehensive set of services that are designed to support integrated health services to individuals across various age groups. This package typically includes a range of components aimed at ensuring effective immunisation practices, improving public health, and preventing vaccine-preventable diseases.

Age group	Service package
< 1 yr.	All missed routine antigens incl. Hep. B birth dose within 7 days, vitamin A after 6months. Check for 1st Dose MR
1 - 4 years.	Missed routine antigens, Deworming, vitamin A, MR, Deworming, vitamin A.Check for 2nd Dose MR All missed routine antigens incl. Hep. B birth dose within 7 days, vitamin A after 6months. Check for 1st Dose MR
5 - 14 yrs.	Deworming, Praziquantel administration in endemic 78 districts
10 yrs.	HPV (Look out for girls aged 11-14 years who may have missed their due doses
15 - 49 yrs. women	Tetanus Diphtheria (TD)

Target setting

The target population included all zero dose children as reported by the National population and Housing census data- 2024 (NPHC 2024). A child was considered zero dose if they reported never having received any vaccine since birth as of May 2024.

According to the National Population Housing Census (NPHS) 2024, 329,359 zero dose children under 1 year were identified through house to house count and 591,210 children aged 1-4 years had never been vaccinated. The under zero dose children identified was our target for DPT1 and 1-4 years unvaccinated children became out target for MR1

To derive the DPT3 target, the number of zero dose children was added to the children who dropped in the previous year giving us a target for DPT3 as 413,350

To derive the target for MR2, the number of children not reached with MR2 since introduction of MR2 in 2022 were our Big catch up target for MR2. Therefore the target for MR2 was 3,081,426. However we had districts that were responding to Measles outbreaks in the Big Catch up month and they did non selective vaccination. The target for outbreak districts was 15.9% of the population to get estimated proportion of 9 to 59 months

Integration of child Health Services in schools

The following proportions were used to set targets for the rest of the Big catch up service package. The target also included children that missed these services for the previous years using the catch up vaccination schedule

Population Category targeted	Target Proportion
WCBA 15 – 49 years	**23%**
Td Immunization	
Non pregnant women	**18%**
Td Immunization	
Pregnant women	**5%**
Td Immunization	
0 – 11 months	**4.85%**
(Live Births)	
0 – 11 months	**4.30%**
(Surviving Infants)	
12-59 months or 1-<5yrs	**16.20%**
Vitamin “A” (200,000 IU)	
6-11 Months	**1.93%**
Vitamin “A” (100,000 IU)	
1year – 14 years	**49.30%**
Deworming	
Girls 10 years	**1.54%**
HPV Immunization	
5-14 years	**33%**
Praziquantel Administration in 78 districts	

Strategies used during Big Catch Up (BCU)

Program Management and Finance

- **National and regional level coordination meetings involving implementing partners, DHT and national level stakeholders.**

Coordination meeting at National and districts with all expanded partners and stakeholders from within and beyond the health sector were conducted to contribute to promoting and delivering vaccination during Big catch up

- **Resource mobilisation and partner mapping**

Resource mobilization for Big catch up was done to ensure widespread immunisation coverage. It involved securing the necessary financial, human, and logistical resources to effectively implement and sustain immunization program.

- **Planning and budgeting**

Planning and budgeting for Big Catch up was done to assess the need for for implementation of Big Catch Up, determining the resources required, and allocating funds effectively to ensure that vaccination efforts are efficient, equitable, and sustainable

- **District funds disbursement**

Funds to districts to support big catch up was sent one months prior the Big catch up together with financial guidelines to ensure efficient and effective program implementation.

Participation of other partners during BCU

Service Delivery

A. Orientation meetings:

Prior to the catch up, the service delivery sub-committee at national level conducted physical and Virtual meetings to develop training tools, fast track progress of the BCU plan and reviewed the district micro planning template which was shared with the districts during the orientation/planning workshops before the planned implementation date (November 2024) . The orientation was conducted in a cascaded manner beginning with central, district and sub county level.

i. Central level Orientation of supervisors

Teams were selected from MoH, Partners, Regional Referral Hospitals, community health departments and EOCs. One national supervisor from each district/city, Regional Referral hospital CHD teams, and partners, were trained through a 1-day virtual meeting at the National level. The orientation focused on the implementation strategy, review of micro-plans, monitoring, supervision, reporting and the catch-up guidelines. Supervisors were deployed to districts to support in these areas. District health teams worked with the sub county supervisors and health facility in-charges/ EPI focal persons to complete the microplans.

ii. District level orientation

Orientation of stakeholders and harmonization of the microplans was conducted for 1 day, led by the DHO with support of the central supervisor. The micro-planning process was used to determine the appropriate strategies that were employed and to identify strategic partners to support the Catch-Up Plan.

Inclusiveness during BCU: Security team were part of BCU

Village to village model was planned and implemented during BCU

iii. Sub County level

Sub-county level orientation training for health workers and mobilizers was conducted for one day. The training focused on Big catch up vaccination strategy, micro planning and development of daily movement plans for the teams.

B. Implementation

A village model was used to reach all eligible populations within the allocated days. The model involved the following;

- Mobile Vaccination teams were deployed both at selected community posts (villages and schools) as guided by the micro plans for the catch-up in addition to static vaccination at all health facilities (public and private).
- Teams were estimated based on the number of villages in the district to bring the services closer to the communities including schools. Team allocation was based on comprehensive microplans aided by a standard micro planning template with all health facilities, sub counties and district stakeholders taking into consideration district specific peculiarities. A total of 35,607 teams were deployed during the big catchup exercise with each team composed of 1 health worker and 1 mobiliser.
- Each vaccination team was assigned 2 villages to reach the target population within the stipulated period. Teams were guided by the daily movement plans on where to place the vaccination posts for each day and shifted only when the targets were achieved to another post or home or community where there were missed children or missed communities as guided by the microplan.
- Teams worked with the education department at district level to map out all targeted schools (secondary, primary and kindergarten) within their catchment areas and planned to reach them during the catch up period. The number of schools, school enrolment and targeted population guided the duration of the school outreaches and team deployment.
- The vaccination catchup in the communities was supervised by the district health teams and health facility incharges who provided onward support to the teams till the exercise ended.

Reaching the Hard to reach areas: Lady Health worker riding to the vaccination team for outreach

Under 5 years children were mobilised in the outpost

Vaccines and Logistics

Vaccine Quantification: Vaccine quantification for the districts was done based on district stock balances, doses used and number of children un/under immunised as per the National routine immunization schedule. Districts submitted vaccine order requests using the routine ordering tool while putting into consideration the surge demand created during the ICHDs in the adjustments for doses. Quantification for MR vaccines was done centrally for the non selective vaccination in the measles outbreak districts considering the target population of 9 months to 5 years children.

Supplies Allocation and Distribution: All orders for vaccines and related supplies were processed at NMS and distribution from National to district level was conducted by NMS using the available refrigerated trucks. Distributions were conducted at least two weeks before start of implementation with a few exceptions where delays were experienced. Districts were encouraged to adjust their implementation dates based on availability/receipt of vaccines and related supplies. Distribution from District to Health Facility level was conducted by the districts at least two days before the start of implementation.

