IMMUNIZATION AND HEALTH SECTOR REFORM DEVELOPING GUIDELINES BASED ON EXPERIENCE FROM ZAMBIA AND UGANDA

September 1997 to January 1998

Rachel Feilden
Ole Frank Nielson

Basics Technical Directive 000 ZA 51 025/000 AF 51 025
USAID Contract Number HRN-C-00-93-00031-00

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ACRONYMS

ARA	Division for Analysis, Research and Assessment, formerly the Division of Strengthening Health Services
BASICS	Basic Support for Institutionalizing Child Survival
CBoH	Central Board of Health
CO	Clinical Officer
DANIDA	Danish International Development Agency
DAP	Action Programme on Essential Drugs
DfID	Department for International Development, formerly ODA
DHO	District Health Office
DMO	District Medical Officer (and Office)
EHT	Environmental Health Technician
EPI	Expanded Programme on Immunization
GPV	Global Programme for Vaccines and Immunization
HC	Health Centre
HI	Health Inspector
JICA	Japan International Cooperation Agency
PHN	Public Health Nurse
RHC	Rural Health Centre
SWOT	Strengths, Weaknesses, Opportunities, and Threats
UCI	Universal Child Immunization
UEDSP	Uganda Essential Drugs Support Programme
UNEPI	Uganda National EPI
USAID	United States Agency for International Development
VVM	Vaccine Vial Monitor
WHO	World Health Organization

I PURPOSE OF VISITS

The purpose of this consultancy is to identify key issues for immunization services in health reform settings and to provide guidance for sustaining and increasing the impact of immunization services in settings where health systems are undergoing reform The terms of reference are attached in Appendix A The consultancy involved four phases preparation, including assembling background documentation, field visits to Zambia and Uganda, debriefings in the EPI Unit, WHO/Geneva, and desk work (analysis, and preparation of a reference guide)

II BACKGROUND

In recent years, a number of countries have embarked on health sector reform The processes and progress of reforms differ greatly between countries there is no single model for "health reform " However, the common features include decentralization, or devolution, or deconcentration, which may include planning, and/or budgetary control, and/or management Reforms may involve a radical shift in personnel policy so that the Ministry of Health no longer employs staff at the district level and the periphery Instead these staff become local employees of their hospital board, of the district health authority, or of the local council This major shift has been called "delinkage" and "retrenchment "

Health reform has been described to some extent at the macro level, but detailed information on the effects of reforms upon specific health programs is less readily available Donors and technical agencies working in the area of immunization, including WHO, BASICS, and DANIDA, agreed to support a consultancy to study how health reforms are affecting immunization programs and services, and to prepare a reference guide for countries to use during the process of health reforms

III ACTIVITIES

Two consultants, Ole Frank Nielsen (DANIDA) and Rachel Feilden (BASICS), travelled to Zambia, where they participated fully in the review of immunization services (17 September-8 October 1997) At the same time, they carried out their own terms of reference, this contributed to some fundamental modifications in the approach to the review, which now took into account how Zambia's UCI, a "traditional" vertical immunization program, becomes integrated with other services and support functions at all levels The review report (first draft) was presented to the Central Board of Health (CBoH) in Zambia and circulated in October A more complete report was distributed in December, and final revisions are expected to be completed by March 1998

The consultants left Zambia on 11 October and travelled to Uganda, where they stayed for one week During this short stay they visited facilities in two districts, using the new review formats

(modified for Uganda-see Appendix E) with two colleagues from UNEPI (Uganda National EPI) Based on these field trips, our Ugandan colleagues prepared an excellent debriefing for others on the UNEPI team and took the major role in presenting the findings (see Appendix F) It is hoped that the formats presented in Appendix E will be used in the immunization review planned for Uganda

From Uganda, Feilden and Nielsen went straight to Geneva to debrief staff in the EPI Unit of the Global Programme for Vaccines and Immunization (GPV), and to discuss health reform issues with other departments

Appendix B shows the schedule of activities, and Appendix C lists people met during these visits

After a period of desk work, a draft reference guide (temporary working title Document B) was sent to WHO and BASICS The consultants returned to Geneva in early January 1998 and presented a seminar to the EPI Unit and key people from other departments, including the Division for Analysis, Research and Assessment (ARA), formerly the Division of Strengthening Health Services (which has been studying health reform for several years and runs a forum), and the Action Programme on Essential Drugs (DAP) The overheads presented at this second debriefing are attached in Appendix D

IV RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

The two seminars presented at WHO/Headquarters produced some notable reactions and responses to the fundamental changes in administrative structures and policy priorities that health reform may bring about In the past it may have been possible to provide technical advice and earmarked funding to vertical immunization programs without becoming involved in issues of political economy Now, to be effective and acceptable, technical advice must respect local structures, priorities, and resource constraints, and must, therefore, be aware of a larger set of actors and processes Document B explores the structural changes in Zambia and Uganda, identifies where essential immunization functions are (intended to be) carried out, and gives a list of indicators that will give early warning of problems with quality of services This document is being revised to include an analysis of strengths, weaknesses, opportunities, and threats (SWOT) to immunization services operating within health sector reform Feilden and Nielsen will make an updated presentation on this topic to the EPI Technical Network (TechNet) in March 1998

The review in Zambia produced many detailed findings and recommendations, which are being followed up For example, the CBoH is in the process of refining and updating strategies and policies on logistics, immunization standards, and the immunization component of the curriculum

5

It is hoped that the review in Uganda will benefit from the experience of using robust indicators of service quality collected in an open-ended, but systematic process

V FOLLOW-UP ACTION REQUIRED

The reference guide (Document B) and the case study descriptions of immunization services in Zambia and Uganda (Document A) are to be completed and circulated

REFERENCES

Feilden RM and Nielsen OF Reference Guide (Document B) Draft, January 1998

Foster SO et al Sustaining and Improving Benefits of Immunization within Zambian Health Reform Draft, December 1997

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APPENDIXES

APPENDIX A

TERMS OF REFERENCE

Terms of reference

A WHO consultancy on Health Reform and the Expanded Programme on Immunization

Background

During recent years a number of mainly developing countries have initiated reforms of their health systems and services Assisted by donor countries, international organisations, and development banks, these efforts have concentrated on poorer developing countries in Africa and Asia The preparations and planning of new health systems have been time consuming and cumbersome, very few countries have yet reformed their system, but the process is ongoing

Major elements of the health reform include the financing mechanisms, the decentralisation of health systems management, and development of effective district capacity for planning and implementation of the reform (update this based on AC) The health services are expected to be better coordinated and rationalised, and the concept of basic health packages is being promoted in many countries Needless to say, reform components must be tailored to national situations and the capacity of the health system to implement reform activities

Some essential health services, such as immunizations, have traditionally been delivered through a programme approach, which has contributed to their success, notably in EPI No other health service reaches such a big proportion of the world's children (global average 80%) and national ownership, as well as demand for these services, is evidence of the utilisation of the service as well as the sustainability in technical and manpower terms which characterize most national EPI programmes

The reform process will inevitably affect EPI leading to a reduction in central programme management input but strengthened district authority and more integration at the point of service delivery This represents a challenge to traditional EPI approaches, and it is necessary that EPI respond to this challenge by analysing the development, and designing how, in a reformed health care setting, high quality immunization services can be accessed and utilised to the greatest extent possible within the context of decentralisation and essential health services Furthermore, immunization services are essentially a public good which justifies public investment and it is unclear how such a strategy for health systems will impact preventive services such as immunization

EPI targets for disease control will be broadened in coming years as more antigens become available and target groups are expanded The concern is that health reforms should support international and national strategies for disease control through immunizations and vice versa

The purpose of this consultancy is to identify and provide guidance for changes in immunization services that increase disease impact on EPI targets in settings with reformed health systems

Objective

A review of the EPI in Zambia and Uganda in relation to the health reform process

The development of a reference guide for nation immunization programmes during health reforms

Outputs

A report reviewing EPI in Zambia and Uganda before and during the health reform process The findings from Zambia may be incorporated into the overall EPI review planned for September 1997 The report should assess the global applicability of the findings in the respective countries

A reference guide for national programmes in countries which are undertaking health reforms

Scope of work

The scope of work shall comprise but not necessarily be limited to

- an analysis of the organisational and management issues related to the immunization services and the health reform,
- a qualitative assessment of the expected impact of the health reform on immunization service delivery,
- an identification of quantifiable impacts that can be analysed after the reform process has been implemented,
- a review of the financial and human resource allocation of immunization services before and after the health reform,
- an assessment of the community involvement in immunizations before and after the reform,
- an assessment of political commitment to immunizations before and after reforms at central and decentralised levels,
- an analysis of the potential contradiction between increased decentralisation and the implementation of regional and global disease control efforts,
- an assessment of the effects of decentralisation versus continued centralisation of EPI functions,
- assess the role of immunizations in basic health services packages,
- identifying ways to ensure the prioritization of immunizations as a core health service at central, district and peripheral levels,
- identifying key issues for immunization services in health reform settings that are applicable at the global level,
- preparing a reference guide for EPI, WHO for use in other countries undertaking reforms,
- suggest ways of ensuring the adaptation and use of the reference material by all major partners involved in health reforms

