



Ministry of Health

NATIONAL
CHILD SURVIVAL STRATEGY

BRIEFING PAPER FOR POLICY MAKERS
AND PLANNERS

2009/10 – 2014/15

DECLARATION MADE BY HEADS OF STATE AND GOVERNMENT

“We, the Heads of State and Government meeting at the fifth Ordinary Session of the Assembly of the African Union in Syrte, Libya from July 4th to July 5th 2005 Pledge and Resolve to commit our political capital towards improving on child survival in Africa, and using our national resources, and with the support of the international community, to reduce the annual number of child deaths occurring in Africa by 1.5 million by 2010, in order to achieve MDG4 by 2015. We know what works, and we are committed to make it happen.”

The Sirte Declaration on Child Survival.

Fifth Ordinary Session of the Assembly of the African Union in Sirte,

the Libyan Arab Jamahiriya,

4-5 July 2005

INTRODUCTION

Child survival, which refers to the survival of children under-five years of age, is a major public health concern in Uganda. The past 20 years have witnessed modest improvements in child survival, due to public health interventions and improving economic and social performance. Nevertheless, more than 200,000 children under-five years die every year, mainly during the first year of life. With this performance **Uganda is among the top 10 countries in the world with the highest number of deaths of under-five children**. According to the most recent Uganda Demographic and Health Survey, between 1990 and 2006, under-five mortality declined from 167 to 137, a reduction by only 18% for the 16 year period or an annual reduction of 1.5%. Uganda needs to accelerate this trend and reduce mortality by 9.1% annually if the Millennium Development Goal # 4 (MDG 4), to reduce by two-thirds the mortality rate among children under-five is to be achieved by 2015.

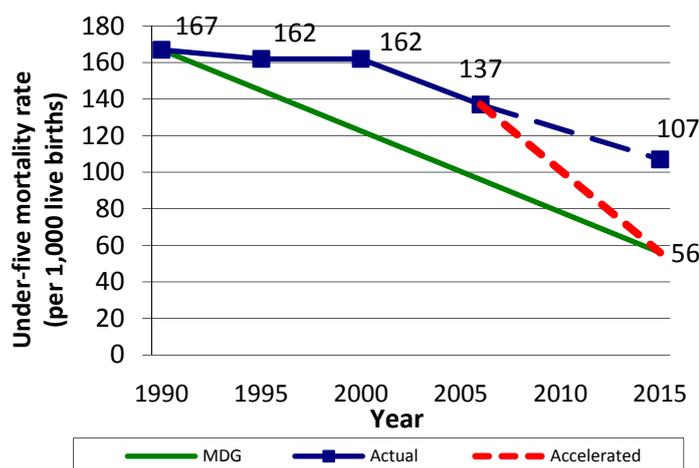
The level of child mortality in across Uganda is uneven. Infant deaths, those in the first year of life, contribute 55% of under-five mortality, of which the first 24 hours of life is the most vulnerable period. Under-five mortality is also much higher rural areas, specifically in South-western, Northern and Northeast (Karamoja) regions.

The majority of deaths in children under-five are due to a small number of common, preventable, and treatable conditions including malaria, pneumonia, diarrhoea, vaccine-preventable diseases (e.g. measles), HIV/AIDS, and neonatal conditions, occurring singly or often in combination with malnutrition. The key to making rapid progress towards attaining MDG 4 is to reach every newborn and every child in every district and village with a priority set of high impact

interventions, with emphasis on saving the lives of the very young living in remote, poorly developed regions. Child survival interventions are well known and affordable, for which evidence on a global level has shown when implemented universally can prevent over 60% of current childhood mortality. With only 8 years remaining to achieve the MDG targets, what is needed now is not new science, but a new and serious commitment to prioritize, allocate resources to, and accelerate child survival efforts in Uganda.

The purpose of the Child Survival Strategy is to provide policy makers and practitioners alike with a clear direction on the priority actions required to reduce the unacceptable burden of child deaths in Uganda.

