A TOOLKIT FOR ENGAGING NON-HEALTH STAKEHOLDERS IN SUPPORTING ROUTINE IMMUNIZATION IN UGANDA

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JSI RESEARCH & TRAINING INSTITUTE, INC.

SS4RI
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ACRONYMS AND ABBREVIATIONS

CAO	Chief Administrative Officer
CDO	Community Development officer
CSO	Civil Society Organization
DCDO	District Community Development Officer
DEO	District Education Officer
DHO	District Health Officer
DHT	district health team
EPI	Expanded Programme on Immunisation
HPV	Human Papillomavirus Vaccine
HW	health worker
HUMC	Health Unit Management Committee
HSD	health sub-district
JSI	JSI Research & Training Institute, Inc.
LC	Local Council
MCHIP	Maternal and Child Health Integrated Program
MCSP	Maternal and Child Survival Program
MNCH	Maternal, Newborn, and Child health
MOH	Ministry of Health
NHS	non-health stakeholder
PCV	Pneumococcal Conjugate Vaccine
PDSA	Plan-Do-Study-Act cycles
PHC	primary health care
QI	Quality Improvement
QRM	quarterly review meetings
QWIT	Quality Work Improvement Teams
RDC	Residence District Commissioner
REC-QI	Reaching Every Community/Child using Quality Improvement
RED	Reaching Every District
RI	routine immunization
SAS	Senior Assistant Secretary
SDA	Safari Day Allowance
SS4RI	Stronger Systems for Routine Immunization
TPC	Technical Planning Committee
UNEPI	Uganda National Expanded Programme for Immunisation
VHT	Village Health Team

FOREWORD

Over the course of seven years (2012-2019), John Snow, Inc. and JSI Research & Training Institute, Inc. (JSI) has provided technical support to the Ministry of Health and the Ugandan National Expanded Programme on Immunization (MOH/UNEPI) and 27 districts of Uganda to strengthen routine immunization (RI) systems through implementing the Reaching Every Community/Child with Quality Improvement (REC-QI) approach. This support was provided through three projects: the Maternal and Child Health Integrated Program (MCHIP, 2012-2014) and the Maternal and Child Survival Program (MCSP, 2014-2019), both supported by the United States Agency for International Development (USAID); and the Stronger Systems for Routine Immunization (SS4RI) project, supported by the Bill & Melinda Gates Foundation.

Through these projects, JSI applied concepts and methods from the field of quality improvement to the Reaching Every Community/Child (REC) approach already adopted by UNEPI. This enhanced approach builds the managerial capacity of national and, especially, district and health facility teams to diagnose and prioritize problems affecting immunization service delivery and utilization, identify their root causes, and introduce and test solutions using Plan-Do-Study Act (PDSA) cycles.

It became increasingly apparent over time that the success of immunization program management at decentralized levels requires not just the technical capability of health personnel but also commitments from local "non-health stakeholders," meaning local civil servants, administrative officials, political figures, and community leaders. When actively engaged by their local counterparts in the health system, these individuals have demonstrated that they play unique and vital roles that improve the reach, provision, and utilization of immunization services, thereby improving the health of communities.

This toolkit consolidates JSI's learning from the past several years in engaging non-health stakeholders (NHS), making use of existing structures and processes. It presents clear, step-by-step guidance that district health teams (DHTs), district leaders, MOH/UNEPI, immunization partners and Civil Society Organizations (CSOs) can use to engage NHS and maximize the benefits of their participation in strengthening routine immunization.

SECTION 1: RATIONALE FOR AND BENEFITS OF ENGAGING NON-HEALTH STAKEHOLDERS IN ROUTINE IMMUNIZATION

Rationale

In Uganda, the immunization activities fall within the broad context of the public sector, which is controlled and influenced by players and actors, referred to here as non-health stakeholders (NHS), who are beyond the confines of the health sector. Without their involvement challenges at implementation level have persisted, hindering sustained improvement in coverage despite heavy investment in capacity building of health personnel. Little effort has been made to reach out to these essential stakeholders at district and lower government levels. Yet their decisions, actions, and behaviors have substantial impact on immunization service delivery.

NHS for immunization are all the personnel and offices needed to reach every child, wherever they are, with high quality immunization services. In Uganda, JSI has found that they include, in broad terms:

- District and sub-county political, civic, and administrative leaders;
- Religious and cultural leaders;
- Parish chiefs, Local Council 1 (LC1) leaders, and
- Village Health Team members (VHTs).

A detailed breakdown of these and other categories of NHS is presented in Table 1.

JSI has observed that to improve immunization services and create ownership of the program on a sustained basis, the NHS must be engaged and empowered at district, sub-district and community levels because they:

- Make policies and monitor their implementation
- Set priorities for the district development program
- Mobilize and control the allocation of resources
- Influence infrastructure development
- Employ and manage health workers: hiring, deploying, supervising, and termination
- Influence the opinions of their communities in seeking health services

Health programs, including immunization, traditionally have focused on building the technical skills of health managers and service providers while overlooking those who control the resources, set policies, and influence community opinions. But at different levels, local leaders are key, as shown below.

Table 1. Category of non-health stakeholders at different levels in the district

Level of system	Functions
District	Key decisions are made by the district chairperson and district secretaries/ministers (district executive), district council, and the Chief Administrative Officer (CAO). The Resident District Commissioner (RDC), as the President's representative at district level, plays a key role in mobilizing and holding public servants to account. They have structures up to village level that can be harnessed to improve routine immunization (RI) services at all levels.
Sub-county	The Senior Assistant Secretary (SAS) or Sub-county Chief and Local Council III Chairpersons control local revenue and supervise health facility staff.
Community	The Parish Chief is the only civil servant at parish level that oversees all government programs and the LCI chairperson is a politically elected village leader. Though actively involved in other programs such as of Universal Primary Education to track defaulters, National Agriculture Advisory Services and Water and Environmental Sanitation, immunization programs have not engaged these individuals.