Districts were provided with resources to support Cleaning and freezing of ice packs 10 days prior to the start of implementation. Fuel (diesel) was provided to support generator running, this is to enable un disrupted running of the deep freezers for ice pack freezing and ice lined refrigerators for vaccine storage, paraffin was provided for waste disposal in line with existing waste management guidelines.

Proper vaccine management during BCU

Cold Chain Maintenance: National Medical Stores (NMS) maintenance teams were deployed to supervise the BCU in districts with cold chain maintenance challenges such that they could support these identified districts to conduct preventive cold chain maintenance and develop contingency plans for proper storage of vaccines and related supplies.

Advocacy, Communication, and Social Mobilization

Nationwide Social Mobilization Efforts

A nationwide social mobilization campaign was conducted at both national and subnational levels, targeting all children under five, 10-year-old girls, and women of childbearing age. These groups were guided to designated vaccination posts to receive appropriate immunization interventions. The mobilization efforts ensured broad community participation and increased vaccine uptake across various demographics.

Media Campaign

A comprehensive media campaign was launched to raise awareness and educate the public on Routine Immunization (RI), Measles and Rubella, Malaria Vaccine Introduction (MVI), and the Big Catch-Up (BCU) initiative. This multi-platform approach utilized television, radio, newspapers, and digital media to ensure that accurate and persuasive messaging reached diverse audiences. The campaign was designed to dispel misinformation, encourage vaccine uptake, and mobilize communities through strategic communication.

Radio Spots

To reinforce key immunization messages, strategic radio spots were developed and aired on 40 national and regional FM stations. These short, impactful messages were delivered in multiple local languages, effectively reaching various demographic groups, including parents, caregivers, and community influencers. Given radio's extensive reach, especially in rural areas, this medium played a critical role in awareness-building efforts.

District leadership orientation during BCU

Radio talk show during BCU

Newspaper Publications

Three newspaper articles and one opinion piece were published in leading national dailies to complement the broadcast campaign. These publications featured expert insights, success stories, and myth-busting content on immunization. By engaging print media, the campaign ensured that in-depth discussions on RI, MVI, and BCU reached policymakers, professionals, and urban audiences who rely on newspapers for credible information.

Information, Education, and Communication (IEC) Materials

One brochure containing frequently asked questions about the Big Catch-Up campaign was developed and used as a key communication tool. It was shared electronically with all districts, cities, and municipalities involved in the campaign.

Social Media Messaging

To expand the campaign's digital reach, 20 influencers were engaged, posting 120 times daily across various social media platforms. Their involvement helped generate discussions, increase visibility, and engage different audience segments in the immunization drive.

Community Mobilization and Training

Sixty-seven District Health Educators (DHEs) were trained on the Big Catch-Up Campaign to enhance community involvement in immunization efforts. These educators played a key role in sensitizing communities, addressing concerns, and mobilizing local populations for vaccine uptake.

> "Health educators played a key role in sensitizing communities, addressing concerns, and mobilizing local populations for vaccine uptake.

Mobilisation vans were used to mobilise during BCU

Health education to caretakers during BCU at facility level

Town Hall Engagements

One live town hall meeting was held in Fort Portal City and broadcast on UBC TV and three FM radio stations to reach a wider audience. The session featured discussions with health professionals, local leaders, and community members who shared their experiences and addressed common misconceptions about immunization. Broadcasting the event live amplified its impact, allowing audiences across the region to engage with and benefit from the discussions.

Internal Memo Distribution

To ensure alignment and commitment among government agencies and key institutions, internal memos were distributed across relevant ministries, departments, and organizations. These memos provided official guidelines, updates, and calls to action regarding immunization initiatives, reinforcing the collective responsibility of stakeholders in promoting vaccine uptake.

Media Practitioner Orientation

In Jinja City, an orientation session was conducted for media practitioners, including presenters, DJs, editors, and journalists. The training aimed to enhance their ability to communicate accurate immunization information effectively. Equipped with factual content and strategic messaging techniques, these media professionals played a crucial role in ensuring responsible reporting and widespread dissemination of RI, MVI, and BCU-related information.

Cultural Leader Engagement in Busoga Kingdom

Cultural leaders in the Busoga Kingdom were oriented in Jinja City as part of efforts to enhance community-driven support for immunization. Recognizing their significant influence on public opinion, the session provided them with accurate information and advocacy tools to promote vaccine uptake within their communities. Their endorsement helped reinforce the importance of immunization from a cultural perspective, fostering greater acceptance among their followers.

Faith Leader Engagement in Busoga Kingdom

Similarly, faith leaders in the Busoga Kingdom were engaged in Jinja City to support RI, MVI, and BCU efforts. Given the trust communities place in religious leaders, their involvement was critical in dispelling vaccine hesitancy and encouraging positive health-seeking behaviors. The orientation equipped them with factual, scripturally aligned messages to advocate for immunization within their congregations.

National-Level Inter-Ministerial Engagement

One high-level inter-ministerial engagement was conducted between the Ministry of Health and the Ministry of Education and Sports to strengthen immunization programs in schools and communities. This strategic collaboration aimed to integrate immunization initiatives into the education sector, ensuring that school-going children receive necessary vaccinations. The partnership enhanced the sustainability of immunization efforts and contributed to improving health outcomes among children nationwide.

Media Breakfast Engagement

As part of the campaign's conclusion, one media breakfast engagement supported by PATH was held to consolidate and wrap up the Big Catch-Up initiative. This event brought together key media stakeholders, government representatives, and immunization experts to review the campaign's achievements, discuss lessons learned, and plan for sustaining immunization efforts. The session also provided an opportunity to appreciate media practitioners for their role in amplifying immunization messages and countering misinformation.

Monitoring and Evaluation

The program developed a robust monitoring and evaluation strategy for the BCU ranging from data management to reporting and dissemination.

The M&E strategy for the BCU was categorised into two phases:

1. **Pre-Implementation:**

House to House (H2H) registration of all <5-year children's data:

House-to-house registration was done prior big catch-up to identify and list all eligible individuals, particularly children, in a specific area who are due for vaccination. Children registered facilitated the development of EPI micro-planning

The house to House registration forms were developed and designed targeting all under 5 year children including their vaccination status.