Figure 1 Uganda is off-track for achieving MDG-4, reduction in child mortality, and needs to accelerate progress to achieve its MDG 4 target



UGANDA'S COMMITMENT TO CHILD SURVIVAL

The **Uganda Constitution** and the **Children Act** provide the legal framework for protection and promotion of child health. Commitment to the fulfilment of these rights is evident in the comprehensive development programme pursued by the Government of Uganda, which has seen important progress over the past decade, particularly in terms of economic growth, macroeconomic stability, and poverty reduction. Under the guise of the forthcoming National Development Plan (NDP), the government aims to consolidate and expand earlier

gains of the Poverty Eradication Action Plans (PEAP), including improvements in social sectors. At sector level, the Health Sector Strategic Plans (HSSP) has aimed to fulfil the child survival goals by ensuring the effective implementation of the Uganda Minimum Package of Health Services. The Child Survival Strategy is a detailed recommendation on steps needed to fulfil the minimum package of health services for children.

In addition, the Government of Uganda is signatory and actively participates in international and regional treaties and conventions, including the 1990 United Nations Convention on the Rights of the Child, the WHO/UNICEF global consultation on Child and Adolescent Health and Development held in Stockholm in 2002, emphasizing the inherent right to life and the urgency to reduce child mortality for future prosperity, and The Delhi Declaration (2005) on maternal, newborn and child health and the subsequent 58th World Health Assembly Resolution call for the highest political commitment to achieve universal coverage of maternal, newborn and child health interventions and to reach MDGs 4 and 5. In Africa, the African Charter on the Rights and Welfare of the Child, and more recently, the African Union Assembly Tripoli Declaration on Child Survival in July 2005, recognizes a pressing duty to accelerate action for child survival. The African Union decision calls upon all Member States to mainstream child survival into their national health policies. Health and child survival in particular, has been prioritized by the New Partnership for Africa's Development. Furthermore, the African Peer Review Mechanism, a concept of assessment and design of the African Union, is giving emphasis to the monitoring of MDGs, particularly MDG 4 on reducing child mortality.

THE CHILD SURVIVAL STRATEGY

The preparation of the Child Survival Strategy has been a long process involving the contributions and expertise of many individuals and organisation working for child survival in Uganda. The strategy building process started from the evidence-base on high impact, effective child survival interventions as clearly outlined in the Lancet Series on Child Survival published in 2003¹ and expanded with specific evidence for newborn survival in 2005². From the evidence-base of proven interventions, child survival experts in Uganda have examined the potential for increasing coverage and reducing the burden of child mortality and recommended appropriate actions based on the main constraints and the potential of new approaches to increase coverage of key interventions. As proven, high impact, child survival interventions reach across many specialities, the Strategy adopts a broad, intersectoral approach.

The analytical processes for preparation of the Strategy was support by the Marginal Budgeting for Bottlenecks (MBB) toolkit developed by UNICEF and the World Bank with technical inputs from WHO, UNFPA, UNAIDS as well as many others. Following the steps of the tool, the Strategy has mapped the current or baseline coverage of key interventions, assessed the bottlenecks to improved coverage, and matched the proposed, realistic expansion of coverage targets to likely impact and additional costs. The Strategy presents an intervention package and accompanying actions and targets to be implemented that are expected to achieve or exceed the MDG #4 target. As part of the process, less ambitious and more ambitious scenarios were considered – these are documented in the longer Strategy paper.

Based on global evidence as well as careful and critical review of the current performance and bottlenecks of child survival interventions in Uganda, the Child Survival Strategy outlines a detailed approach to prioritise key interventions and actions towards rapid reduction of child mortality and morbidity. Under the overall goal to

¹ Jones, G., Steketee, R. W., Black, R. E., Bhutta, Z. A., Morris, S. S., & Group, t. B. (2003). *How many child deaths can we prevent this year?* The Lancet , 362, 65-71.

² Darmstadt, G. L., Bhutta, Z. A., Cousens, S., Adam, T., Walker, N., de Bernis, L., et al. (2005, March). *Evidence-based, cost-effective interventions: how many newborn babies can we save?* The Lancet , 19-30.

reduce the under-five mortality rate, three strategic objectives to address the main bottlenecks of child health interventions delivery at household and community level, population level, and at clinical/facility level are identified.

GOALS AND OBJECTIVES

Goal: To reduce the under-five mortality rate from 137 per 1,000 live births to 56 per 1,000 live births by 2015.