Plan of work

The consultancy will be undertaken by two persons

One expert in health systems and health reforms

One expert in health service and EPI management at national levels

The expected duration is 8 weeks This will include 3-4 weeks in Zambia in conjunction with the EPI review in September, 7 to 10 days in Uganda, and two debriefing sessions in WHO, HQ The remaining period can be spent working at the consultants' normal place of work

The consultants shall present a summary of their findings to the MOH Zambia, and development partners at the end of the stay in Zambia, and to the UNEPI Team in Uganda, with copies to EPI, HQ, and AFRO The final reports shall be delivered at the end of the assignment

The reference material will be subject to editing in WHO prior to publication

APPENDIX B

SCHEDULE OF ACTIVITIES

Schedule of Activities

August-Sept	preparation, collecting documents and reference material
17 Sept	Depart for Lusaka, Zambia
18 Sept	Arrive in Lusaka Met Ole Frank Nielsen, Mogens Munck
19-21 Sept	Modifying WHO modules on cost management with Review Team
22 Sept	Designing new formats for the review service delivery, planning and Budgeting, District Health Board
23 Sept	Short briefing from Health Reform Implementation Team member Visits to Central Board of Health
24 Sept	Production of final formats, briefing on use of formats Six teams depart for their field work
25 Sept	Visit to Lusaka Urban District Health Office Visit to Chipata Urban Health Centre Community survey in Ackson Piri, Unit 6 of Chipata catchment area
26 Sept	Visit to Chainda Urban Health Centre Meeting with Health Centre Advisory Committee Community survey in Venta, in Chainda's catchment area
27 Sept	Meeting with Ackson Piri Neighbourhood Health Committee at Chipata
28 Sept	Sunday
29 Sept	Concluding interviews at Lusaka Urban District Travelled to Monze District, met DHO
30 Sept	Meeting staff at Monze District Health Office, selecting HCs to visit Visited Chisikesi RHC, started interviews, but outreach visit cancelled due to death of a child in the outreach village Shifted to Rusungu and joined the EHT and nurse for outreach visit to Simukale Health Post, a self help building Integrated services including immunization, family planning and a nutrition demonstration Usually they achieve this travelling from Rusungu on their motorbike from WaterAid Conducted community survey at the Health Post (most Simukale mothers were there at the session, not at home)
1 Oct	Interviews at Monze District Health Office Met Neighbourhood Health Committee members at Rusangu covering 27 communities Community survey for next site (Njola Mwanze), far side of Monze town Dinner with the Director of Health and the District Health Board
2 Oct	Interviews at Njola Mwanze RHC Meeting with members of the Neighbourhood Health Committee Return to Lusaka

3 Oct Contacted international agencies for meetings on health reform
Visit to UNICEF Lusaka
Created EPI-INFO data entry formats for service delivery data

4 Oct Report back from six field teams, assignment of writing tasks
Prepared presentations for debriefing to CBoH

5 Oct Drafted chapters on policies, standards and guidelines, and vaccine forecasting, funding and procurement

6 Oct First debriefing to CBoH and donors
Drafted chapter on costs of immunization

7 Oct Revising review chapters
Meeting with DfID Urban Health Advisor
Dinner hosted by BASICS

8 Oct Second debriefing presented to Director General, CBoH
Meeting at CBoH with Dr Paul Zeitz

9 Oct Meeting at UNICEF re procurement
Meeting at SIDA with Regional Health Advisor
Debriefed WR at WHO Zambia office

10 Oct Met Chief Health Planner at MoH
Meetings at CBoH
Attended meeting on NIDs (1997 and 1998) at UCI Secretariat

11 Oct Wrote memorandum on our meeting, requested by Chief Health Planner
Travelled to Uganda

12 Oct Sunday

13 Oct Meeting with WR, WHO/Uganda and collected information from library
Met Uganda Essential Drugs Support Programme (UEDSP) Assistant Programme Coordinator at National Medical Stores
Meeting at UNEPI

14 Oct Meeting with Dr Prosper Tumusime, Ministry of Local Government
Meeting with DANIDA in Entebbe
Meeting with SIDA in Entebbe
Meeting with UNICEF in Kampala

15 Oct Field visit to Jinja District Council, DMO, hospital and Busede HC

16 Oct Debriefing with team who travelled to Sembabule District
Meeting with European Union (EU) in Entebbe
Meeting with DfID in Kampala
Meeting with Save the Children Fund in Kampala

17 Oct Debriefing with UNEPI and discussion of the planned review, VVM study, children's register for identifying drop-outs
Visit to UNICEF in Kampala to collect documentation
Departure for Geneva

18 Oct Arrival in Geneva

19 Oct Sunday	
	Met Lora Shimp, BASICS
20-21 Oct	Debriefing with staff in EPI Unit, GPV
	Meetings with staff in ARA and DAP
22 Oct Brown	bag lunch seminar for staff in EPI Unit
	Departure for home
November-December	Desk work preparing reference guide and description of immunization services in Zambia and Uganda, finalizing chapters for the review

1998

6-9 Jan	Travel to Geneva
	Discussions with WHO staff
	Presentation of 3-hour seminar to staff from GPV, ARA and DAP
	Return home
January	Follow-up via e-mail of discussions arising from seminar
	Further documents sent from EPI Unit in Geneva

APPENDIX C

PEOPLE MET

People Met

ZAMBIA

Review Team Members from Ministry of Health and UCI Secretariat
Dr Dean Phiri (National Manager), Annie Radoka Besa, Dunganı Cheembo,
Leo B Chivundu, Maurice Chuni, Grace Mbali, Sikeba Mulamata, Elizabeth Mulamfu, Martha Mulenga, Gina Mulundu (Virology Lab), Desideria Mvula, Grace Phiri,
Kennedy Siputuma

Other Review Team Members
Dr Stan Foster (team leader), Dr Stella Anyangwe (WHO/AFRO),
Kenneth Chindedza (UNICEF), Rachel Feilden (WHO/BASICS), Mary Kaoma (BASICS Zambia), Dr Doug Klauke (WHO Regional Epidemiologist), Morgens Munck (BASICS), Ole Frank Nielsen (WHO/Danida), Tomoko Zama Sichone (JICA), Fred Simuyu (WHO)

Ministry of Health Mr Vincent Musowe, Chief Health Planner

Central Board of Health
Dr J J Banda, Director of Health Services Commissioning
Peggy Fulilwa, Services Support Manager (in Health Services Commissioning)
Christine Mushe Zulu, Procurement Specialist (in Services Support) and
Dr Elvira Beracochea (MSH), consultant on integrating logistics
Dr Mwendaveli Maboshe, Quality Assurance (in Directorate of Monitoring & Evaluation)
Jenny Meya Nyirenda, Child and Reproductive Health Specialist
Dr Paul Zeitz (CBoH/USAID)

Health Reform Implementation Team Mr Mulungu

HMIS team Mimi Church, Jap Koot Mariat Wiebenga, Gil Burnham

WHO Zambia Dr Wilfred Boayue, Dr Ini Huijts, Dr Mary Ngoma

UNICEF Christiane Rudert, Dr Halima Dao

BASICS Dr Remi Segunro, Emily Moonze, Alasdair Wylie (consultant),

JICA Mr Naoki Ando, Mrs Tomoko Zama Sichone

SIDA Dr Anders Nordstrøm, Regional Health Advisor

USAID Paul Hartenberger, Dr Peggy Chibuye

Lusaka Urban District
Dr Rose Kumwenda Phiri (District Health Director), Dr Sinkala (Dty Director Planning), Mrs Simonga PHN, Mrs Banda, Andy O'Connell (DfID Urban Health Advisor)

Chipata Urban HC Sister Kunda (I/C) and staff

Ackson Piri Neighbourhood Health Ctee Robert Tembo, Estella Mwansa, Alaida Phiri

Chainda Urban HC Sister Banda (I/C) and staff
and the HC Advisory Committee Felix Chendu, Agnes Banda, William Ambali

People Met **(continued)**

Monze DHO District Director of Health, Mrs Eunice Skatulou PHN David Mpaka (accountant), Daniel Mukupa HI Miss Annie Mutunda

Monze Hospital Dr Keane, staff in MCH outpatient department

Rusungu RHC Mr Lilembalemba EHT, Mr Mwiindwa (nurse), Mr Matesamwa CO and Rusangu HC Advisory Committee/Neighbourhood Health Committee members

Njola Mwanze RHC Paul Kasongo EHT, Ms Skaswe (nurse), Enoch Mugoba (nurse), Mr Desai CO and members of the Neighbourhood Health Committee

UGANDA

UNEPI

John Barenzi, Dr Sam Oumo Okiror, Elly Tumwine, Zura Asauda, Pamela Zaninka, Dr Jennifer Mugisha, Dr Grace Murindwa, Betty Irwasi, Edward Tumusime, and two other staff who attended the debriefing