The data from House to House registration was used in the mobilisation and tracking of un/under immunised children. The data set summarised from house to house registration was secured in the MOH ODK database for future use especially defaulter tracking and deployment

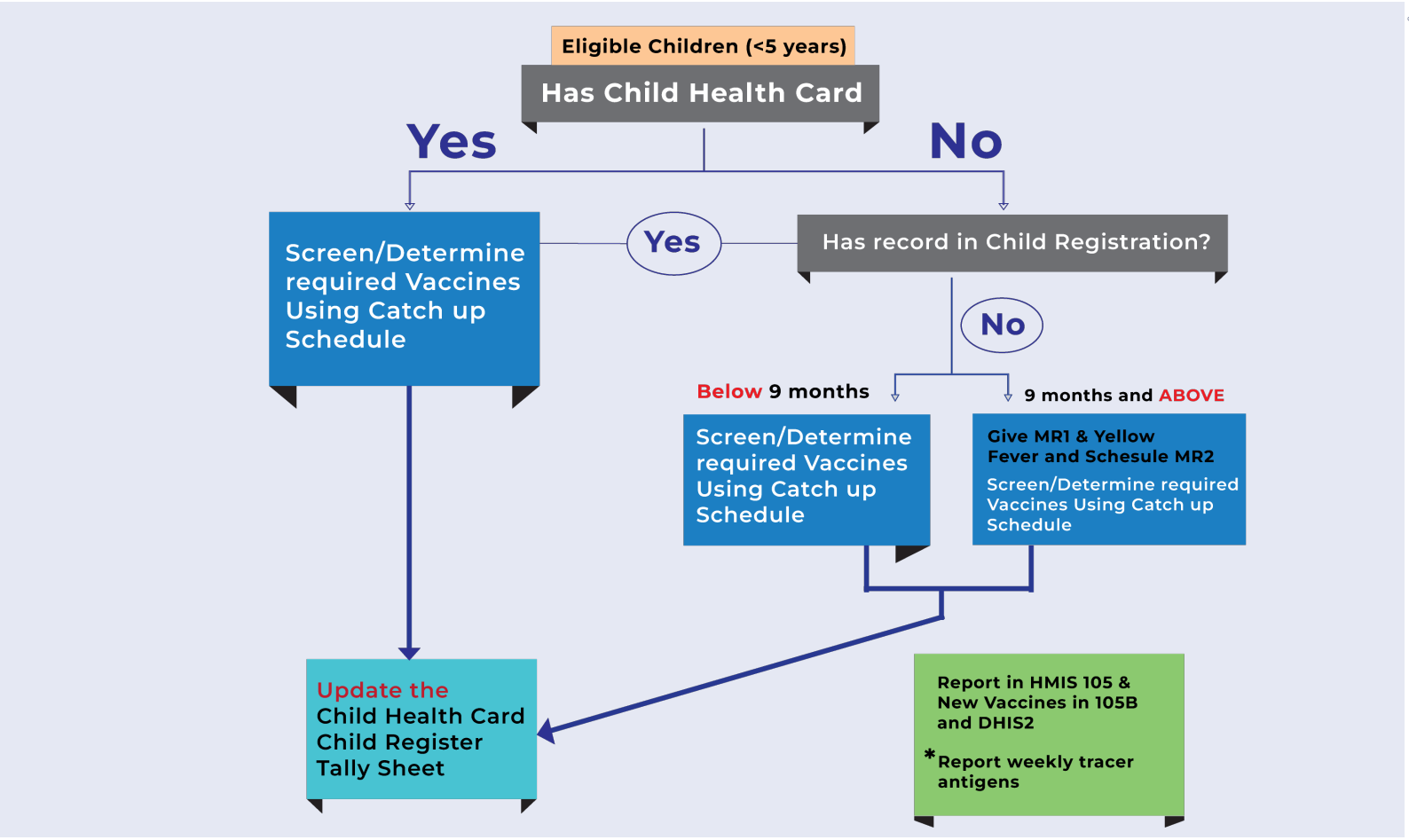
Readiness assessment: Three(3) sets of readiness assessments at both national and sub national levels were done to assess the level of preparedness across all immunisation core components (pillars)

The readiness assessment was conducted through virtual and physical engagements. The assessment was done to provide actionable insights into infrastructure, human resources, supply chain systems, healthcare worker capacity, and community engagement mechanisms. The standard supplementary immunization activity (SIA) readiness assessment tool was shared with districts to keep updating the status of the key areas of; 1) planning, coordination and financing, 2) vaccine, cold chain and logistics, 3) Training of SIA for quality, 3) Monitoring and supervision and 4) Advocacy, social mobilization and communication.

District led readiness assessments were conducted 1 month to the implementation of the big catch up. Using a contextually pre-designed tool shared with districts, a series of virtual meetings were conducted with the districts to ascertain district preparedness basing on the completeness of the tool. A district was only allowed to start implementation once it was 80% and above ready

During Implementation Recording

Routine data tools (HMIS) including Child Health Card, HPV/TD card, Child Health Register. HPV/TD register and Tally sheets were used during Big catchup for both zero dose and under immunised children both at static or outreach. Below is the guidance used to record children during big catch up



The Data Management flow chart for Measles outbreak responce districts that did non selective vaccination, special Measles vaccination cards were used

Reporting

Daily reporting

To support real time monitoring, daily reporting tools were designed to support reporting of tracer antigens ie BCG, DPT1,DPT3,MR1,MR2,HPV1 and TD2+. The daily reports were reported to EPIVAC (DHIS2 Instance). This helped in real time monitoring on daily basis which helped in decision making especially deployments.

Measles outbreak districts reported measles vaccination data through EPIVAC (DHIS2).

Monthly reporting: At the end of the month, all the outputs from big catch up was aggregated into monthly report (HMIS 105). The monthly data (BCU data) was reported to DHIS2 system.

Facility Reporting rates was 91% (4110/4507 facilities).

Routine data tools were used during BCU

Post-Implementation

Data Verification and Cleaning

The team followed up with the district biostatisticians on the quality of the data submitted before the data could be analyzed and shared with both national and district level stakeholders.

At the end of the month of implementation, data was entered into DHIS2 by the 15th day of December 2024. Between 15th and 31st December 2024, the national data management team conducted data verification and validation. Districts with outliers, inconsistencies and incompleteness were identified and followed up to clean.

In order to further improve the quality of the BCU information for decision making, data triangulation was conducted to improve the quality of the analytics from the BCU.

Daily feedback meetings

The information generated from the daily data reported through the EPIVAC was shared at the national, regional and district stakeholders including the implementing partners. Daily virtual meetings were conducted to disseminate the information for corrective action

Performance review meetings

A national stakeholder meeting was conducted to assess the performance of the BCU against the set targets. The performance review of the BCU focused on all the pillars of the program with emphasis on lessons learnt from the intervention. The meeting involved MOH team, District Health Team (DHO, ADHO-MCH & Biostat)

Data use

The EPI dashboard was designed to visualise and promote data use for evidence based decision making. The District Health Teams(DHO, ADHO-MCH & Biostat) were trained on how to navigate the DHIS2 dashboard to promote data use for immunisation

Big Catch up Results

At national level, the big catchup targeted to reach 95% of the 329,359 zero-dose children, however, we vaccinated 292,907 (89%)

DPT3 was given to 288,960 out of the 413,350 targeted children thereby giving a coverage of 70%. Out of the 591,210 targets for MR1, we reached 570,189 (96%). Out of the 3,081,426 targets for MR2, we reached 1,557,831 (50%) as shown in the table below

Antigen	Big catch-up Target	BCU Results	BCU Coverage
(Zero-Dose	329,359	292,907	89%
Under Immunized (DPT3)	413,350	288,960	70%
Under immunized (MR1)	591,210	570,189	96%
Under immunized (MR2)	3,081,426	1,557,831	50%

Reaching Zero-Dose Children (DPT1 Coverage)

Seven regions reported over 90% coverage for DPT1 while 6 regions reported coverage of between 80 and 90%. The highest DPT1 coverage was reported in Bugisu, Kampala and Teso regions. Karamoja and Bunyoro had the least percentage of 56% and 69% respectively. See the Map below.