Overall objective: To scale-up and sustain high, effective coverage of a priority package of cost-effective child survival interventions.

Strategic objectives:

1. To increase **availability** of essential health inputs and **access to** service providers of cost-effective child survival interventions.
2. To improve **demand** and **utilisation** of cost-effective child survival interventions.
3. To enhance **quality** of cost-effective child survival interventions.

THE INTERVENTION PACKAGE

The Strategy has adopted a broad, intersectoral approach, including the highest impact, evidence-based interventions and strategies proven to reduce under-five mortality, such as water and sanitation, malaria/HIV prevention control as well as treatment of common illnesses and conditions. The priority, high-impact child survival intervention package to be implemented and scaled up include the following:

- Maternal and newborn healthcare: promotion and expansion of antenatal care and postnatal care/visits, clean and skilled delivery in facilities, newborn resuscitation, newborn temperature management as well as improved management of pregnancy complications (e.g. PPROM, eclampsia, EmONC) that affect mother and infant, antibiotics for neonatal sepsis, treatment of neonatal jaundice;
- Appropriate treatment of major childhood diseases: ORS/T + therapeutic use of zinc for diarrhoea, antibiotics for pneumonia and dysentery, management of malaria/HIV (see below) with expanded effort to integrate malaria and pneumonia management at the community level in some areas;
- Vaccination against preventable diseases: tuberculosis, diphtheria, tetanus, pertussis (DPT), polio, measles, Hepatitis, *Haemophilus influenzae*, pneumococcal, rotavirus with expanded efforts for integrated outreach and campaigns to cover the hard-to-reach populations with a wider service package;
- Nutrition interventions: promotion of early, exclusive, and prolonged breastfeeding, complementary feeding, vitamin A supplementation; as well as growth monitoring and referral of complicated malnutrition cases to facilities for treatment relying heavily upon trained VHTs to counsel families;
- Malaria prevention and treatment: insecticide-treated bednets (ITNs), indoor residual spraying (IRS), diagnosis and treatment using ACT at community and facility level, intermittent preventive treatment in pregnancy (IPT);
- HIV prevention and treatment: PMTCT, early detection of infant HIV infection, cotrimoxazole prophylaxis for children of HIV+ mothers, ARVs for HIV+ children;
- Water and sanitation interventions: adequate quantity of clean water, proper sanitation, hygiene improvement.

STRATEGIC APPROACHES

The strategic approaches outlined below cut across the strategic objectives and have guided the formulation of actions to be undertaken and prioritisation of those actions in line with the NDP.

- a) *Empower families and communities*, especially the poor and the marginalized, to improve key childcare practices and to make the management of malaria, pneumonia and diarrhoea possible within the community. Available evidence points to a great opportunity to support communities at relatively low cost to improve the well-being of children. While many intervention require health facility and skilled health worker inputs, a great deal will be achieved by helping communities to address priority health needs. In addition to support on specific interventions and in line with national policy of decentralisation, community involvement in governing clinical health services would be fostered as well.
- b) *Strengthen the health system*, by building capacities at all levels of the health sector, both in terms of human resources and physical infrastructure (through consolidation). Priority will be given to health system investments that are anticipated to bring rapid returns in terms of improvements of child survival interventions. At the same time, a long-term view will be maintained to develop a strong and stable health system for future generations. Health system inputs will avoid excessive infrastructure investments by consolidating inputs in existing facilities and task-shifting, where possible, to lower levels of the health system.
- c) *Integrate and harmonize maternal, newborn and child survival efforts*, by invigorating collaborative working relationships at both policy and operational levels to gain greater efficiency in implementation while recognising the commonality of objectives. At a national level, the MOH plans to organise itself around MCH, in many ways mirroring the service delivery at grassroots level.
- d) *Organize and expand operational partnerships*, by formally and informally engaging NGOs, private sector, donors and other stakeholders in joint planning, implementation, and financing and performance review of child survival activities.
- e) *Mobilize additional resources* — at local, district, national and international levels for child survival. To scale up proven child survival interventions, resource mobilization and allocation will rely on district capacity to plan, implement, and use monitoring results as a strong advocacy support for leveraging resources. While additional financial resources will be critical, additional support for demand generation and supervision should be tapped at local levels, drawing in community leaders and institutions as well as civil society organisations as ‘resources’ to advance child survival.
- f) *Expand knowledge and evidence base for child survival* including formative research on new interventions and implementation strategies, rigorous, systematic monitoring programme implementation, and joint evaluation of performance. Drawing upon the wide range of stakeholders, including, but not limited to, civil society / academia, community and professional organisations, private sector, as well as traditional implementators, collect and critically analyse qualitative and quantitative data that will contribute to more effective implementation of the Strategy.