When actively engaged, NHS and their communities have contributed local resources to supplement the primary health care (PHC) grants provided by the national government, thereby improving the delivery of immunization services. As important social influencers, NHS and political, religious and cultural leaders can also mobilize their constituents to make use of immunization services, thereby improving protection against disease in their communities.

JSI has also observed that NHS make important contributions by identifying root causes to immunization challenges that are sometimes intentionally missed by health personnel themselves – particularly if the responsibility for the problems lies with health worker practices. This helps ensure that the resultant plan resolves the true causes of problems. In addition, because NHS work on a range of civic issues, they can identify and address other areas (e.g., transport, roads, and finances) that directly or indirectly affect immunization services.

NHS often perceive health as a well-resourced sector. In this era of limited resources, however, the central government is not always able to provide adequate resources for health services. The participation of NHS in processes related to health has uncovered additional opportunities that can be tapped to supplement government efforts, thereby increasing self-reliance and ownership for immunization within the district. For these reasons, it is imperative to engage and empower NHS.

Benefits of NHS engagement in routine immunization

In the 27 districts where JSI Research & Training Institute, Inc. (JSI) has worked, the engagement of NHS has registered tangible contributions of resources to improve RI, including the following:

Financial support

- Private organizations (local bank) provided a motorcycles to transport health workers for outreach activities
- Sub-county governments provided funds to support payment of immunizers' allowances for outreach sessions.
- District Council allocated 1% of local revenue to support immunization
- Sub-county governments allocated 5% of their local revenue to support RI services at facility and community levels.
- District engagement resulted in identification of several communities lacking access to immunization services. For example, in Bulambuli district, their actions led to the creation of five new health facilities that now provide immunization and other primary health care services.

In-kind resources

- SASs and Chief Administrative Officers (CAOs) procured gas cylinders for maintaining the cold chain for vaccines.
- SASs, CAOs, and Local Council Chairpersons provided fuel for transport for distribution of vaccines.
- Some district heads (Residence District Commissioners [RDC], CAO) have provided the use of their official vehicles to enable health workers to reach distant communities with RI services.
- Sub-counties purchased megaphones for RI social mobilization activities
- CAOs provided vehicles and funding that enabled other NHS to participate in supportive supervision visits.

Political and social visibility

- Districts, such as Mbarara and Bushenyi, signed performance engagement letters with health facility in-charges highlighting better immunization performance as one of the district's development targets.
- RDCs provided airtime on local radio stations so that health workers could educate communities on the importance and timing of RI services.
- RDCs engaged with vaccine-hesitant communities to successfully encourage their use of vaccination services.

- Religious leaders and politicians have provided time to health workers for sharing key messages on RI at public gatherings such as church sermons, burials, and weddings.

NHS engagement has produced other important but less quantifiable benefits that have improved the management, delivery, and utilization of immunization services.

Stronger teamwork for strengthened systems

- NHS engagement has strengthened the working relationships between the technical, civic, and political systems of Uganda's decentralized government so that they work together synergistically to improve health services. The increased appreciation that the different teams have of each other's roles and challenges and creates a platform for collaboration has contributed to the development of new local guidelines and by-laws.

Better appreciation of the health service environment

- Involving NHS in planning, implementation, performance review has increased their understanding of the contextual factors that affect health service delivery. They are thus informed and empowered to effectively advocate for health, mobilize communities, and better supervise health workers.

Increased accountability and ownership

- NHS engagement complements the health system building blocks.[1] The implementers, recipients and influencers are all equally responsible for ensure that resources are used efficiently and effectively to achieve the intended outcome. It has been observed that people who influence both implementers and the recipients of immunization services are the policymakers and these should be equally answerable to the people they serve.
- Participation of NHS in program implementation, particularly in planning, enhances ownership and helps ensure that community concerns are addressed, so that as leaders they fulfill their cardinal role 'serving the community'. They own what they understand once they appreciate the benefits and challenges facing the program.

Monitoring that leads to action

- Engagement of NHS empowers them to monitor health programs and use the findings to contribute to their improvement. For example, in districts that have signed immunization performance commitments with individual health facility managers, NHS have reviewed progress toward targets during supervision visits, quarterly review meetings, random spot check visits, and during facilities' annual performance appraisal.

Responsiveness

- Because most NHS are directly elected by the community, they are responsive to community concerns about the quality and availability of health services. As employers of civil servants, they are in a position to affect the actions of every player in the health system in carrying out their duties while also encouraging communities to recognize their own responsibility in support and use services.

[1] World Health Organization (WHO). 2007. "Everybody's business - strengthening health systems to improve health outcomes: WHO's framework for action." WHO: Geneva. http://www.who.int/healthsystems/strategy/everybodys_business.pdf

SECTION 2: STEPS FOR ENGAGING AND EMPOWERING NON-HEALTH STAKEHOLDERS TO SUPPORT ROUTINE IMMUNIZATION

This section provides step-by-step guidance on how JSI, through MCSP and SS4RI, has worked with health personnel to engage and empower NHS to support RI at district, sub-county, parish and village/community levels.

Despite decentralization in Uganda, there are three challenges that minimized NHS empowerment and engagement by the health teams:

1. Historically, the immunization program has been vertical in nature with ring-fenced resources coming from the central level and the district health team (DHT) reporting directly to MOH.
2. Health and immunization has seen as a program for health workers and inputs of NHS were not envisaged or articulated.
3. Because communities and caretakers were envisaged as passive consumers of immunization services, the health system made limited efforts to empower and engage them. For immunization to be successful, however, three inputs must be brought together at the same time and in the same place:

    - **The intended beneficiary (child, brought by the caregiver);**
    - **High-quality, potent vaccine; and**
    - **Capable health worker to administer it.**

    Therefore, efforts must be taken to mobilize all three inputs if the goals of immunization are to be met and resources used effectively. Because the community "owns" the child and decides whether to take the child for vaccination, it is critical that community members understand the benefits of immunization and are empowered to ensure that services are tailored to their needs.