Figure 1: Big catch-up DPT1 Regional Coverage

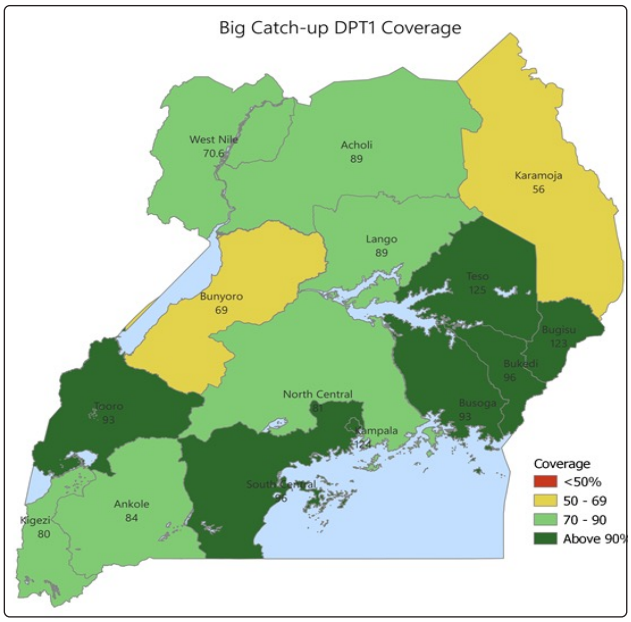
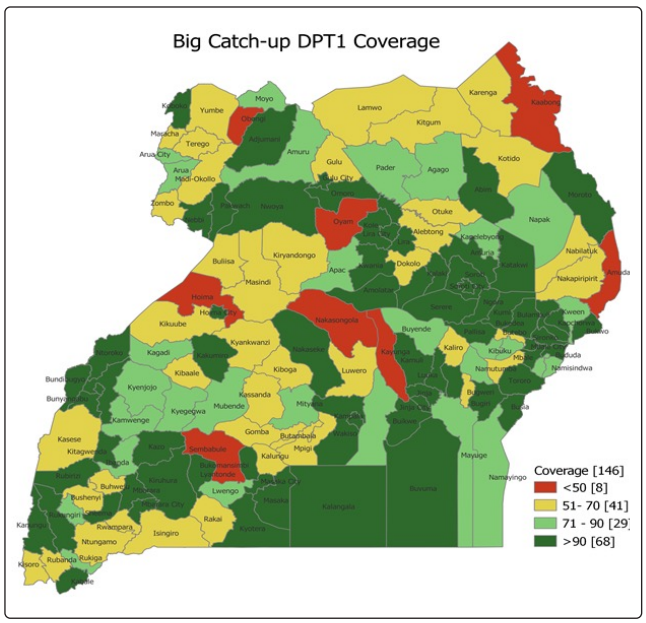


Figure 2: Big catch-up DPT1 district Coverage



60/146 districts (47%) reached over 90% of the target for DPT1. Low coverage (less than 50%) was registered in 8 districts spread across different regions.

Reaching the under-immunized BCU DPT3 Coverage

Five regions reported coverage between 80 and 90 percent for DPT3, while three regions reported coverage over 90 percent. The regions of Bugisu, Kampala, and Teso still had the highest DPT3 coverage. Six regions had a coverage of between 50% and 69%.

Karamoja had the lowest DPT3 coverage rates of 48%. See the map below

Figure 3: Big catch-up DPT3 Under immunised performance (DPT3 regional Coverage)

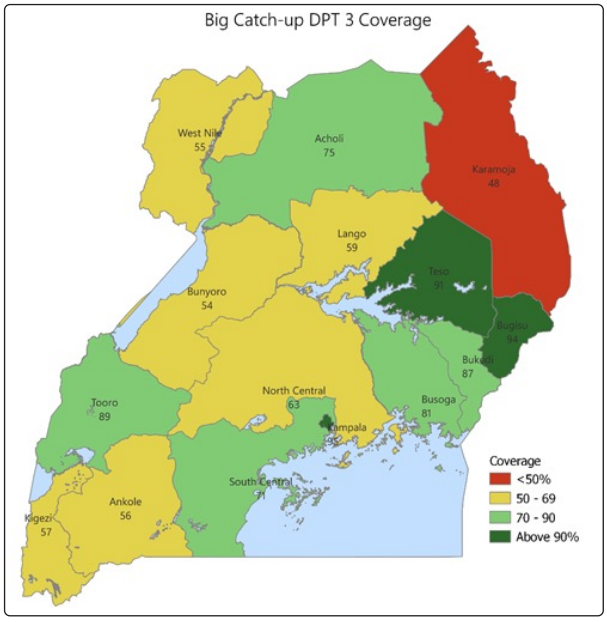


Figure 4: District level BCU Under immunised performance (DPT3 district coverage)