Ministry of Local Government Dr Prosper Tumusime

WHO Uganda Dr Hatib Njie

WHO/AFRO Dr Andrei Lobonov

Danish Red Cross Jesper Gerner Jensen, UEDSP

Danida Dr Lars Erik Frische, Health Sector Support Programme

DfID Ros Cooper

EU Dr Rene Christensen

SIDA Dr Anders Jeppson

UNICEF Dr Vivienne van Steirteghen, Grace Ekudu, Ulrike Suesser

Save the Children Fund Dr Peter Poor, Dr Ovberedjo, Juan Ortiz, Mr Buwa

Jinja District Council
Mr Muhwezi Mugisha (Asst Resident District Commissioner/Health),
Ms Betty Luigake (Asst CAO Education)

Jinja District Medical Office Florence Kasigwa (District Nursing Officer),
Joyce Isiko (District Health Visitor), Dawson Kitimu (Stores Assistant)

Jinja Hospital
Dr Wanume Benon (Medical Superintendent), Florence Ameso (Principal Nursing Officer) Staff at Children's Ward

Busede Health Centre Mr Wabulembo Saidi, I/C

WHO HQ, GENEVA

Tony Burton, Andrew Creese, Peter Evans Dr Ana Maria Herao, Dr Katya Janovsky, Dr Mark Kane, John Lloyd, Dr Bjorn Melgaard, Dr Jean-Marc Olive, Dr Jonathan Quick, Barbara Stillwell, Dr Rudi Tangermann, Michel Zaffran

APPENDIX D

OVERHEADS FOR SECOND SEMINAR PRESENTED TO WHO GENEVA

Overheads for Second Seminar presented to WHO Geneva

Immunization
and
Health Sector Reform

Overheads

1 What are we going to present

2a What is health sector reform

2b What is health sector reform (continued)

3a Zambia

3b Zambia Old MoH to (New MoH+CBoH)

3c Zambia Health reform processes

3d Zambia Districts' work plans prepared [*not presented*]

4 Ghana

5 Uganda

6 Uganda Local government Structure, 1997 (numbers of staff shown at right)

7 Uganda Typical District administration

8 Goal of immunization, Objectives of immunization services

9 Essential functions

10 Zambia Organogram of UCI Secretariat, 1997

11 Zambia Organogram of reformed health system, October 1997

12 Implications of health reforms for key functions Zambia and Uganda

13 Conclusions

14 Zambia immunization coverage 1982 to 1996

15 Uganda immunization coverage 1981 to 1996

16 Spectrum from policies through inputs, outputs and outcome to impact

17a Zambia Monitoring funding
Proposed funds approved for 1996, and approved funds received by Districts

17b Zambia Monitoring reported coverage
FIC <1 in 1996, by province and district

18 Opportunities offered by health reform general

19 Opportunities offered by health reform specific

20 Threats

21 Where to go from here?

What are we going to present? OHJ

- What is Health Sector Reform?
- Examples of structural changes
- Implications for immunization?
- Measuring impact?
- Opportunities for immunization services?
- Addressing the threats: supporting sustainable immunization services

What is Health Sector Reform? OH2a

- It is about change;
- It is about change which is more than incremental;
- It is about changing health policies and the institutions through which policies are implemented (Cassels);
- It is about
  - Improving health status and consumer satisfaction with better quality and effective services;
  - Greater equity with better access to care;
  - Greater value for money with costeffective interventions considering better distribution of resources (allocative efficiency) to priority activities and better management and use of allocated resources (technical efficiency) (WHO);

What is Health Sector Reform? Cont. . . . OH2b

- It is a phenomenon which varies tremendously between countries in the way it is initiated, how it evolves and how it is implemented;

- It incorporates new global theories and practices about the public sector and how it (should) work(s):

  "New Public Management"

- It is a phenomenon which coincides with dramatic changes in geo-politics and policies;

- The importance of recognizing that it is driven by a "Constellation of Circumstances"

Zambia: Zambians must **commit themselves** to building a health care system that guarantees **equity** of access to **cost-effective, quality** health care as **close to the family** as possible"

- **Originated in the political manifesto of the new MMD government,**
- **Formulation of Package of Essential Services (BOD and cost-effective intervention)**
- **Major revision of staffing pattern and competence required and retraining according to the basic package**
- **MOH to concentrate on formulating policies, strategic planning, serving parliament and resource mobilization**
- **Creation of Central Board of Health (CBOH), Hospital Boards and District Management Board**
- **Abolition of programmes, EPI among others**
- **Delinkage of staff**
- **Donors encouraged to agree to providefunds for the "basket" and not for separate programmes**
- **It is NOT a reform which involves other sectors (Local Government)**
- **It has NOT been possible to achieve the required level of financing of district health services, approximately US$**

Old MOH

400 staff

9 Provinces

61 Districts

New MOH

67 staff

Central Board of Health 118 staff

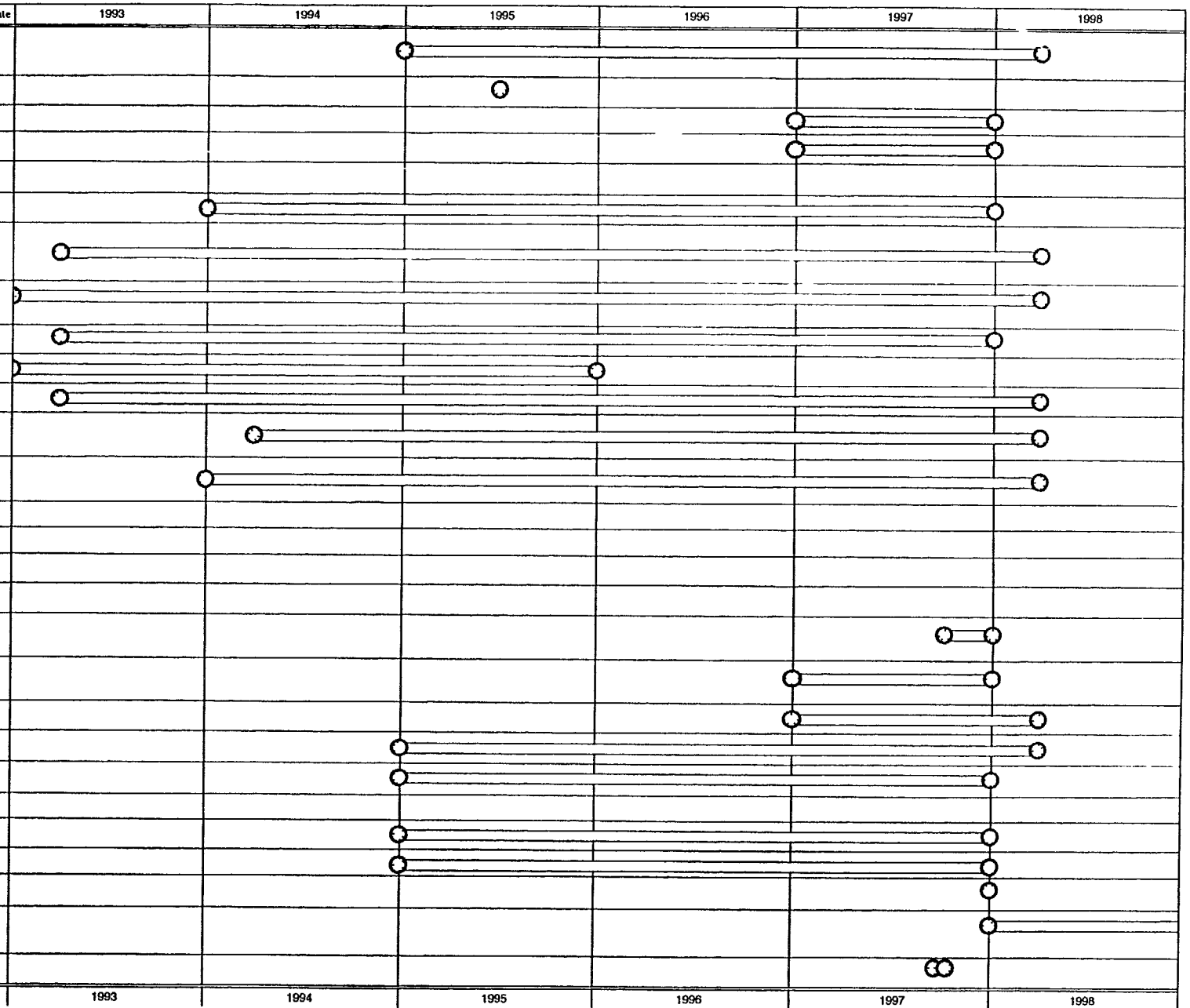
including 4 Regional Directorates

71 Districts & HB (Hospital and District)

1992 HRIT Building District Capacity 1997

Health reform processes in Zambia

Process	Start Date	Finish Date
Decentralization with the assignment of a budget to an approved District Health Plan	1/1/95	1/4/98
New Health Act	1/7/95	
Establishment of Central Health Board	1/1/97	1/1/98
Establishment of Regional Health Boards	1/1/97	1/1/98
System development and capacity building		
Quality Assurance development and capacity building	1/1/94	1/1/98
Development of the details of the new District Health Management and Administrative setup and apacity bu id ng	1/4/93	1/4/98
Establishment orientation and capacity build ng D strict H alth Boards	1/1/93	1/4/98
Constitution of new DHMT and capacity building	1/4/93	1/1/98
Capacity building Distri t Health Directors (DHD)	1/1/93	1/1/96
De elopment of accounting procedures and capacity building	1/4/93	1/4/98
Development of new Health Management Information System (HMIS)	1/4/94	1/4/98
Development and implementation of the new Financial Administration Management System	1/1/94	1/4/98
Accounting capacity building		
Clinical capacity building		
Gender and health analysis and capacity building		
Publication of "Technical Guidelines for Frontline Health Workers		
Curriculum development for Public Health Practitioners and Community Heralth Practitioners	1/10/97	1/1/98
Curriculum development for new Master of Public health training course	1/1/97	1/1/98
Development of new Integrated Supply Management System	1/1/97	1/4/98
Establishment of Area Health Committees	1/1/95	1/4/98
Partnership establishment (neighbourhood Committees	1/1/95 1/1/95	1/1/95 1/1/98
Health Systems Research		
Functioning Neighbourhood Committees	1/1/95	1/1/98
Functioning District Heasith Boards	1/1/95	1/1/98
EPI/UCI to be abolished in its present form	1/1/98	
Establishment of the new organization for immunization services	1/1/98	1/4/99
"EPI" review	18/9/97	10/10/97