At district level, the **Chief Administrative Officers (CAO)** takes the lead in ensuring participation of NHS while the District Health Officer (DHO) provides technical in puts into the process. For example, the DHO provides technical information on sub-county performance, technical facts necessary for social mobilization and public education and provides guidance on interventions that work and those that do not work according to global, regional and national perspectives.

At sub-county level, the **Senior Assistant Secretary (SAS)**, formerly called the sub-county chief, takes lead in mobilizing other stakeholders and coordinating the activities while the health facility in-charges provide technical and logistical support.

The engagement of NHS should adhere to the following principles:

1. **Transparency** – No hiding facts or covering up, it is very helpful to use available district data. In the same way, health workers should feel that they can honestly share facts on actual performance, even if low, without fear of blame or retribution. Rather, they should anticipate that by creating a shared understanding of their challenges, support to overcome those challenges will be forthcoming. Health workers should openly discuss resources available from Government and all partners such that NHS can appreciate the gaps.
2. **Avoid 'blame game'**. Engaging NHS should promote collective problem solving and identification of solutions in a mutual way. Health workers and NHS should work together to improve services.
3. **Inculcate a spirit of ownership** – good and bad performance and the challenges therein.
4. **Commitments to change status quo** by all stakeholders
5. **Realization that every actor is key** – has a role to play, appreciating each member's contribution

While the CAO and SAS are key non-health stakeholders for RI, JSI's experience indicates that a number of actors from outside the health sector have important roles to play in RI. These are described in Table 2.

Table 2. Roles of non-health stakeholders in supporting routine immunization Expanded Programme on Immunisation (EPI)

Stakeholders	Potential Roles and Responsibilities
Administrative/Civic leaders – (CAO, SAS Parish Chief)	The CAO is the accounting officer for district local government. The SAS is the accounting officer for the sub-county local government The Parish Chief is head of the parish and is the only government employee at this level Other civil servants who can support RI include the Community development officer, the District Planner, and the District Education officer. Specific roles and responsibilities: • Mobilize, allocate and manage resources locally • Supervise, monitor and provide accountability for the implemented government programs • Recruit, deploy, supervise and appraise staff (CAO and SAS) and demand for reports from the supervisees • Planning and budgeting including macro and micro mapping (attaching parishes to health facilities and villages to serve delivery points – static or outreach to ensure that every community and people are reached with services) alongside the HWs • Members of the Quality Work Improvement Team (QWIT) who use RI data to routinely identify broad health facility problems, diagnose root causes and identify and test local solutions through PDSA cycles. • Ensure equitable service delivery within catchment area • Use their positions and opportunities to create awareness of the services available and mobilize communities for those services • In addition to the above, Parish Chiefs also, track immunization defaulters, coordinate the work of VHTS and LC1s, follow up immunization resistant groups and ensure that planned outreaches are conducted.
Political – Resident District Commissioner and Local Council (LC) Structures	Within the (LC) structure, chairpersons at LC1, LC3 and LCV are particularly important, as are Secretaries for health at LC3 and LCV, and Councilors • Advocate for resource allocation in council meetings • Advocate for passing bylaws and ordinances • Follow up on funds utilization at all levels of service delivery according to the set guidelines • Monitor and supervise government programs • Review performance • Mobilization of communities to utilize the services • Provide feedback to communities on progress in implementing the planned programs (social accountability) and also channel community concerns to health workers

Others – (Village Health Team members, religious leaders, teachers/ schools)	VHT
	• Participate in planning for immunization services delivery
	• Record all populations eligible for immunization in their Village register
	• Mobilize communities through home visiting and any other opportunity
	• Track defaulters and left outs for immunization and other services
	• Report suspected cases of unusual and reportable diseases in the community especially measles, polio or neonatal tetanus
	• Refer immunization hesitant groups, families and any rumors and misconceptions on immunization to the Health Facility team and Parish Chief for follow up
	• Serve as members of the health facility QWIT, hence contribute to RI problem-solving
	RELIGIOUS LEADERS
	• Mobilize communities for immunization services
	  ○ Make announcements in places of worship on the days, dates and places of immunization
	  ○ Provide a platform for HWs to talk to the congregation about the benefits of immunization
	TEACHERS/SCHOOLS
	• Mobilization by notifying parents on the days, dates and sites for immunization through school children
	• Participate in service delivery together with the HWs especially HPV and Td vaccination plus Child Health Days

Existing platforms and opportunities that can be leveraged to engage NHS

Uganda's administrative and health structure offers several opportunities for engaging the NHS noted in Table 2 to support RI. Those opportunities and the steps for using them are outlined below.

District-level opportunities and processes

At district level, there are three main opportunities to engage NHS:

1. District planning and budgeting meetings
2. Quarterly review meetings
3. Supportive supervision visits

Table 3. District platform #1: District planning and budgeting meetings

District planning and budgeting meetings • **Annual budget conference:** a one-day meeting to discuss the budget proposals. • **District Technical planning committee meetings:** a one-day meeting held monthly at district level, attended by all heads of departments to plan or review implementation.	
Feature	**Description**
Rationale	These meetings are convened by the CAO who is a lead in the district and therefore all sector departmental heads are obliged to attend, particularly to share performance reports and plan for service delivery
Purpose	To build awareness to the non-health stakeholders' regarding the health services' environment (current performance and existing gaps) in the district, and solicit for to improve health service delivery including RI
Lead Person	District Health Officer with support from the CAO
Tasks for lead person	1. Present current district performance of select health service indicators including immunization: - Immunization target per sub-county and health facility - Current performance and its interpretation - Gaps in performance - Reasons for gaps 2. Highlight the role of the various stakeholders (refer to table 1 for the various roles and responsibilities of the stakeholder in question) in solving the priority challenges. 3. Solicit for commitment to support service delivery - Brainstorm the action to be undertaken by each stakeholder category - Agree on the mechanism of monitoring implementation
Participants	• District Executive Committee • CAO (or Assistant CAO in charge health) • RDC • District councilors • Sub-county leaders (LC III and SAS) • Heads of departments • Civil Society Organizations (CSOs) • Religious leaders • Implementing partners
Tools	• Current district league table • Annual district health performance report • RED categorization tool for health facilities/sub-counties (Annex 1) equity