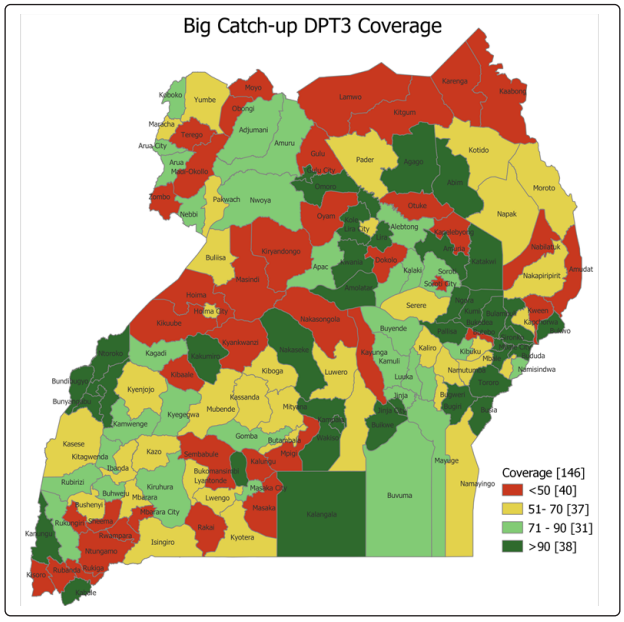


Figure 5: BCU MR1 Regional Coverage

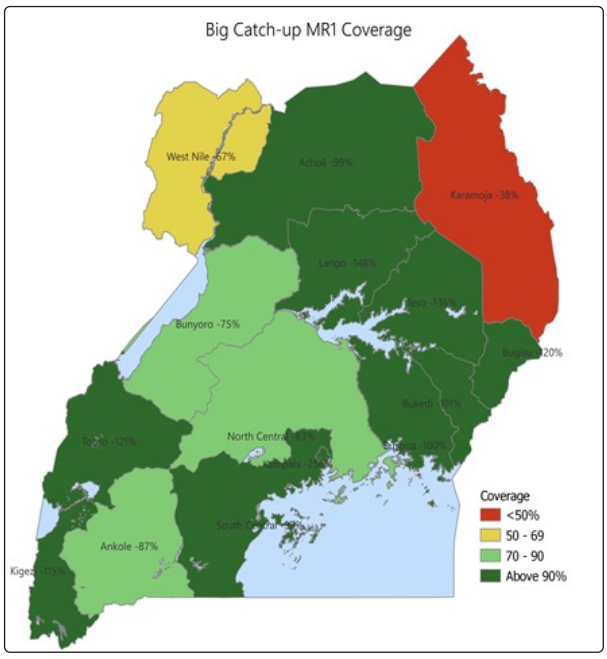
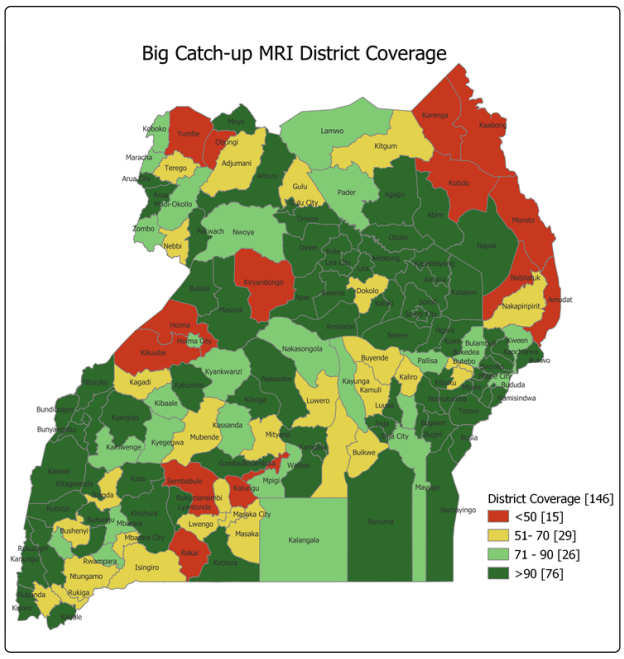


Figure 6: District MR1 BCU coverage



Summary Table of BCU Regional Coverage for DPT1, DPT3 and MR1

Region	DPT1 Coverage	DPT3 Coverage	MR1 Coverage
Acholi	89	75	99
Ankole	84	56	87
Bugisu	123	94	120
Bukedi	96	87	101
Bunyoro	69	54	75
Busoga	93	81	100
Kampala	124	95	256
Karamoja	56	48	38
Kigezi	80	59	115
Lango	89	59	148
North Central	81	63	83
South Central	96	71	93
Teso	125	91	136
Tooro	93	89	121
West Nile	70	55	67
Overall	89	70	96

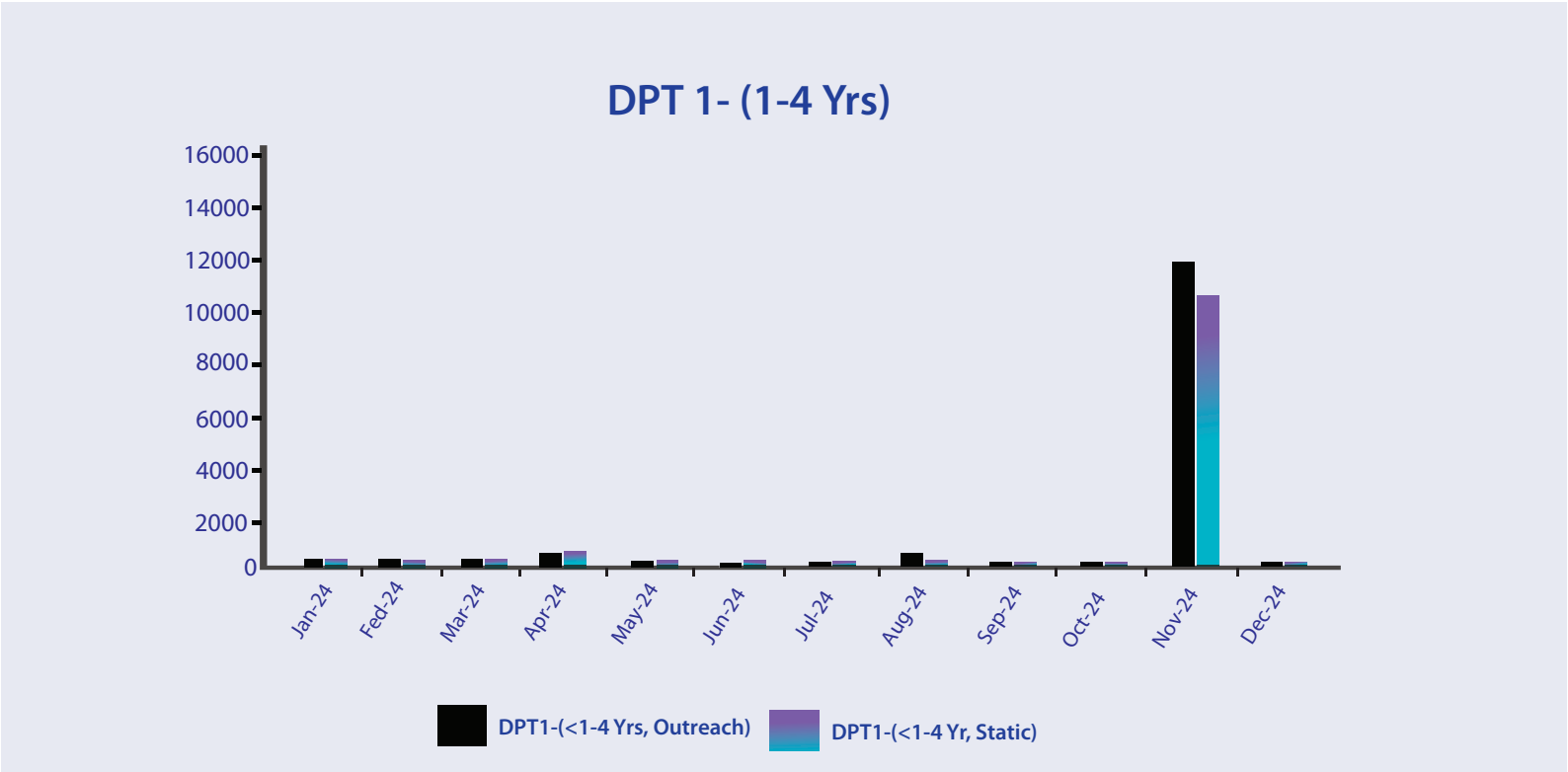
Number of children reached by age

Out of the 306,432 zero dose children reached, 13,525 children were above one year (1-4 years). Out of the 306,059 children reached with DPT3, 17,099 were in the age blacket of 1-4 years. Out of 570,189 children reached with MR1, 389,472 were in the age range of 1-4 years. And all the children reached for MR2 were in the range of 1-4 years (1,557,831)