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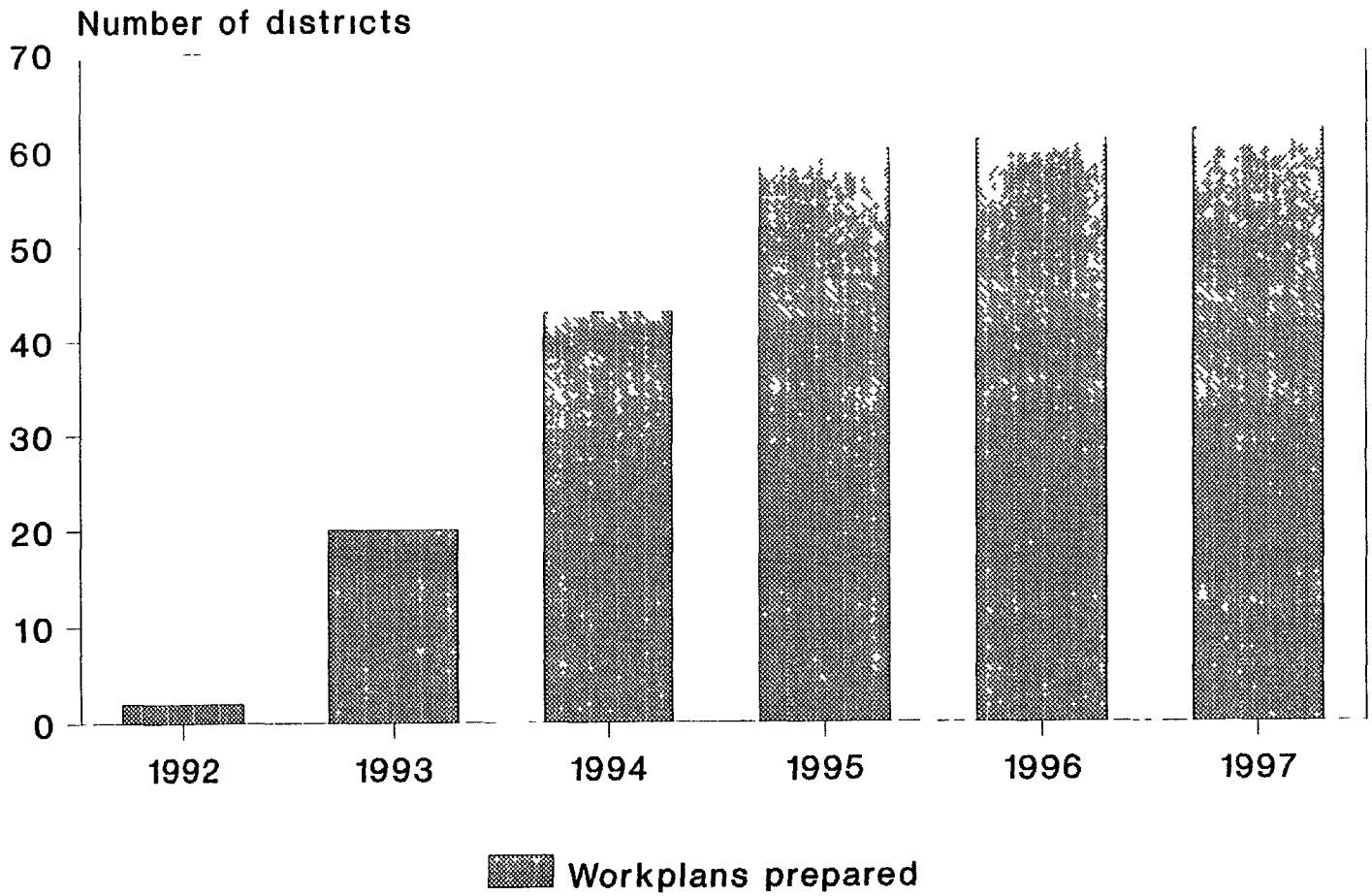
Zambia districts' work plans prepared



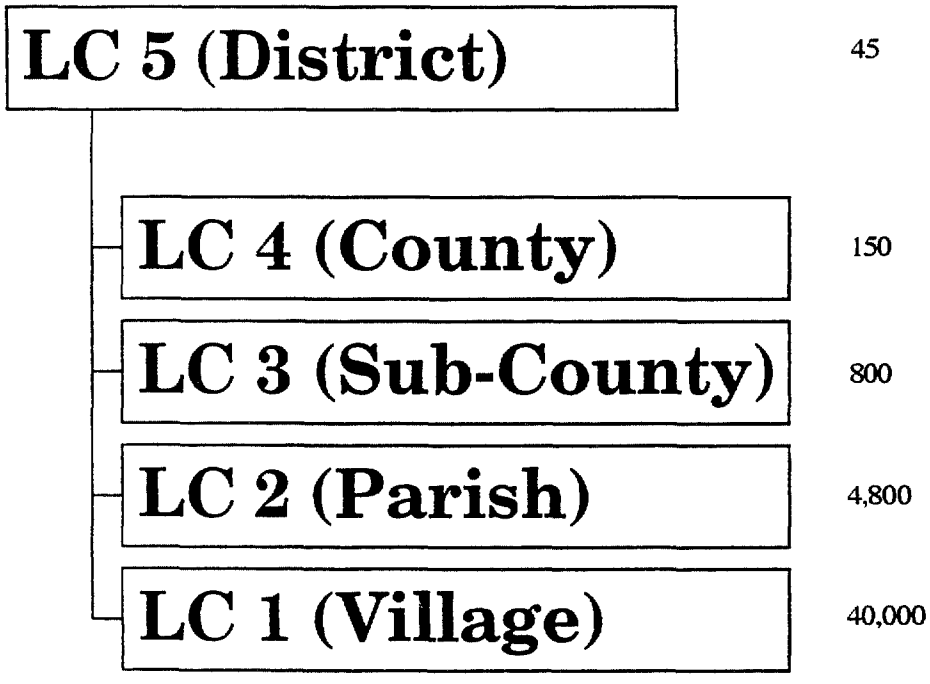
Ghana:

- Originated in a mounting pressure from a well trained cadre of Regional and District Health Officers which culminated in a meeting in 1988.
- Cost reduction
- Change in pattern in resource allocation
- Increase in financing

Uganda:

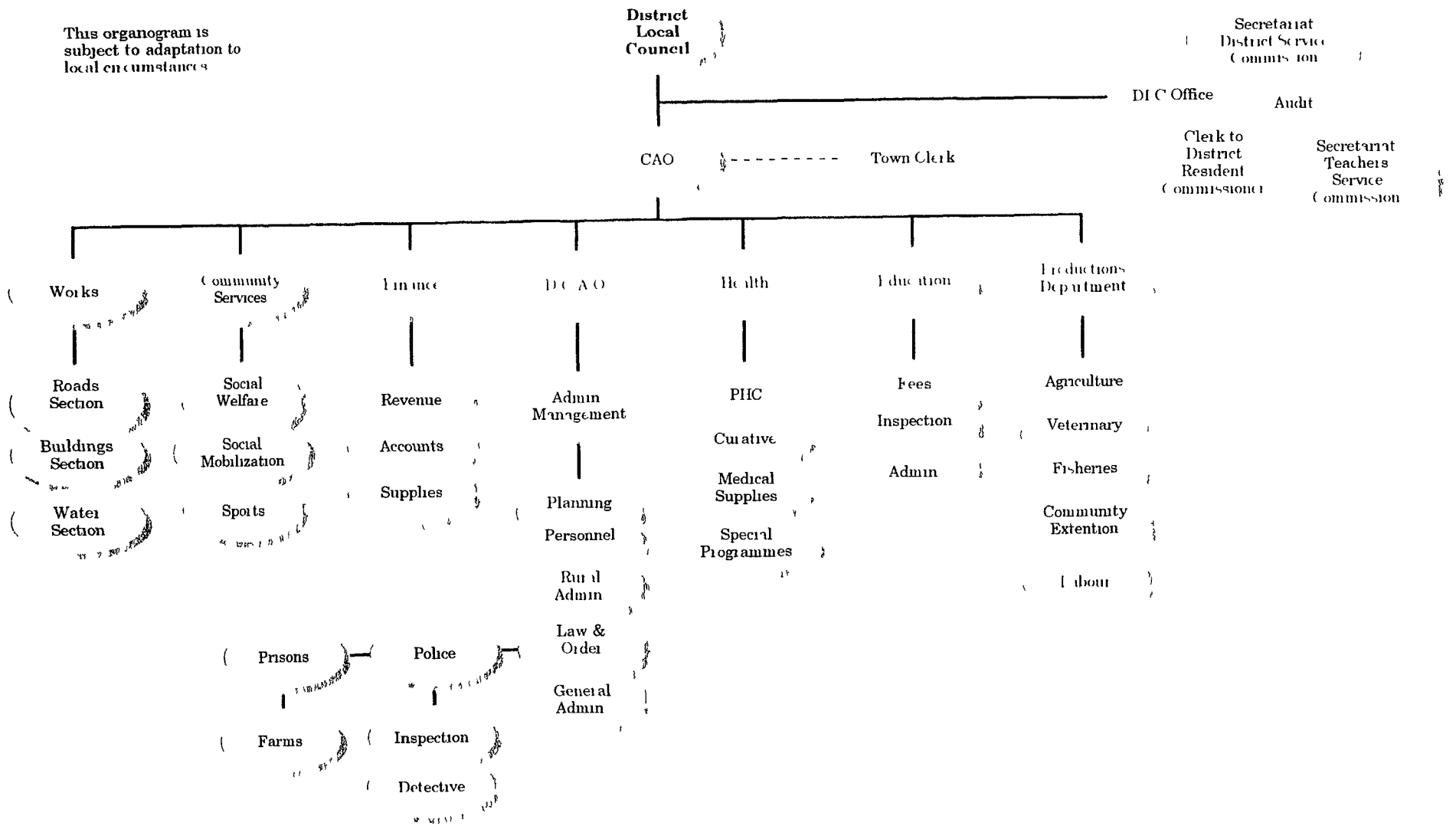
- Part of a general reform of the public sector and government institutions;
- Grew out of the National Resistance Movements 10 point programme (decentralization);
- Effective decentralization of district health services to Local Councils with an unconditional block grant mechanism (recurrent), later conditional grant;
- Delinkage extended;
- District health planning , budgeting and approval by Local Council;
- MOH has changed its role to being responsible for health policies, strategies and regulation of the sector;
- Uncertainty about the role of the MOH?

Local Government
Structure, Uganda 1997



Uganda Typical District Administration

This organogram is subject to adaptation to local circumstances



Source Uganda District Planning Manual - 1996

Text for overheads OH 8 to OH 17

For a number of historical and technical reasons, EPI developed into a strong vertical programme with financial backing from donors to fund investments in equipment, vehicles, some buildings, and recurrent costs of supplies

In the late 1980s the push for 80% coverage of the world's infants re-emphasized the vertical role of national immunization programmes This role appeared to be unaltered by the debate over selective versus comprehensive primary health care

Health sector reform causes concern in some quarters especially if an objective of reforms is to integrate health services In some quarters reforms are perceived as a threat to the continuation of vertical programmes, whose staff have described their fear of "losing control" of immunization activities, and by extension reforms are perceived as a threat to immunization itself

We have been looking at the implications of health sector reform upon immunization In Zambia, institutional reform in the health sector has been quite radical, so we chose to start by analysing the essential functions at central level These functions were based on the following goal and objectives

Goal and objectives OH8

(The numbers in parentheses are the number of indicators assessed in the review in Zambia to check whether each component of the objective was being met)

Essential Functions OH9

The essential functions shown here do not include some that have traditionally been included in vertical EPI structures, such as a cold chain repair workshop, or a national vaccine store This is because there are effective immunization programmes which contract out these services, so they don't fit the category of essentially a central level function

The next challenge is to identify who would carry out the essential functions in the reformed institutional structure We asked ourselves, Whom should technical advisors contact about immunization when visiting the country?

In Zambia the UCI Secretariat fell under the direction of the National Manager who was the Director of Maternal and Child Health in the MoH

Organogram, old UCI Secretariat OH10

During the review we noted that this structure had not resulted in reviewing and updating policies, standards and guidelines since the EPI Manual was prepared in 1992 This meant that several technical developments were not formally incorporated into current policy and guidelines, such as VVMs, OPV at birth, and recording and reporting of measles doses given below 9 months

Goal of immunization

to reduce morbidity and mortality from vaccine preventable diseases, doing no harm in the process

The objective of immunization services is to

- provide potent vaccine (20*)
- correctly administered (13*)
- safely (13*)
- properly documented (8*)
- at a time when client is susceptible and prior to exposure (7*)

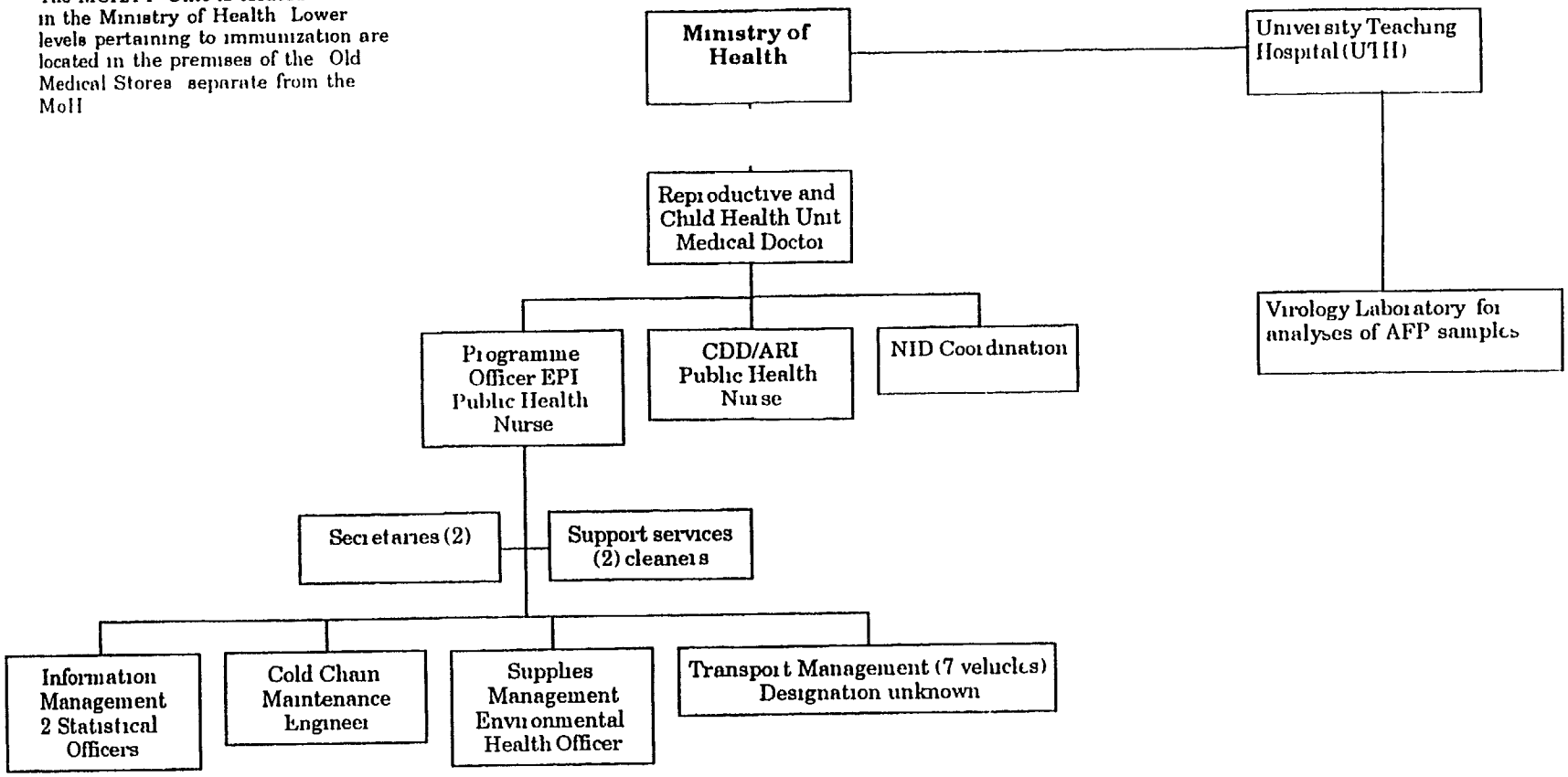
Essential Functions at Central Level:

- ✓ formulating national policies, standards and guidelines
- ✓ planning at national level
- ✓ procurement of equipment, vaccines and other supplies
- ✓ stock management
- ✓ monitoring, surveillance and reporting
- ✓ research functions
- ✓ organizing reviews

OH 10 15

Organogram EPI/UCI
Zambia October 1997

The MCH/FP Unit is located in the Ministry of Health Lower levels pertaining to immunization are located in the premises of the Old Medical Stores separate from the MoH