Table 4. District Platform #2: Quarterly review meetings

Quarterly review meetings • **Quarterly council meetings:** The meeting involves politicians and technical staff and it discussions around budget allocation including priority setting, policies and bylaws. • Quarterly in-charges meetings	
Feature	**Description**
Rationale	To highlight key RI gaps, especially where monetary and non-monetary resources are required**.**
Purpose	To expose non-health stakeholders to the current RI performance and draw their attention and commitment in closing service delivery gaps in the next quarter.
Lead Person	Chief Administrative Officer (CAO) with technical support from the DHO
Tasks	1. Present current district health service performance for routine immunization: - Target - Actual performance - Gaps, highlighting sub-counties that need a lot of support. - Challenges 2. Highlight the role of the various stakeholders as shown in Table 1 below and also refer to annex 7 that highlights non health stakeholder roles and commitments 3. Solicit for commitment to support service delivery - Brainstorm the action to be undertaken by each stakeholder category - Agree on the mechanism of monitoring implementation 4. Present progress on previous commitments/pledges of support by the various stakeholders - What was the problem(s) - What was the commitment to address the problem(s) - How far have the commitments been implemented - Highlight the stakeholder's contribution/support to the current performance - Reiterate the commitments made by the various stakeholders
Participants	District council meeting • CAO/Assistant CAO • RDC • Chairman LC V/Secretary social services / health • Heads of departments • All district councilors
Tools	• Brief of various stakeholder's commitments (minutes) • Quarterly district performance report • RED categorization Tool Tip: *Bullet iv and v will hold if this was the first engagement opportunity. Otherwise the lead person uses this forum to reiterate the commitments made by the various stakeholders and highlight what has been implemented.*

Table 5. District Platform #3: Quarterly supportive supervision

Quarterly DHT supportive supervision visits: a meeting held every quarter at health sub-districts (HSDs) or health facilities to support them identify and address gaps in RI service delivery. A standardized checklist is used to identify key strengths and weaknesses and guide mentorship efforts.	
Feature	**Description**
Rationale	(a) Highlight key RI gaps, especially where monetary and non-monetary resources are required, and (b) generate actions to close those gaps prior to the next supportive supervision visit, based on the use of a supportive supervision checklist
Purpose	To provide an opportunity for the non-health stakeholders to interact with health workers and appreciate the work environment (e.g., workload compared to current workforce, existing logistics like fridges, transport situation with regard to outreach sessions, and current budgets to support RI relative to their needs.
Lead Person	District Health Officer
Tasks	1. Identify the stakeholders/participants and estimate how much time they will participate in the activity. It is likely to be one full week per quarter, or 4 weeks per year. 2. Organize a planning meeting to interest the different stakeholders to participate (refer to participant text box on who needs to attend) ; - Present current performance and other areas of interest - Brainstorm and agree on the areas of focus for that quarter (priorities) - Tailor the current supportive supervision checklist to rhyme with the prevailing RI performance gaps, simplify it to make it user-friendliness for the NHS and also make it short to fit within the existing resources especially time available for both the supervisor & supervisees. Annex 3 presents the checklist for this purpose - Set time line for field work - Mobilize resources including a budget for Safari Day Allowance and transport for the NHS to attend this meeting: refer to budget annex- costing NHS strategy 3. Hold debrief meeting - Present field findings - Highlight observations that require district support and follow up - Agree on stakeholders' commitments to address the observed gaps
Participants	• DHT • Co-opted health facility in-charges • CAO / Assistant CAO • Resident District Commissioner • Secretary Social Services • Co-opted SAS
Tools	NHS Supportive Supervision tool

Sub-county level opportunities and processes

At Sub-county level, there are two main opportunities to engage NHS in immunization:

1. Monthly sub-county Technical Planning Committee (TPC) meetings.
2. Quarterly review meetings and bi-monthly sub-county council meetings

Table 6. Sub-country platform #1: Quarterly supportive supervision

Monthly sub-county Technical Planning Committee (TPC) meetings: These are one-day meetings held monthly at sub-county level and attended by all heads of departments

Feature	Description
Rationale	Because these meetings are convened by the SAS, who is the Administrative Head in the sub-county, all sector departmental heads are obliged to attend, particularly to share performance reports and plan for service delivery. The SAS coordinates service delivery in the sub-county.
Purpose	To build awareness among NHS regarding the current performance and existing gaps in health services in the sub-county, and solicit for support to improve service delivery with particular focus on RI
Lead Person	Health facility in-charge within the sub-county
Tasks	1. Prepare a monthly performance report 2. Present the performance report to the committee highlighting the following: a. Targets b. Current performance c. Gaps d. Challenges 3. Solicit for support to address the observed challenges 4. Share results of the sub-county's contribution (if any) to the Council in relation to the current performance. Tip: *In-charges participate in Sub-County technical planning meetings as a routine monthly event. Therefore, they should be able to share the observed benefit of the sub-county's contribution in addressing health service gaps/challenges at subsequent sittings.*
Participants	• SAS • LC III chairperson & Secretary social services/health • Sub-county councilors • Parish Chiefs • Health Facility In-charges • Health Assistant • Local CSO
Tools	Health facility monthly reporting format (Annex 4)

Table 7. Sub-country platform #2: Quarterly review meetings and bi-monthly sub-county council meetings

Quarterly review meetings and bi-monthly sub-county council meetings

1. **Quarterly review meetings:** These are held every quarter with the participation of all stakeholders, including politicians, civic, and technical leaders, who discuss RI performance and identify solutions to existing problems including commitment of leaders to support interventions.
2. **Bi-monthly sub-county council meetings:** The meeting involves politicians and technical staff who discuss budget allocations, priority setting, and bylaws.