Antigen	Results		
	Under-1 BCU Results	1-4 Yrs BCU Results	Total
DPT1	292,907	13,525	306,432
DPT3	288,960	17,099	306,059
MR1	171,717	398,472	570,189

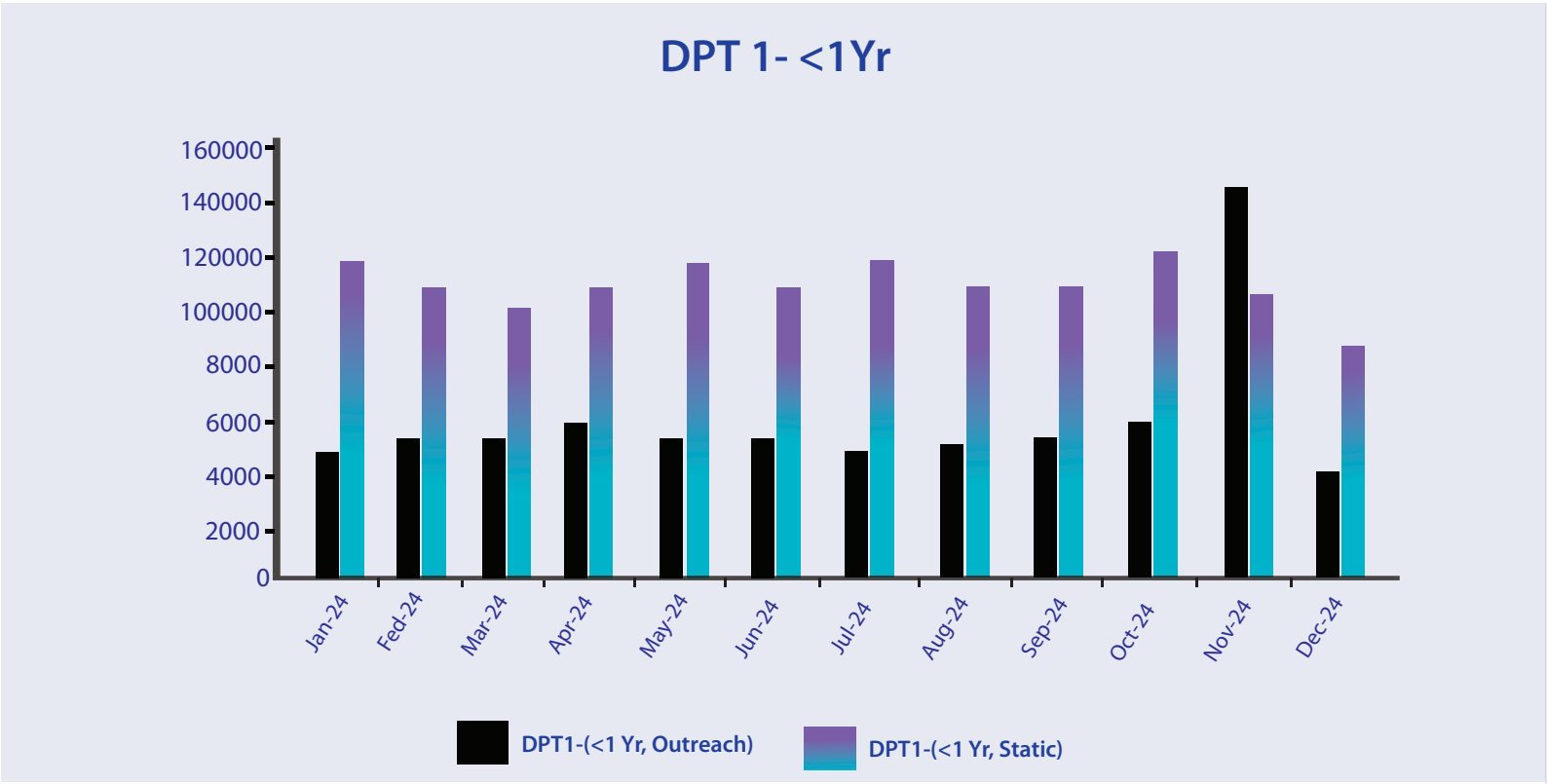
Attribution to Reaching zero dose children (1-4 years) during BCU

During the Big catch up month, We reaching to more zero dose children (1-4 years) in an outreach mode and over and above the average numbers the program is able to reach with routine immunisation as illustrated in the graph below



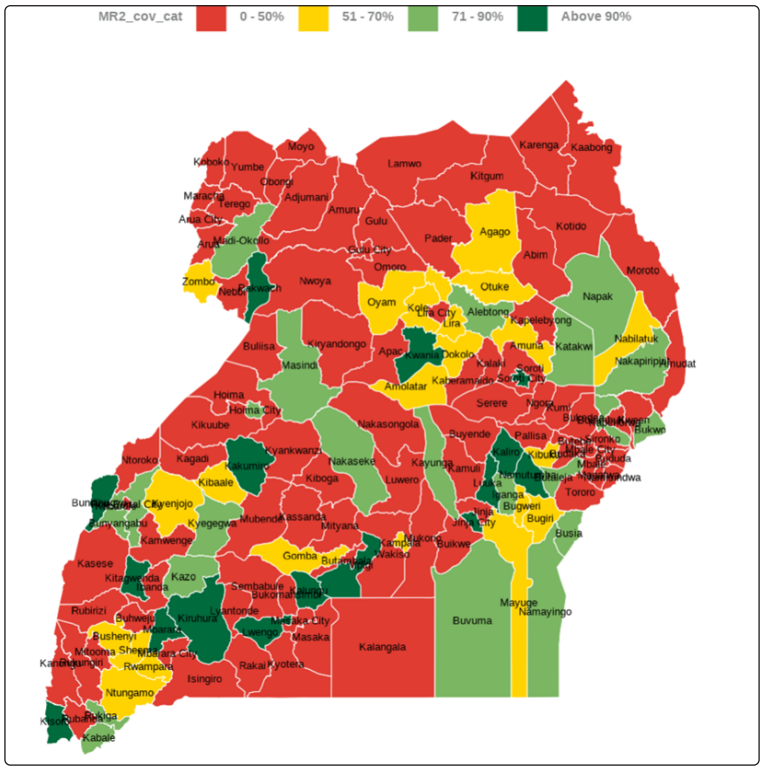
Attribution to Reaching zero dose children (<1 years) during BCU

During the Big catch up month , the program reached to more children under one through outreach efforts above and beyond the typical numbers of children who are vaccinated through routine immunization services as illustrated in the graph below