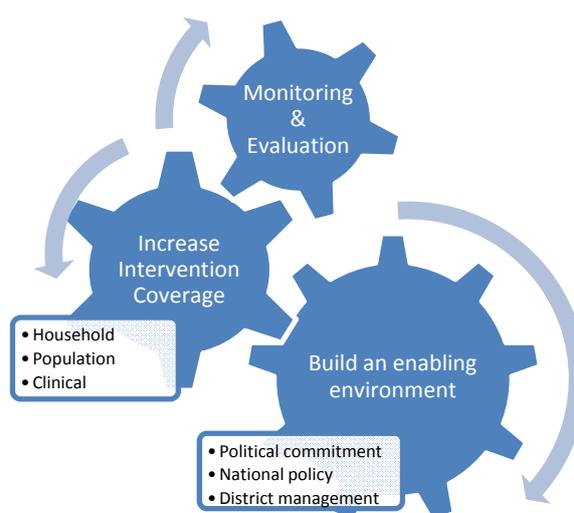
Box 1 Principles guiding the Child Survival Strategy

- Results-based orientation
- Equity, ensuring equal access and utilisation of key interventions
- Advancement of child rights
- Integration to maximise efficiency
- Multi-sector collaboration
- Expanding partnerships across public and private sectors
- A life cycle perspective on child health

IMPLEMENTATION FRAMEWORK

The implementation framework organises the main activities planned for fulfilment of the three strategic objectives as outlined above. To systematically plan actions to increase intervention coverage, the Strategy has been organised around three “service delivery modes”, namely *family-oriented, community-based services* that are supported or delivered by Village Health Teams (VHTs) with periodic supervision from skilled health staff; *population-oriented, schedulable services* that require trained health workers with basic skills (e.g. enrolled nurses/midwives) and that are delivered either by outreach or in health facilities in a scheduled way; and *individually-oriented, clinical services* that require health workers with advanced skills namely registered nurses, midwives, clinical officers, and physicians available on a round-the-clock basis in HC III, HC IV and hospitals. In addition, improvements in the enabling environment are needed, including political commitment as well as improvements in the district and national capacity for policy, planning, and management. Finally, monitoring and evaluation to guide policy makers and practitioners in the corrective actions required during the implementation of the Strategy.

In total 21 priority outputs have been identified. These are presented below with a short explanation. Detailed discussion of actions to be taken is given in the longer paper. In many cases, linkages across the service delivery modes are needed to promote demand, ensure effective referral, and provide supervision.



FAMILY-ORIENTED, COMMUNITY-BASED SERVICES

Family-oriented/community-based services are delivered on a daily basis with support of trained Village Health Teams (VHTs) periodically supervised by skilled health staff. Patchy, inequitable and overall limited coverage of community-led interventions delivered by different volunteer cadres is currently being harmonised into a single VHT with a view to integrating efforts to provide a complete package of services to benefit the community and its children (Outputs 1, 5), supported and supervised by trained health workers (Output 6). VHTs, as volunteers, will be motivated during regular trainings and meetings and supplemented with incentives for specific, high priority activities such as post-natal visits or ITN use/promotion as resources become available.

Output 1. Improve access to fully functional VHTs.

Output 2. Increase community access to child survival commodities.