415

The reforms have introduced a new structure at the centre Now the MoH has a new role - of policy and planning, resource mobilization, contact with parliament, and donor coordination

Reformed Health System, Zambia OH11

The CBoH is responsible for Health Services Commissioning, Monitoring and Evaluation, and Systems Development in three separate Directorates, plus four Regional Directorates replacing the nine Provinces

The Central Board of Health was still filling some of the posts of manager and specialist, and while we were there it was not certain whether the functional responsibilities of the National Manager would remain within MoH or be located in CBoH

The implications for immunization are that essential functions at the centre probably reside with three or four individuals located in all three central directorates

locate on chart

the Reproductive and Child Health Specialist in Systems Development
the Service Delivery Specialist and
the Epidemiological Monitoring Specialist in Monitoring and Evaluation
the Procurement Specialist in Health Services Commissioning

the 9 provinces have been replaced by 4 regions (*locate on chart*)
some of which were not fully functional at the time of the review The dismantling of the provinces means that there are no longer provincial vaccine stores and cold chain technicians at that level

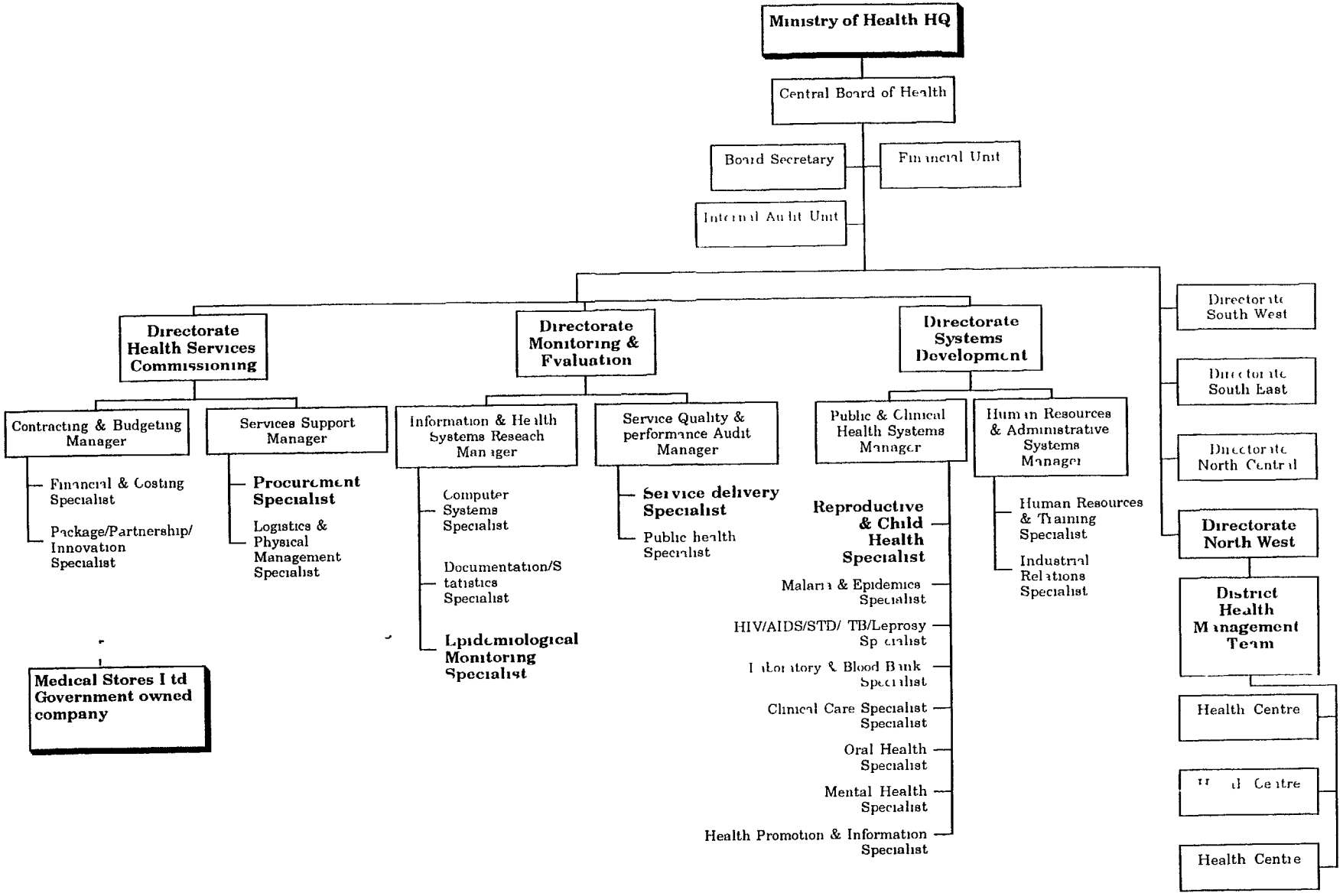
For the districts, 10 new ones were created in 1997 increasing the total to 71 districts District Health Boards have been created which work with their District Health Management Teams, who receive a budget from CBoH - so they are not competing for resources with other sectors The allocation is worked out on a fairly complex weighting scheme and the use of funds is closely directed in the CBoH's planning guidelines and by ceilings and proportional limits on spending for hospitals, DHMT administration, health centres and community activities

Currently the largest institutional change in progress at District level is the delinkage of health staff from the civil service, and the transition on 1st January this year that all health staff will be employed directly by the District

The general impression is that as long as immunization supplies continue to flow, services will continue much as before, with the caveat that we await the longer term effects of delinkage

For more detail on the implications of health sector reform OH12
we have highlighted some features of the implications in Zambia
COVER RHS (Uganda column) OF OH12

Organogram Reformed Health System
Zambia 1997



In Zambia the opportunity was seized to completely redesign the various information systems An integrated HMIS has been developed over several years It is designed for use at the local level to enable health staff to analyse their own data, with the local advisory group, and take action
The number of data items from each programme had to be reduced, and we would point out that saying "We Need All of what we already get" is not helpful to the creation of an integrated HMIS
A summary format called the Public Health Flag has been developed, containing 5 indicators, one of which is a local choice
All the immunization service statistics reported in the EPI Global Summary are in the system It has been field tested in 14 Districts and nationwide roll-out was 1 Jan 1998 Data go to the District and thence to the Directorate of Monitoring and Evaluation Some reservations have been voiced about the choice of quarterly reporting and the speed of reporting notifiable diseases but the consensus seems to be review the HMIS after a year

Immunization is already integrated with child health services The training programme for IMCI is still under development, and at present it is not clear to us how far this aspect will be implemented

Integrated in-service training will be purchased by the Districts from a training institute This may mean an end to single purpose workshops for immunization Training on updated policies, standards, guidelines and special topics will probably have to be provided through the training institutions

The curriculum for basic training is being developed through a large committee in the CBoH with participation of several technical advisors How well immunization PSG are represented in this group has depended on the individuals attending the meetings The manual for health workers is smaller than the EPI Manual, which is referred to as a reference document This manual is in the process of being updated, with TA

Supervisory visits are made by the Region to the Districts, and Districts to health centres These visits are designed as a management audit rather than clinical supervision The review found that 74% of health centres had had a recent visit but the present emphasis lacks the necessary orientation towards service delivery
The PHNs spoke of competition for use of the District vehicle and were frustrated that the priority accorded to their outreach work has apparently been downgraded by the emphasis on management

Logistics - Provinces are no longer the interim level of storage Districts appear to be collecting from Lusaka, but flexible arrangements may develop so that 71 Districts do not have to make the journey for supplies
We do not know whether a role is planned for the Regions

11

OHIZ

	ZAMBIA	UGANDA
• HMIS	Integrated	Aggregation
• Services	Integrated	Loss of staff
• In-service training	Integrated	UNEPI overstretched
• Basic training	Integrated	?UNEPI involved
• Supervisory visits	Management audit	Constraints
• Logistics	Districts collect	UNEPI delivers
• Forecasting	Bottom up	Top down
• Procurement	Focal point may shift	MoH funds vaccine
• National store	?	No effect so far
• Cold chain workshop	?	Funds for Districts?
• Cold chain equipment	Districts buy locally	Ownership issue

Forecasting has been top down with astonishing wastage inside the national store It is being moved towards bottom up, based on the health centres' estimates, aggregated at District level The Review made some recommendations on guidelines for bottom up forecasting

Procurement The focal point has been UNICEF and needs to be reassessed As the MoH has a line item for vaccines and has agreed in principle to start funding vaccines, the past arrangements will have to be reassessed, possibly with CBoH Procurement Specialist as the focal point

National Store If the national programme is dissolved there are at least 2 possibilities having storekeepers at the existing site but supervised by MSL, or moving the stores within the MSL/EDMSS complex and integrating storage, stock management, and distribution

Cold chain workshop - we don't know

Cold chain equipment The review found that some districts had been buying locally because they could not get their fridges repaired (for a number of reasons) and because the national programme did not have any on offer The review recommended developing procurement and sale of vaccine CC equipment along similar lines to CBoH's strategy for vehicle replacement