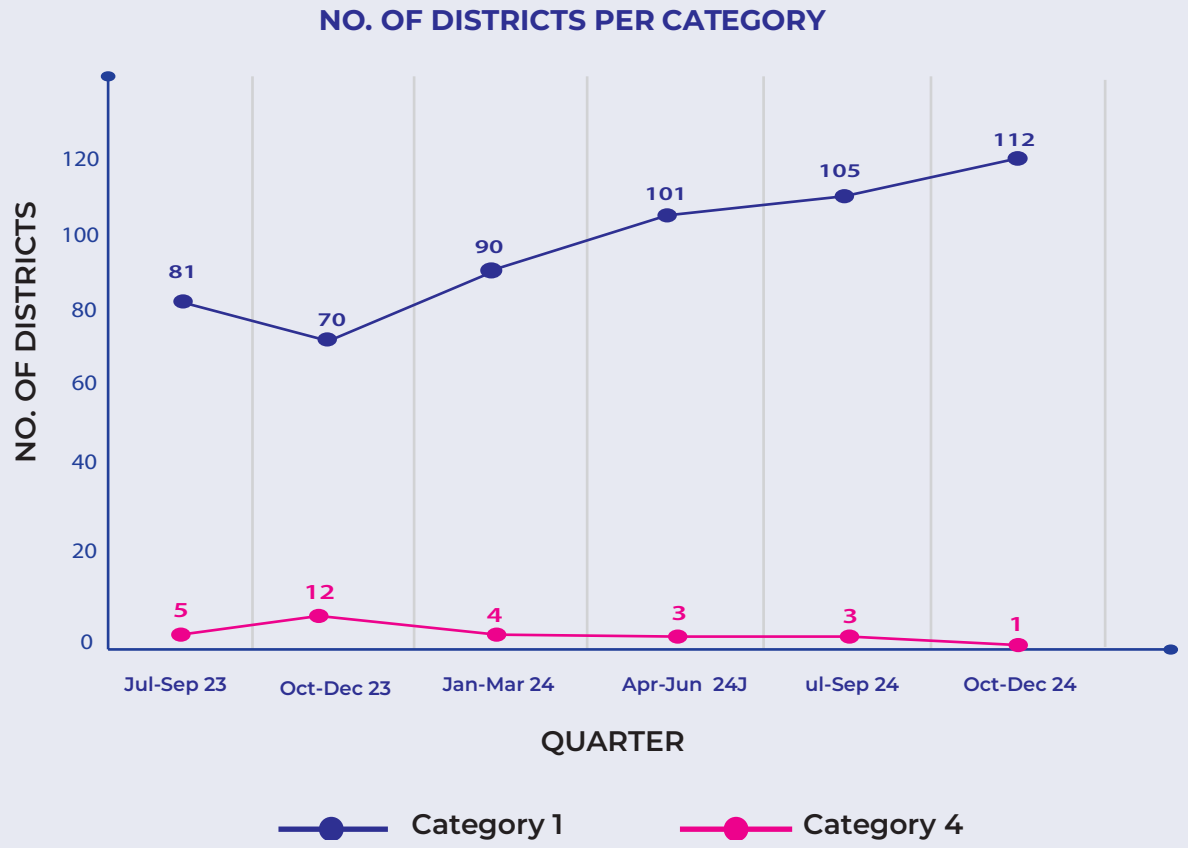
Reaching the under-immunized (MR2)

Most of the districts did perform below 50% MR2 coverage from the target (2 cohort target). At national level, 50% of the targeted children were reached during Big catchup

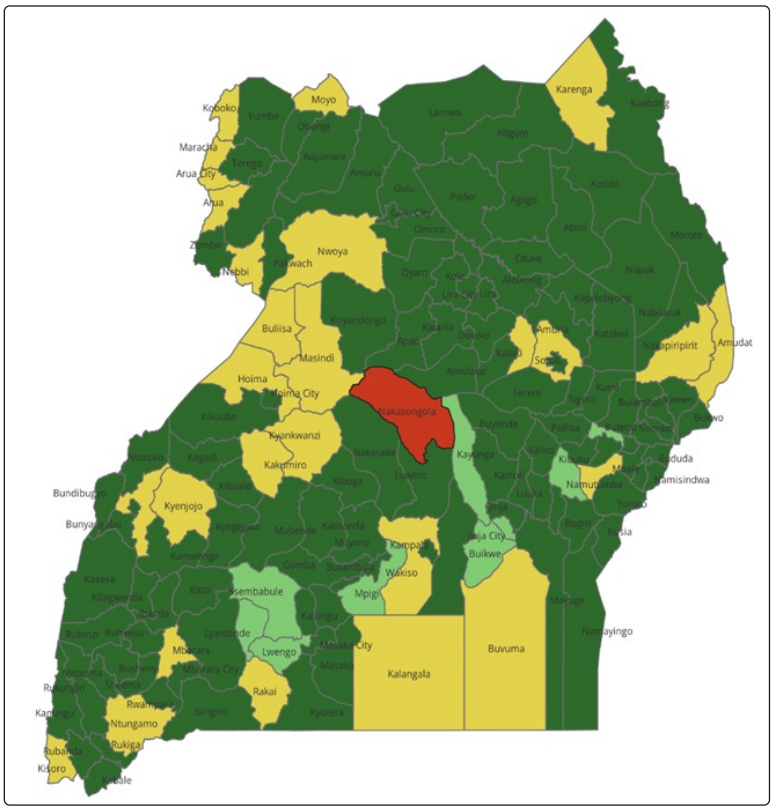


Categorisation after Big catch up

To assess effective program performance, EPI categorisation was done. Notably the program was able to push more districts to category one and lessen districts in category 4 in the quarter Big catch up was implemented



EPI Categorisation after Big catch up



Only one district (Nakasongola) remained in category 4. The district was followed up, a root case analysis done and supported to improve

Challenges during Big catch up (By Pillar)

Program Management and Finance

- Competing Priorities/ activities in the districts: The overlap of the campaign with other health interventions and community programs like the OPM assessment,Mpox outbreak activities stretched available resources especially the human resource and created scheduling conflicts and delays in the implementation of the activity.
- Integration of services continues to challenge the HR available for the exercise. Whereas increasingly more components are suggested to be added, the teams find it hard especially at outreaches. The BCU incorporated Praziquantel administration in 75 districts from the program of Neglected Tropical Diseases, Surveillance Vitamin A and Deworming administration and other Maternal child health services
- Some regions had minimal or no support by regional Implementing partners to facilitate /support the activity.
- The first week had PLE examinations which affected some activities and vaccination in schools.
- Heavy rainfall disrupted outreach activities, making roads impassable and delaying vaccine transportation to remote areas.