Output 3. Raise awareness and demand among community members and families

Box 2. Evidence-based interventions promoted at Community/Family Level

- Insecticide Treated Mosquito Nets
- Quality of drinking water
- Supply of safe drinking water
- Use of sanitary latrine
- Hand washing by mother
- Indoor Residual Spraying (IRS) Early initiation of breastfeeding
- Community management of LBW infants
- Exclusive breastfeeding, birth to 6 months
- Prolonged breastfeeding, 6-11 months
- Complementary feeding
- Therapeutic Feeding
- Oral Rehydration Therapy
- ACT for children
- Antibiotics for U5 pneumonia
- Management of neonatal sepsis

Output 4. Increase utilisation of community and population health services through provision of incentives and linkages to outreach activity.

Output 5. Build capacity of VHTs in priority areas

Output 6. Improve supervision / monitoring of child health and nutrition at community

POPULATION-ORIENTED SCHEDULED SERVICES

Population-oriented, schedulable services require health workers with basic skills providing services that can be delivered to groups by outreach or in health facilities following a fixed schedule. Outreach strategies can be diverse including: scheduled facility clinics, regular visits by mobile teams, biannual (e.g. CHD) or periodic campaigns (e.g. polio or measles). Building on relatively good performance The Strategy will aim to consolidate achievements and expand coverage in reach hard-to-reach areas. The introduction of rotavirus and pneumococcal vaccines is also envisaged.

While on the whole availability of supplies and access to outreach performs reasonably well, as a path-finding interventions, providing critical contacts with the health system, efforts to further improve the management of vaccines and other commodities are planned (Output 7) as well as greater community involvement in planning of services (Output 8) with intensive efforts to reach and follow-up more children on regular as well as on an exceptional basis through campaigns (Output 9) in line with the “Reach Every District” approach and targets with simplified mechanisms to access operational resources for outreach. Greater emphasis is given to ensure effective ANC services within static and outreach sessions, including support for the participation of a qualified midwives from higher level facilities, as needed (Output 8). To improve compliance and provide support for HIV+, previous PMTCT clients will be enlisted to provide in their home villages to new PMTCT clients and pregnant mothers in general (Output 9).

An important aspect of outreach is timely communication. The main channels of communication include the Child-to-Child Strategy, radios, and faith-based organizations and through letters to local leaders, which will be further strengthened (Output 10). While most health workers have required skills in immunisation, on-going refresher training will be supported to maintain those skills. In addition, extra effort will be put into strengthening skills of health workers in basic ANC/MCH and HIV testing and counselling (Output 11).

Output 7. Strengthen and maintain vaccine / micro-nutrient / PMTCT supply chain

Output 8. Integrate and expand routine outreach services to cover all interventions

Output 9. Expand involvement of stakeholders in routine outreach activities (linked to output 3)

Output 10. Expand coverage using campaigns and innovations to ensure “missed-outs” and “drop-outs” from routine services are identified, particularly in remote, underserved areas

Output 11. Strengthen health worker capacities for quality provision and monitoring of immunisation and PMTCT services

Box 3. Evidence- based interventions promoted at population level

- Antenatal Care
 - Tetanus toxoid
 - Deworming in pregnancy
 - Detection/treatment of bacteriuria, syphilis
 - Prevention/treatment of anaemia
 - Intermittent preventive treatment (IPT) for malaria
- PMTCT (counselling/testing, ART and infant feeding counselling)
- Cotrimoxazole prophylaxis for children of HIV+ mothers
- Routine immunization : BCG, OPV, DPT, Measles, HiB, Hep B
- New immunisation: rotavirus, pneumococcal
- Postpartum Vitamin A supplementation
- Vitamin A – supplementation
- De-worming children 1-14 years

INDIVIDUALLY ORIENTED CLINICAL SERVICES

Individually-oriented clinical services require health workers with advanced skills available on a 24-hour/seven days a week basis to respond to medical needs as they arise. Three tiers of the clinical health system are also distinguished by the types of services that typically provided at each tier. To focus planning and costing efforts, the level at which each specific service is supported is listed in Box 4.