Turning now to Uganda,

The impact of reform is being felt in the new structure of local government At the centre there is uncertainty in UNEPI and a feeling that control over the immunization programme has been lost For example departures of facility level staff are beyond their control being a function of retrenchment and delinkage of employment, and UNEPI staff must now pay a courtesy call to the Local District Administration when they wish to visit health staff in that District UNEPI has to consider how to communicate with other sectors because Ministry of Local Government now holds the key, not the MoH

At District level they are preparing annual plans as in Zambia but there has not been the extensive capacity building in preparation for reforms being implemented The big difference is that Health at district level is now competing for resources with other sectors - agriculture, education, roads

The first two annual allocations of funds were unconditional grants to the Districts Problems with allocations between sectors arose in most Districts, so in FY 1996/97 the Districts received conditional grants for health and education to ensure that some services were funded

We think that UNEPI will continue as a vertical programme unless the MOH decides otherwise

Returning to the summary chart of implications

HMIS - looks like an aggregation of existing data items, rather than a new concept It seemed extremely unwieldy

Integrated services ? by default Understaffed facilities mean that a few individuals have to do everything We were told that retrenchment has led to loss of staff and that underqualified people were giving immunizations
Interestingly UNEPI produced a plan which included vaccinators as a job description

In-service training no conceptual change as in Zambia Staff continue to be pulled away from work to attend numerous workshops for vertical programmes UNEPI staff are responsible for in-service training and said that loss of previously trained staff meant that they could not keep up with the training requirements of the replacement staff who were hired

Curriculum development and basic training UNEPI job description says that the training staff will participate in basic training of health staff

Supervision Similar problem of resource constraints at District level, but different causes (not getting the funding for visits by any District supervisors) There seems to be a shortage of staff time for supervision due to the work load, of priority given to supervisory visits, and of transport
At national level UNEPI staff are uncertain how to exercise their role in the District as they have been told they must report to the Dist Admin when they visit

Logistics UNEPI has three refrigerated trucks with the slogan Be Wise, Immunize They will continue to deliver and decide how much vaccine they deliver at each District store

Forecasting - central

Procurement MoH started funding measles vaccine in FY 1995/6 and added DPT the next year in a Vaccine Independence Plan We are not sure whether this development was related to the reforms

National store Local govt reforms have had no effect A recent statute in 1995/6 for the medical stores covers vaccine, drugs and medical supplies This part of reforming the medical supplies system, not part of an integrated health reform

Cold chain Workshop UNEPI runs a remote radio repair system but our own field visits were affected by the district radio not working If Districts lack funds, will UNEPI pay for repairs?

Ownership of CC equipment is a question, who is responsible for replacing it?

Conclusion OH13

Health sector reform *per se* does not have immutable consequences for immunization

The implications depend on

- the content of reforms
  - structures
  - institutional arrangements
  - functions
- how they are implemented
- the starting position of immunization services when reforms are introduced.

Measuring impact

Coverage continues to be a useful indicator of service activity, always remembering that we are looking for trends, not blips

Zambia Immunization coverage 1982 - 1996 OH14

In Zambia the drop-out rate between BCG and measles in 1996 was 11% in children 12-23 months, but the difference between BCG and fully immunized was 20% according to Demographic and Health Survey data UCI's own data for 1996 indicate a difference of 27% between BCG and fully immunized before first birthday So although coverage is high there is room for improvement in completeness and timeliness of doses

The peak in 1991 and the temporary dip in 1992 illustrates the importance of looking for trends

Uganda Immunization coverage 1982 - 1996 OH15

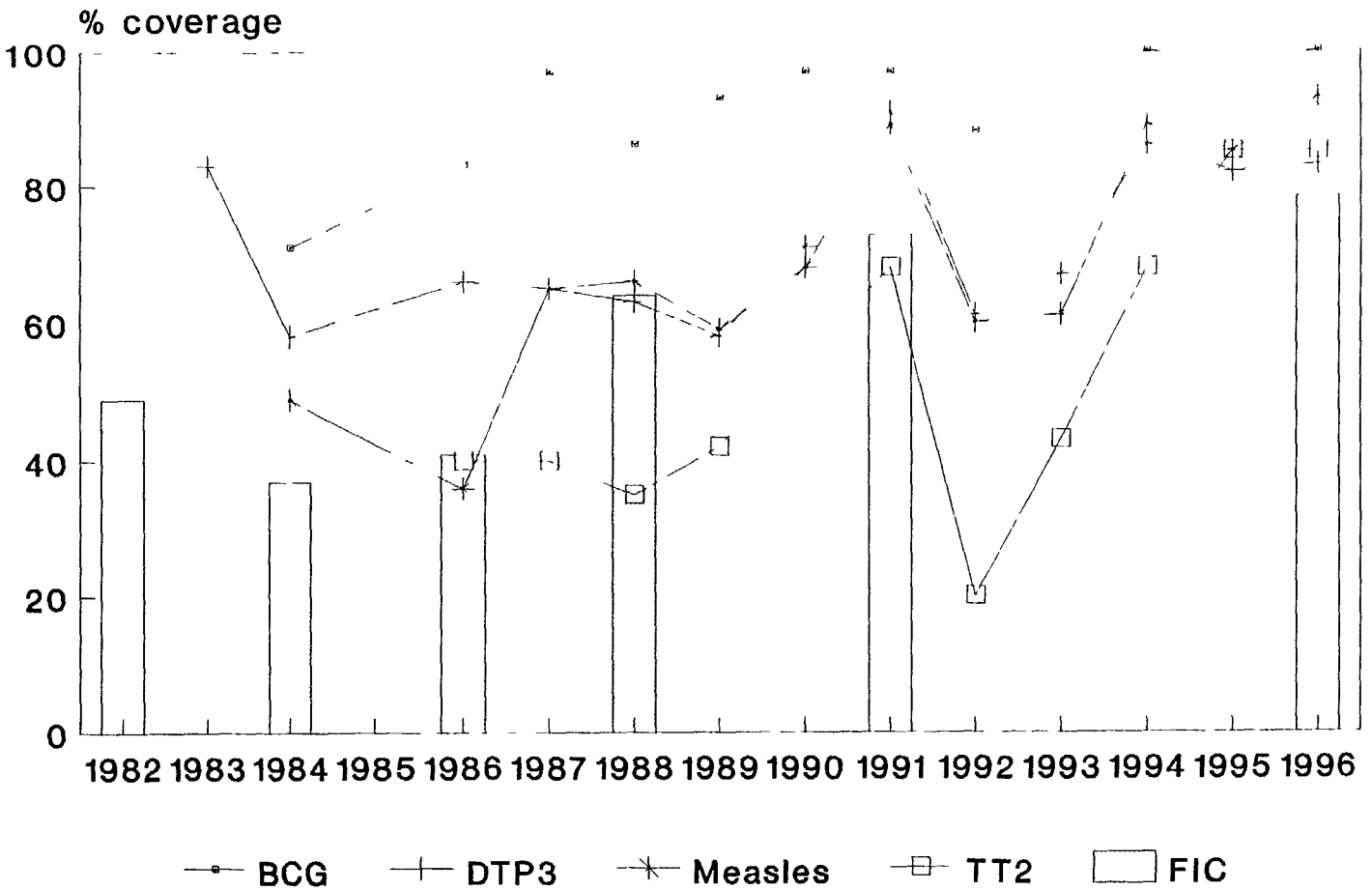
In Uganda we see a long climb to coverage of 80% to 100% reported by UNEPI, but Fully immunized under 2 reported in the 1994 Demographic and Health Survey was 47%, and Fully immunized by first birthday was 36%, with drop-out rate between BCG and measles was 43% High drop-outs have been a recognized problem for several years, but the programme does not appear to be promoting tried and tested strategies for reducing drop outs at the point of service, such as a child register Drop-outs may indicate poor quality of service and interaction between health workers and clients and we hope that the review will look into this

Reasons for lower coverage and higher drop-outs are the result of a chain of causes and effects, which this chart helps to separate into individual factors
This chart is in Document B, page 8 OH16

POLICIES →	INPUTS →	OUTPUTS →	OUTCOME→	IMPACT
Plans, strategies for best use of resources	Activities	Services provided, documented by reports and surveys	Protected children and women	Reduction in morbidity and mortality
Policies, norms and plans are developed within the local context of available resources infrastructure, staff, skills, budget	*Preparation, advocacy by health service and others including the community, staff provide sessions at clinic and outreach*	*Awareness encourages uptake, resulting in immunized children and women Coverage documents the quantity*	*Time passes*	*Health status indicators show improvement over time, reflecting the quality of services provided*