Challenges in Reaching the zero dose and under immunised children in the hard to reach areas during BCU

Service Delivery

- The late start of daily outreach sessions by the vaccination teams affected the utilization and uptake of the services.
- Vaccination teams faced significant challenges of tracing vaccination records for children, girls and WCBA who had already received one or more doses of the eligible vaccine records. This lack of accurate record-keeping often resulted in target groups receiving multiple doses of the vaccines.
- Fatigue of health workers and DHTs from multiple vaccination exercises and other competing priorities hampered readiness in certain areas causing delays in implementation
- Inadequate stock of some essential supplies and vaccines (Hep B, HPV, Vit A and Dewormers) affected uptakes despite the demand created.
- Vaccination outreaches were significantly affected by natural barriers particularly Hard to Reach areas, which affected both accessibility to service delivery.
- Continued measles outbreaks. 14 districts registered measles outbreaks in January 2024

Vaccine Supplies and Logistics

- Delayed delivery of logistics and supplies to health facilities (Last Mile Delivery)
- Cold Chain Constraints: Inadequate cold chain infrastructure like vaccine carriers in some districts led to difficulties in implementation and staggering option considered
- Poor temperature monitoring in some facilities due to lack of fridge tags that arose from expiries of fridge tags
- Knowledge gap in vaccine management especially among the health workers

Advocacy, Communication and Social Mobilisation

- In some areas, insufficient community mobilization and weak collaboration with local leaders hampered efforts to generate demand and ensure household-level participation.
- Pockets of vaccine hesitant parents/Caretakers in some communities were preventing their children from attending school on vaccination days, with some families fleeing their homes upon seeing vaccination teams.
- Misinformation and miscommunication among some anti vaxxers
- competing Media space

Monitoring and Evaluation

- Denominator challenges: Due to the dynamic nature of the populations, The populations from Uganda Bureau of Statistics (UBOS) is not reliable since it doesn't take care of the nomadic nature of the populations like Influx of refugees, Security displacement, Cross boarder movements, Rural Urban migration, pastoral nomads etc. this sometimes causes moving denominator causing over performance in some areas
- Inadequate Use of Data : Districts do not regularly use data to identify gaps that affect access and utilization of EPI services. Inadequate data use affects planning, decision making, and resource mobilization.
- Inadequate Data Collection Tools: A widespread shortage of data collection tools was observed across districts, primarily due to many teams going out. This impacted timely and accurate data recording, leading to potential gaps or inconsistencies in vaccination reports. Without the necessary tools, health workers faced challenges in documenting immunization activities effectively.
- Delayed Implementation of the House-to-House Registration: The house-to-house registration exercise was designed to provide essential statistics for planning and implementing immunization activities. However, inconsistencies in execution were observed across districts with some delayed implementation,. These delays disrupted the availability of accurate and timely data, which in turn affected resource allocation, target setting, and overall immunization planning. As a result, decision-making processes were based on incomplete or outdated information, potentially leading to inefficiencies in service delivery.
- Data quality challenges: Some districts were reporting outliers attributed to data entry errors. Additionally, there were challenges of few or no recordings in the child health register which will affect defaulter tracking
- Good Practices and Lessons Learnt (by pillar)

Pillar	Lessons learnt
Program Management and Finance	▪ Daily feedback meetings with the vaccination teams helped supervisors to monitor progress. ▪ Regional Emergency Operation Centre are critical in supporting and coordinating vaccination activities ▪ Adequate budgeting and early mobilization of resources, including early disbursement of funds supports early planning and preparation for Big Catch Up ▪ Involvement of all key stakeholders right from planning to implantation is essential for a successful campaign. ▪ Strong Collaboration with Stakeholders: Strong partnerships with NGOs, development partners, and private sector actors can provide additional resources and technical support to complement government efforts evidenced by good performance in districts where partners extended support for the BCU activity. ▪ Good governance and leadership at district level is critical for efficient implementation of the activities.
Service Delivery	▪ Health Worker Support and Capacity Building: training and incentivizing health workers enhance their effectiveness and motivation, ensuring consistent service delivery. ▪ Integration of Health Services: Combining immunization with other health services, such as deworming, malnutrition screening, and Vitamin A supplementation, maximizes impact and improves community uptake. ▪ Timely micro plans by districts shared with the EPI program was key to providing reliable information on the target population and administrative units for funding. ▪ The vaccination catch-up schedule provided was useful and supported the BCU implementation thereby enabling the reaching out of missed opportunities under immunised and zero doses. ▪ Timely availability of funds at district level motivates the district teams hence success to BCU. ▪ Mapping ERGS helps to focus immunization efforts where they are most needed, ensuring that no one is left behind.

Vaccine Supplies and Logistics	▪ Cold Chain Investments: Expanding and maintaining cold chain infrastructure, especially in rural areas, is crucial for ensuring vaccine quality and preventing wastage. ▪ Timely delivery of vaccines and other supplies by NMS improves timely availability of supplies at the service point ▪ Proper maintenance of the cold chain led to improved quality of the vaccines during implementation. ▪ Prior development of logistics distribution plans promoted timely last mile distribution of supplies from district level.
	▪ Availability and use of waste management guidelines improved handling of waste generated during BCU
Advocacy, Communication and Social Mobilisation	▪ Ongoing sensitization and education campaigns, using trusted community voices, can significantly reduce misinformation and improve vaccine acceptance. ▪ Active involvement of community leaders, cultural institutions, and grassroots organizations is critical for building trust, addressing vaccine hesitancy, and mobilizing households to participate in immunization program
Monitoring and Evaluation	▪ House to house registration provides actual data of the target population for the vaccinating teams if well conducted and must be done two to 3 weeks prior to the implementation. ▪ Real-time data collection tools and electronic reporting systems are vital for monitoring progress, identifying coverage gaps, and ensuring timely decision-making. ▪ Digitisation of immunisation workflows to foster Electronic Immunisation Registry(EIR) improves data quality and defaulter tracking ▪ House to House registration provided guidance to vaccinators where the pockets/hot spots of unimmunised children were. (Zero dose Identification)

Pillar	Recommendation
Program Management and Finance	▪ Continuously Engagement of DHTs leadership especially DHOS ▪ Support subnational support supervision for continuation of services ▪ Continuously Engagement of DHTs leadership especially DHOS ▪ Support subnational support supervision for continuation of services
Service Delivery	▪ Continuous Immunization in Practice training to new staffs including gate keepers (COs, MOs). this will include the catch up guidance ▪ Map and train specialized clinics to on board them on immunization
Vaccine Supplies and Logistics	▪ Scale last mile delivery to improve availability of vaccines ▪ Introduce and scale eLMIS (Electronic Logistics Management system)
Advocacy, Communication and Social Mobilisation	▪ Continuous social mobilisation with different media platforms all through the months ▪ Continuous collaboration with Health and Non Health Stakeholders ie Ministry of Education, Ministry of Local Government, Cultural and religious leaders etc ▪ Continuous advocacy to improve second year of life platform ▪ Leverage on CSOs for continuous demand generation
Monitoring and Evaluation	▪ Print adequate EPI HMIS tools to support registration and track defaulters ▪ Train health workers in Data management and continuously support the Data Improvement Teams ▪ Digitization of EPI workflows in the electronic Immunization Registry

Conclusion

Uganda has indeed made significant strides in improving its immunization coverage, particularly through initiatives like "big catch-up". This Big catch up was designed to reach children who have missed routine vaccinations, often due to disruptions in healthcare services, geographic barriers, or other challenges including those were affected by the COVID Pandemic restrictions.

REPUBLIC OF UGANDA

MINISTRY OF HEALTH

BIG CATCH UP (BCU) REPORT