The Strategy has relatively modest aims for HC expansion, focusing upon consolidation of services rather than expansion of facilities at all levels. Planned actions aim towards strengthening: the functionality of existing health facilities to offer an integrated package of curative and personal preventive services at all levels of the health care system. To ensure availability of drugs, an initial effort is needed to review the essential drugs list as it relates to newborn care as well as reinforce and supervise the timely allocation of drugs (Output 12). Significant investment is also needed in upgrading physical infrastructure and equipment of health facilities, generally and for newborn care (Output 13) as well as to ensure reliable blood supplies for emergency obstetric cases. To increase utilisation of services, a functional referral system between the levels is needed with particular emphasis on the establishment of linkages between community based child health interventions and health facility activities. Quality improvements will address both the skills of the worker (Output 15) using modular, competence-based training approaches matching the role played workers and the standards of care provided in facilities, following the BFHI (Output 16).

Output 12. Increase availability of essential commodities for management of child illness and EmONC

Output 13. Improve and expand capacity to manage normal deliveries, EmONC, and malnutrition

Output 14. Promote effective referral mechanisms from community to facility

Output 15. Increase capacity of facility-based health workers to manage common childhood illnesses and newborn illness.

Output 16. Improve quality of hospitals in line with BFHI and CFHI.

Box 4. Evidence-based interventions supported at clinical level

Primary clinical level (HC-III)

- Normal delivery by skilled attendant
- Resuscitation of asphyctic newborns at birth
- Antibiotics for pneumonia
- Antibiotics for dysentery and enteric fevers
- Treatment for measles (vit A)
- ACT for children

First referral care (HC-IV)

Services above, plus

- Basic emergency obstetric care (B-EmONC)
- Antenatal steroids for preterm labour, Rupture of Membrane (P/PROM)
- Detection and management of eclampsia
- Management of neonatal infections
- Management of neonatal jaundice
- Management of severe or resistant malaria cases
- First line ART for children with HIV/AIDS

Second referral care (District/Referral Hospital)

Services above, plus

- Comprehensive emergency obstetric care
- Emergency neonatal care (asphyxia aftercare, serious infections, VLBW infant)⁺
- Second-line ART for children
- Other emergency acute care

BUILDING AN ENABLING ENVIRONMENT

Every worthwhile undertaking needs a strong foundation. The capacity for policy formulation as well as programme management needs additional attention to plan, implement and supervise effectively and efficiently the Child Survival Strategy. Clear policy and accompanying guidelines are vital elements to guide the health system towards coherent implementation. Revision of policy and guidelines in line with the upcoming health sector review and latest developments in child survival technologies and strategies will continue through-out the Strategy (Output 17). Policy and guidelines formulation will be enhanced through active efforts to commission meaningful operational research on innovations as well as performance of on-going efforts (Output 21). Consistent with the sector and the Strategy's principles, additional effort will be put into

harmonizing strategies and activities, including IEC, to maximize the use of limited human, physical, and financial resources (Output 19). Given the highlighted gaps in management capacity, additional emphasis is also included on strengthening district and national management capacity and to provide managers with resources to effectively and regularly monitor performance (Output 18, Output 20).

Output 17. Formulation of policy frameworks and regulatory guidelines for promotion of child health interventions, especially around the VHT

Output 18. Expand district and national programme management capacity

Output 19. Ensure coordination of intervention/thematic policy across child health concerned departments.

Output 20. Nationally monitor implementation of activities to provide corrective feedback and inform policy adjustments

Output 21. Build knowledge base on critical areas of child survival

MONITORING AND EVALUATION

The aim of the monitoring and evaluation processes is to provide regular and appropriate supervision and feedback of the implementation of the Child Survival Strategy to ensure technically appropriate, efficient, equitable, and high coverage of the main interventions. As key child survival interventions are dispersed in different clusters of the Uganda National Minimum Health Care Package and across sectors, harmonised indicators and processes will be essential to avoid duplication of effort and conflicting recommendations.

Specific monitoring efforts will include:

- Supervision and monitoring to and by local governments
- Supervision and monitoring of hospitals and lower level health units by technical health workers
- Supervision of central programmes within Ministry of Health and other central institutions

Evaluations such as the follow-up UDHS and other population surveys as well as operational research commissioned to support the Strategy will be used to inform the M&E process and provide mid-term correction as required.