Feature	Description
Rationale	To review RI performance, identify existing performance gaps and gain support and commitment in form of monetary and non-monetary resources required from all stakeholders
Purpose	To expose non-health stakeholders to the current RI performance and draw their attention and commitment in closing service delivery gaps in the next quarter
Lead Person	SAS with technical support from the in-charge of health facility
Tasks	1. Present current sub-county RI performance • Target • Current performance • Gaps • Challenges 2. Highlight the role of the various stakeholders as shown in Table 2 3. Solicit for commitment to support service delivery • Brainstorm the action to be undertaken by each stakeholder category • Agree on the mechanism of monitoring implementation 4. Present progress on previous commitments / pledges of support by the various stakeholders • What was the problem(s) • What was the commitment to address the problem(s) • How far have the commitments been implemented • Highlight the stakeholder's contribution / support to the current performance • Reiterates the commitments made by the various stakeholders
Participants	• Chief Administrative Officer or Assistant Chief Administrative Officer • Resident District Commissioner • Secretary for social services/health • Heads of department
Tools	1. RED Categorization Tool-annex 1 2. Equity Assessment Tool- Annex 2 3. Supervision Guide for NHS- Annex 3 4. Health Facility Monthly Reporting Form-Annex 4 5. District Leaders Commitments to Support NHS in Uganda- Annex 7

Health Facility level opportunities and processes

At health facility level, there are two key opportunities for engaging non-health stakeholders as well as other platforms that can be used.

1. Monthly staff meetings
2. Community dialogues meetings
3. Additional opportunities

Table 8. Health Facility Platform #1: Health facility staff meetings

Health facility staff meetings

1. **Monthly staff meeting:** This is the general staff meeting where both technical and non-technical staff receive updates from the health facility in-charge on the general management of the facility and present sector reports. The meeting is key on guiding the technical planning process for the next month.
2. **Quality Improvement Team meeting:** This is convened monthly by the health facility in-charge to review RI performance. It involves both health workers and NHS particularly VHTs, LC1 chairpersons, the Parish Chief, Chairperson of the Health Unit Management Committee, and the SAS can also be invited.

Feature	Description
Rationale	The health facility is the EPI operational point, where immunization is delivered. It is the point where most challenges impact heavily on the program performance. NHS engagement therefore will create a positive effect on the program given that it will address problems that directly affect the program.
Purpose	To engage NHS to focus on the health facility performance, solicit for their support to address the prevailing challenges and be accountable to the population served
Lead Person	Health facility in-charge
Tasks	1. Prepare health facility monthly performance report (see Annex 4 for format). - Target (Numbers or percentage) - Achieved (Numbers or percentage) - Challenges - Planned steps / actions to address the gaps 2. Convene staff meeting with NHS participating ; the in-charge sends out invites through telephone calls, text messages, and word of mouth through VHTs informing them about the meeting date, venue and time. - Opening remarks by health facility in-charge - Review of previous minutes - Presentation of RI/EPI performance - Discussion 3. Identify areas of support by non-health stakeholders 4. Solicit for commitment 5. Agree on mechanism of their NHS participation and follow up
Participants	▪ All health facility staff ▪ Health Assistant ▪ Parish Chief ▪ VHT coordinators ▪ the SAS can also be invited
Tools	▪ RED categorization tool (Annex 1) ▪ Equity assessment tool (Annex 2), used by VHTs and LC1s to identify previously unserved villages ▪ Health facility monthly report format (Annex 4) ▪ Sample agenda for monthly health facility staff meetings (Annex 5)

Table 9. Health Facility Platform #2: Community dialogue meetings

Community dialogues Meetings: Ideally, these are held on a quarterly basis at parish level.	
Feature	**Description**
Rationale	The community owns the children and determine the utilization of the program. They are the beneficiaries of the program. NHS at community level influence parents/guardians either to come for the service or not. Engaging them will open the door to the community and enhance utilization. NHS at community level are key in creating demand.
Purpose	To engage the community to appreciate the health service environment, the roles and responsibilities of various stakeholders, strengthen linkage with heath facility and improve on accountability.
Lead Person	Health Assistant
Tasks	1. Map out key community events i.e. markets, religious gatherings and social activities, among others to guide scheduling of RI sessions 2. Identify influential persons for each event 3. Prepare for a talk at the scheduled event - Services offered - Health seeking behavior of the target community - Roles of the different stakeholders at that level - Discuss and brain storm on key actions / behavior for inclusiveness and responsiveness for that community - Agree on feedback mechanism
Participants	• All Health facility staff • Health Assistant • Parish Chief • VHTs • Community resource persons • Community: parents, care takers • Local council I chairperson
Tools	1. Equity Assessment Tool- annex 2 2. Health Facility Monthly Reporting Form-Annex 4

Other platforms at facility and community levels can be used to support RI.

Table 10. Facility and community level platforms

Platform	Frequency	Who convenes it	Comments
Village Council meetings	Monthly	Local Council Chairperson	Discuss issues around their community; it can be leveraged on by health facility in-charge presenting the current gaps in access, utilization and mobilization for RI services, and soliciting for community level support from stakeholders including the VHTs, community resource persons, cultural, religious and opinion leaders.
Parish budget conference meetings	Annual	Parish chiefs	Discuss budget priority setting. Health facility in-charge can use these meetings to share RI performance and solicit for both monetary and non-monetary support.
Health Unit Management Committee (HUMC) meeting:	Quarterly	Chairman of the Committee (usually an NHS)	Used to review reports on status of health service delivery at the unit, they can also be used to suggest and follow up on actions for improvement. Health facility in-charge (secretary to the HUMC) and EPI focal persons utilize this meeting to discuss RI performance and point out gaps/ challenges that need the support of NHS to fill.

SECTION 3: COSTING THE ENGAGEMENT OF NON-HEALTH STAKEHOLDERS

JSI's approach has been to engage non-health stakeholders in activities already routinely conducted by the local government but which lacked NHS involvement, for example, supportive supervision, quarterly review meetings, and attendance at Council meetings and Technical Planning Committee meetings. The marginal costs cover additional travel costs for the NHS members and refreshments. However, these costs are minimized by riding on existing or ongoing activities and using an integrated approach. For example, during supportive supervision or quarterly review meetings, adding the RDC or CAO or Secretary for Health to the monitoring team incurs additional Safari Day Allowance for that officer but the fuel used for the monitoring team is unchanged. It also brings the advantage of using the RDC or CAO's vehicle during the visit and uses the budgeted fuel for the activity. The additional Safari Day Allowance (SDA) is factored into the budget at the micro-planning stage. Instead of teaming two health workers for supportive supervision or QRMs, it is better to team a health worker with an NHS because when they go to the field, they address different checklists. Given that the NHSs have the mandate to mobilize and allocate resources, their participation may pay for itself if they come to appreciate the importance of immunization and support it.

Table 11. Activities and associated cost for engaging non-health stakeholders in supporting routine immunization

Activity	Level at which implemented	Frequency of implementation	Targeted NHS	Expected costs
Mapping and Microplanning for RI services	District level	Once per year (one-day meeting for drafting and one-day meeting for harmonization)	District Planner, District Education Officer (DEO), District Community Development Officer (DCDO), CAO, RDC, Secretary for Health, SAS, LC 111 C/Ps, Representatives of religious leaders, VHTs	-Travel costs paid as per distances traveled -Meals and refreshments -Stationery
	Sub-county	One per year at all health facilities	1 VHT per village, Representatives of religious institutions	-Refreshments during the meeting
Supportive Supervision	District	Quarterly	CAO, RDC, LC V Chairperson, Sec for Health, DEO, DCDO	-SDA -Fuel for district vehicles
QRMs	District (Planning meeting held 1st day and DHMT held last day)	Quarterly	CAO, RDC, LC V Chairperson, DEO, DCDO, District Planner	-Hall Hire -Meals and Refreshments -SDA -Stationery
	Sub-county	Quarterly	SAS, LC 111 C/P, Sec for Health, PCs, Representatives of religious institutions, VHTs	-Refreshments -Travel costs based on distances -Stationery

The following annexes are tools needed in the process of engaging NHS.

ANNEX 1: RED CATEGORIZATION TOOL[2]

Tool 3 of Microplanning toolkit: Health Facility performance review Previous F/Year: 20__/20__

District: _____ **Date:** _____ **F/Year: 20** _____ **/20** _____

HSD: _____ **Sub-County:** _____ **Health Facility:** _____ **Level** _____

															Criteria	
Name :	…… District														Penta1 coverage	
															90%	
Goal : Increase immunization coverage to at least 90% with all vaccines in every district															Drop-out Rate	
															10%	
	Compile population, children immunized and calculate immunization coverage data in previous 12 months (FY:_____)															

Service Point	Target Population	Surviving Infants	Doses of vaccine administered				Immunization coverage (%)			Unimmunized (No.)		Drop-out (rates (%)		Identify problem (see table 2*)		Categorize problem according to table 2**
			BCG	DPT 1	DPT 3	Measles	DPT 1	DPT 3	Measles	DPT 3	Measles	DPT 1-DPT 3	DPT 1-Measles	Access	Utilization	Category 1,2,3, or 4
	A	B	C	D	E	F	G (D/B)x100	H (E/B)x100	I (F/B)x100	J (B-E)	K (B-F)	L (D-E)/Dx100	M (D-F)/Dx100	N	O	P
Child Vaccination																
Health Facility																
Static																
Outreach																
Outreach																
Outreach																

[2] Red Categorization Tool Template (Word version): JSI RED Categorization Tool_Template.doc

HPV coverage	Target Population	Doses of vaccine administered		Immunization coverage (%)		Unimmunized (No.)		Drop-out (rates (%)	Identify problem (see table 2*)		
		HPV 1	**HPV2**	**HPV 1**	**HPV2**	**HPV 1**	**HPV 2**	**HPV 1 – HPV 2**	Access	Utilization	
Health Facility											
Static											
Outreach											
Outreach											
Outreach											

Note: Add or switch DPT to Pneumococcal Conjugate Vaccine (PCV)
Tool divided into two to capture both children and girls

Category 1 = high coverage (>90%), low drop out (<10%) 1= Very High
Category 2 = high coverage (>90%), high drop-out (>10%) 2= High
Category 3 = low coverage (<90%), low drop-out (<10%) 3= Medium
Category 4 = low coverage (<90%), high drop-out (>10% 4= Low, based on the number of un-immunized children and category of problem

ANNEX 2: EQUITY ASSESSMENT TOOL[3]

District: _____ **Date:** _____ **F/Year: 20** _____ **/20** _____

HSD: _____ **Sub-County:** _____ **Health Facility:** _____ **Level** _____

- Identify barriers and solutions to access and use of immunization in those communities, parishes and sub-counties with immunization inequities in that district
- Identify focal points and partners to support immunization activities in the high-risk communities and underserved areas
- Incorporate the outcomes of equity assessment into the health unit micro plan and district micro plans

The high risk communities / marginalized communities whose children are commonly missed for immunization in Uganda

Codes:

1 - Remote rural - more than 10 km from the service point
2 - Urban poor settlements
3 - Migrants and Pastoralists
4 - Religious sects and cults such as Bisaka sect, triple six
5 - Upcoming town settlements
6 - Fishing communities
7 - Refugee communities
8 - Island and mountainous communities
9 - Ethnic minorities like Ike, Batwa
10. Others specify: .....