The main performance indicators, consistent with NDP/HSSP and complementary strategies are presented listed below:

Table 1 Summary of main child survival strategy performance indicators

Indicators	Baseline	Target
• Children under-five and pregnant women having slept under an ITN the previous night increased (MCSP)	10%	80%
• Exclusive breast-feeding rate (HSSP II)	60	75%
• DPT-3/Pentavalent-3 coverage for children 12-23 months (HSSP II)	74%	85%
• HIV+ mothers and infant dyad receiving ARV for PMTCT	14%	60%
• Children under-five getting correct treatment for malaria within 24 hours of onset of symptoms (HSSP II/MCSP)	25%	80%
• Deliveries in health facilities (HSSP II/Roadmap)	42%	70%

Additional performance indicators for each strategic objective and output are detailed in longer paper.

RESOURCES REQUIRED AND LIVES SAVED

Considering a five year planning horizon, the additional resources required are detailed in Table 2. The total additional resources requirement is \$US 1.2 billion or US\$ 7.2 per capita/per year resulting in an estimated 56% reduction in under-five mortality. Based on an analysis of likely sources of finance, an estimated 21% would need to be sought from the national revenue sources (US \$1.51 per capita/year) and the remainder from development assistance, NGO and the private sector, and private out-of-pocket expenditure.

In terms of lives saved, it is estimated by the final year, more than 100,000 under-five deaths per year would be averted compared to the baseline U5MR where more than 200,000 children under-five die every year. Additional benefits are a large reduction in maternal mortality (MDG #5) and malaria morbidity and mortality (MDG #6), and important, though small reductions in the incidence of HIV/AIDS through prevention of mother to child transmission.

The detailed breakdown by programme area of the additional investment needed highlights the areas where the largest investments are needed.

Table 2 Additional financial requirement by programme, five years, 2009/10 - 2013/14

	2009/10	2010/11	2011/12	2012/13	2013/14	Total
Programme	176,274	195,959	215,637	218,962	252,543	1,059,375
Child health	3,064	5,290	7,143	8,351	9,748	33,595
Immunization	11,124	21,473	31,950	42,556	53,291	160,393
Water, sanitation and hygiene	96,365	86,614	76,828	62,061	62,079	383,948
BCC/IEC	1,609	2,816	3,630	3,847	4,070	15,971
Nutrition	11,342	18,632	23,572	24,989	26,405	104,941
Maternal health	5,151	8,847	13,659	18,525	24,473	70,656
HIV/AIDS	2,326	4,824	8,002	11,577	15,598	42,326
Malaria	45,293	47,464	50,853	47,056	56,879	247,545
Health system	26,260	30,976	38,437	45,022	53,650	194,345
Human resources	3,738	5,232	7,455	9,627	12,442	38,494
Infrastructure / Equipment	6,082	7,475	11,095	14,289	18,759	57,700
Logistics	14,571	14,779	14,988	15,196	15,405	74,939
HMIS	185	422	743	1,132	1,607	4,089
Governance, supervision	1,684	3,068	4,156	4,777	5,438	19,123
Total	202,534	226,935	254,074	263,984	306,193	1,253,720

NEXT STEPS

The successful implementation of the Child Survival Strategy requires a multi-sectoral approach that brings on board all stakeholders. While the Ministry of Health and the Child Health Division has the leading role of coordinating the Child Survival Strategy, the role of policy makers and practitioners will be decisive in making the Strategy a reality for Uganda's children.

KEY ACTIONS REQUIRED OF POLICY MAKERS, BOTH NATIONAL AND GLOBAL

- Actively support Ministry of Health to provide sound leadership at national, district and local levels through dialog and encouragement of all stakeholders;
- Support the provision of needed financial and material resources through various channels (NDP, MTEF, SWAp, projects, etc);
- Contribute to rigorous monitoring and evaluation and efforts for corrective actions;
- Advice on priorities based on the availability of financial, human, and physical resources;

KEY ACTIONS REQUIRED OF CHILD HEALTH PRACTITIONERS

- Integrate the child survival strategy interventions and implementation framework into all work-plans based on local needs and requirements, coordinating all efforts with the appropriate national, district and local authority
- Ensure quality implementation of facility based, outreach, and community-based services in line with national guidelines;
- Bring innovation and practical expertise to national attention to improve implementation;
- Actively participate in monitoring and evaluation efforts to ensure a complete profile of activities;

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