Service point	Sub-county	Parish	Village name	Inequity code	Description of EPI inequities	Barriers affecting service delivery	Corrective interventions

[3] Equity Assessment Tool Template (Word version): JSI Equity Assessment tool_Template.doc

ANNEX 3: SAMPLE SUPERVISION GUIDE FOR NON-HEALTH STAKEHOLDERS[4]

Theme: Leadership, Management & Accountability

#	Observed Practice	Yes	No	Supervisor's Action
1	Staff on duty roster present on day of visit			**If 'NO'**, *guide the health facility in-charge and discuss actions to address the performance gap*
2	Staff on duty in uniform			
3	Health Facility clean (floor, compound, latrines…)			
4	Monthly staff meetings held with RI performance discussed (***Hint:*** *verify by observing minutes)*			
5	PHC funds allocation openly displayed (Hint: Observe display)			
6	Health facility with Health unit management committee (HUMC)			**Comments: ……**
7	HUMC meetings held quarterly *(**Hint:** Observe minutes)*			
8	Health facility displayed program for immunization			
9	Allowances for health workers and mobilisers for outreaches paid up to date (***Hint:*** *discuss with HWs & VHTs)*			
10	Health facility in-charges shares RI performance at TPC (***Hint:*** *inquire from SAS & observe most current report presented)*			
11	Health facility support supervised in the last 3 months			*If No, support staff to revisit their action points and re-plan. Discuss with team to come up with a schedule for internal supportive supervision and the benefits of documenting findings.*
12	Health facility implemented recommendations in the previous Supportive supervision			**Comments: ……**

[4] Sample Supervision Guide for Non-Health Stakeholders (Word version): JSI Sample supervision guide for non-health stakeholders.doc

ANNEX 4: MONTHLY REPORTING FORMAT BY HEALTH FACILITY[5]

District …… HSD: …… Sub-county: ……
Lead Health Facility: …… Name of In-Charge: ……
Signature: …… Date: …… Reporting Period: ……

A	**Service Area: Immunization**		
1	Number of Routine Immunization Static Sessions	Planned ……	Conducted ……
2	Number of Routine Immunization outreaches	Planned ……	Conducted ……
3	Target population for immunization	Monthly target Under 1 year: …… Girls aged 10 years: ……	Number immunized DPT 1: …… DPT 3: …… Measles: …… Girls 10 years……
	Service Area:		
1			
2			
	Service Area:		
1			
2			
B	**Priority** challenges that health facilities have planned to handle …… ……		
C	**Priority** challenges requiring sub-county leaders' attention and intervention …… ……		

NB: To be compiled by the highest Health Facility level in the Sub-county, merging all the data from the lower Health Facilities in that Sub-county for the reporting period and presented at the sub-county TPC

[5] Monthly Reporting Format by Health Facility Template (Word version): JSI Monthly reporting format by health facility_Template.doc

ANNEX 5: SAMPLE AGENDA FOR MONTHLY HEALTH FACILITY STAFF MEETINGS[6]

Agenda

- Communication from health facility in charge
- Review previous minutes
- Presentation of departmental performance for previous month
- Discussion
- Way forward and closure
    - Summary of planned steps / actions by department

Staff in attendance

SN	NAME	TITLE/CADRE	CONTACT	SIGNATURE
1				
2				
3				
4				
5				
6				

[6] Sample Agenda for Monthly Health Facility Staff Meetings (Word version): JSI Sample agenda for monthly health facility staff meetings.doc

Sample format for performance reviews by department

MONTHLY TARGET (NUMBERS/ %)	ACHIEVED (NUMBERS / %) PER MONTH	CHALLENGES	PLANNED STEPS / ACTIONS TO ADDRESS THE GAPS
Department: ANC Target No. Pregnant women: ……	No. ANC 1: ……. No. ANC4: …….		
Department: Maternity Target No.……..	No. Deliveries: …….		
Department: Postnatal Target No.……..	No. PNC mothers: ……..		
Department: EPI i. RI sessions No. Target static: ……. No. Target Outreaches: ……	No. Static: ……. No. Outreaches: ……		
ii. Number < 1yr DPT 1= …… PCV 1 = …… DPT 3= …… PCV 3= …… Measles= ……	No. immunized & % DPT 1= …… PCV 1= …… DPT 3= …… PCV 3= …… Measles= …… DOR DPT1 – DPT 3: …… DPT 1 – Measles: ……		
iii. Village child registration	Total number registered by VHTs (in each FY cohort) as per the previous month: ……		
iv. Immunization allowances No. Target HWs: ……. No. Target VHTs: ……	No. HWs paid: …… No. VHTs paid: …….		
Department: OPD 1. Catchment population < 5 yr.	No. OPD clients <5 yr. No. Malaria diagnosis: …… No. tested: …… No. Treated correctly: …… No. Pneumonia patients: …… No. Treated correctly: …… No. Diarrhea patients: …… No. Treated correctly: ……		
DQSA by health facility IC/ Focal persons	No. varied per tool OPD Child registers **EPI records** Selected Antigen: …… Month: …… VIMCB: …… CR: ……..……..… TS: ……..……..… HMIS 105: ……		

ANNEX 6: COSTING THE ENGAGEMENT OF NHS[7]

Costing NHS Strategy								
1. District Leaders Meeting:	**Conduct bi-annual 2 day intensive review meeting at national level**							
	Items	**Unit Description**	**#/ quantity**	**# of Days**	**Cost/Unit**	**Total (UGX)**	**No. Rounds**	**Total**
Presentations from district								
	Hall Hire	Hall	1	2	500,000	1,000,000	2	2,000,000
CAO, RDC, Secretary for Health from all districts	Meals & Refreshments	Person(s)	0	1	25,000	-		0
	Transport cost (Fuel refuel depending on mileage cost)	Person(s)	0	1	4,200	-		0
Stationery	Flip charts	Pieces	0	1	15,000	-		0
Total							**2**	**2,000,000**
2. Mapping and Microplanning for RI service delivery:	**Conduct 2 days of mapping at district level- 1 day for drafting the district the district macro-map and 1 day for Harmonizing the map)**							
At district Level								
	Items	**Unit Description**	**#/ quantity**	**# of Days**	**Cost/Unit**	**Total (UGX)**	**No. Meetings**	**Total**
District planner, district population officer, LCIII, Chairpersons, SASs and religious leaders	Hall Hire	Hall	1	1	200,000	200,000	1	200,000
	Meals & Refreshments	Person(s)	0	2	25,000	0		
	Transport cost	Person(s)	0	2	35,000	0		
Stationery	Flip charts	Pieces	0	1	15,000	0		
Total							**1**	**200,000**
At sub-county level								
	Items	**Unit Description**	**#/ quantity**	**# of Days**	**Cost/Unit**	**Total (UGX)**	**No. Meetings**	**Total**
VHTs	Refreshments	Person(s)	0	1	10,000	0	1	0
Total							**1**	**0**
3. Supportive Supervision:	**Conduct 2 days of field work to familiarize themselves with problems affecting service delivery in the HFs)**							
	Items	**Unit Description**	**#/ quantity**	**# of Days**	**Cost/Unit**	**Total (UGX)**	**No. Meetings**	**Total**
CAO, LC V Chairperson, RDC, and Secretary for Health	SDA for District leaders and drivers	Person(s)	0	2	42,000	0	0	0
	Transport cost: Fuel for district vehicles	Lts						
Total								**0**

[7] Costing Tool for NHS Engagement Strategy Template (Word version): JSI Costing Tool for non-health stakeholder engagement_Template.xls

ANNEX 7: DISTRICT LEADERS COMMITMENTS TO SUPPORT NHS IN UGANDA

1. Governance for Routine Immunization in Uganda

Immunization is one of the most cost-effective health services – a "best buy" that can benefit all children and communities in Uganda. But the life-saving vaccines used by the Uganda National Expanded Programme on Immunisation (UNEPI) are only effective if they reach all children and families. To make sure that this happens, District Leaders have critical roles to play in supporting the provision of immunization services.

In Uganda's decentralized system of Government, the Ministry of Health is responsible for policy and standards guiding immunization services. On the other hand, Districts, as local governments, are responsible for implementing immunization services, and the Chief Administrative Officer (CAO) is the technical head of the district services. The district oversees the delivery of health services by health facilities. Immunization services are planned and carried out at health facility and community levels. Health facilities form the bedrock of planning and implementing immunization services, guided and directed by the district through the Sub-county local government structure led by the Senior Assistant Secretary (SAS). At the district level, the Chairperson Local Council V, who is the political head, appoints the Secretary for Health who takes charge of the social services sector in the District Council. The Resident District Commissioner (RDC) is the President's representative in the district to monitor implementation of all government programs on behalf of the President. The District Health Officer (DHO) is the technical head of the district health team. Each of these leaders has important roles to play in making sure that effective immunization services reach all communities and families.

It was based on the critical role of these district leaders in supporting routine immunization services that they were gathered in Kampala in October 2017.

2. Clarifying the Role of District Leaders in Routine Immunization

In October 2017, the Ministry of Health-UNEPI, National Medical Stores, and John Snow, Inc. convened and facilitated an immunization meeting in Kampala with delegates from 18 districts (Otuke, Mbarara, Butambala, Kanungu, Bulambuli, Mayuge, Mitooma, Kole, Nakaseke, Bushenyi, Apac, Pallisa, Oyam, Kalungu, Butalejja, Ntungamo, Kibuku, and Buikwe). The delegates present at the meeting were mainly RDCs, CAOs, DHOs, SASs, and Secretaries for Health.

The meeting reviewed immunization performance across these districts, shared experiences and lessons learned, and discussed how to institutionalize best practices. Most important, the district leaders clarified their own roles and responsibilities in monitoring and supporting the immunization program. From this action, each district leader agreed upon a set of commitments to improve routine immunization provision within their districts.

District Leaders' Commitments to Routine Immunization

Chief Administrative Officers' Commitments

1. To ensure that the guideline for allocating at least 20% of primary health care (PHC) and 5% allocation from local and unconditional grants for EPI activities are implemented at district, sub-county and health facility levels.
2. Demand for monthly and quarterly EPI Performance reports from DHO to CAO and from health facility In-charge to SAS detailing the vaccine stock levels at district and health facility levels, outreach sessions planned and implemented, status of cold chain, and progress in social mobilization.

Resident District Commissioners' Commitments

1. On a quarterly basis, carry out social mobilization using public gatherings, radio, and TV.
2. Monitor EPI performance through reports from DHO, support supervision and quarterly review meetings and take appropriate action to make sure that relevant district structures address the challenges identified.

Secretary for Health Commitments

1. Use all opportunities available to mobilize for immunization services at every public function.
2. Advocate for a minimum 5% allocation of part of local revenue and/or un-conditional grants to support immunization services at district and Sub-county levels.
3. Monitor EPI performance through reports from the DHO, Supportive Supervision and quarterly review meetings, and draft a separate report highlighting achievements and challenges. This should include the proportion of sub-counties that have allocated 5% of local revenue to EPI to the District Executive Committee (DEC) and District Council for appropriate action every quarter.

District Health Officers' Commitments

1. On a monthly basis, share with the CAO and other district leaders a brief report on the vaccine stock situation and distribution to HSDs, HCIII and IIs, as well as cold chain status.
2. Provide a monthly summary to the CAO on performance of outreach sessions, including the number planned vs. implemented, reasons for not implementing sessions, and propose actions, including redirection of PHC funds to facilitate outreaches.
3. Ensure that health facility and district micro-plans are completed and utilized such that all planned RI sessions are conducted as per the micro-plan.

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