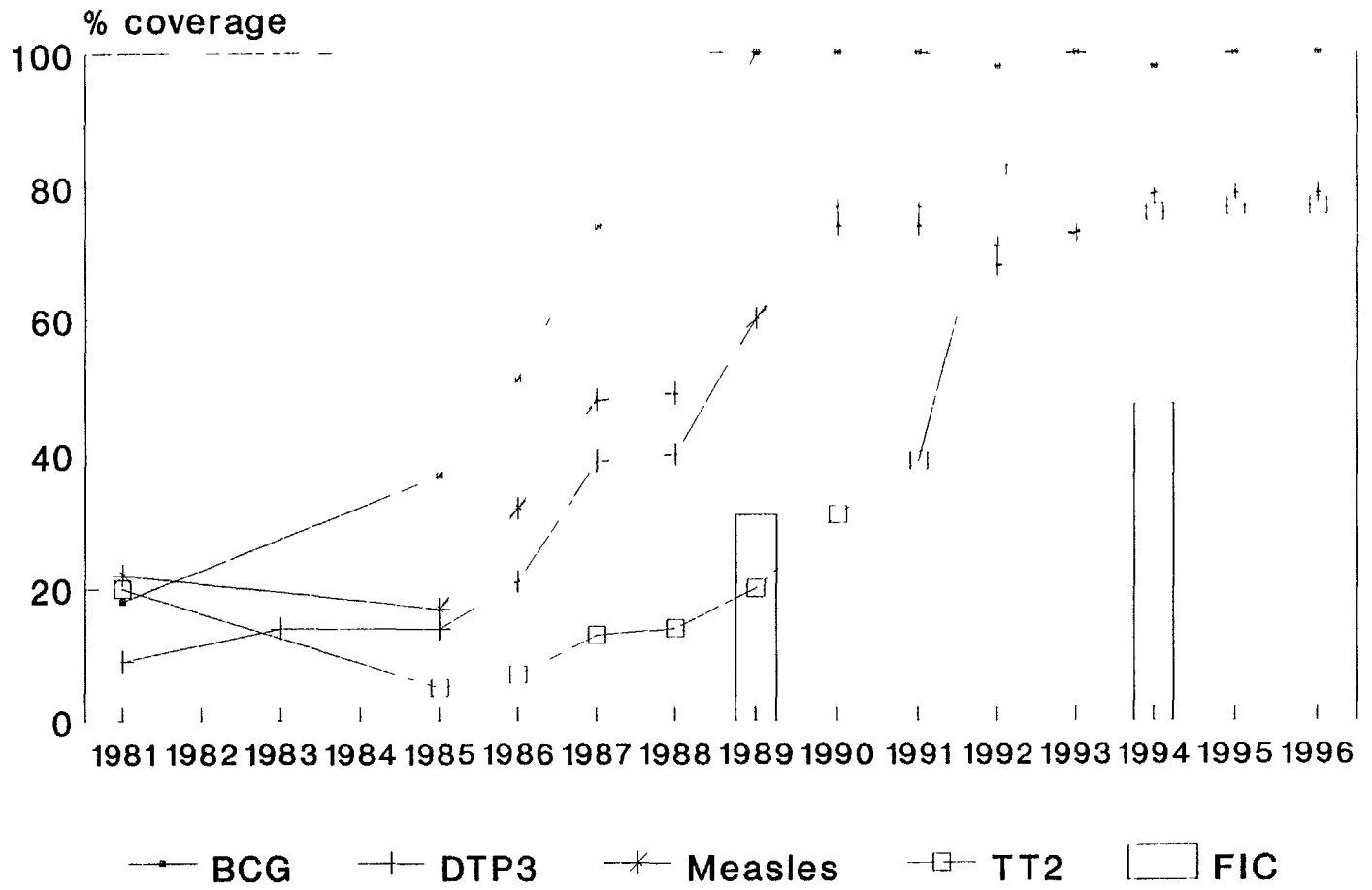
Annex 4 Seminar at WHO Geneva Text for Overheads - page 6

Zambia· immunization coverage 1982 to 1996



OH15

Uganda immunization coverage 1981 to 1996



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For example (*first column*) poor infrastructure in the way of roads or facilities, shortage of human resources, lack of funding for resupply, outreach and supervision can all limit the quantity of immunization services offered

Quality of service as reflected in high drop-outs - children who were reached once but didn't complete the schedule - may be compromised by poor communication with parents, cancellation of advertized services leading to loss of faith by clients, and so on Some of these indicators come through the regular reporting system, others can be collected during reviews or periodic surveys designed for the purpose

Our argument in the document is that the elements that go into an immunization service should be monitored not just in vertical programmes or just to track the effects of health reform but to ensure that a sustainable service of adequate quality is being delivered

The document discusses monitoring national level functions and essential supportive activities (such as making available suitable equipment), and also monitoring quantifiable indicators, and quality of service delivery

Continuous monitoring allows early action to be taken promptly

(*last column*) If you wait for impact measures, the problems may have been continuing for several years, lost time for the children eligible for immunization

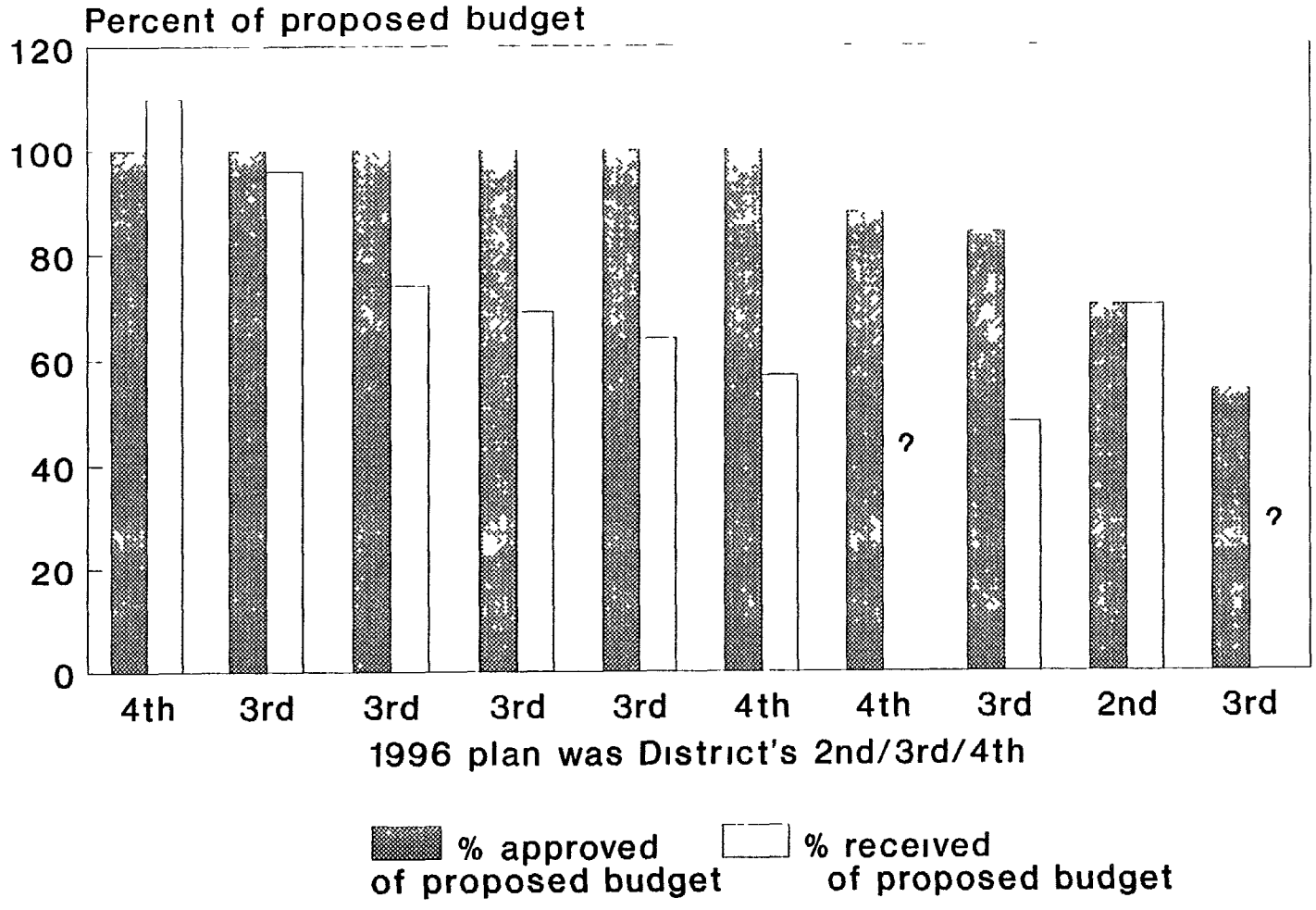
Something outside the usual EPI indicators in a decentralized system funding is so crucial that we should be monitoring it In the recent review in Zambia we asked District Health Planners two sets of questions one was to find out how much of their proposed budget was finally approved, the other was to measure how much of the approved budget was received OH17a
Half the districts visited had 100% of their proposed budget approved
But 10 out of 12 never received the full amount of the approved budget

A similar indicator developed for 1997 showed that funds typically arrived late and when they did arrive the amount was less than expected This does cause uncertainty and disruption of service delivery It also causes some resentment, especially when districts have been held to such tight top-down guidelines in preparing their annual plans and budgets
Zambia FIC< 1 by province and district OH17b

There are 3 districts for which UCI had zero FIC reported There were also some anomalies, like Lusaka Urban reporting 50% more FIC<1 than any other indicator for under-1s, and coincidentally zero FIC over 1
The local level - facility and district - is best placed for taking timely action, and provides an opportunity for increasing the awareness of local managers But this depends on local capacity to interpret and act on the information This is why the HMIS in Zambia offers such interesting possibilities

POLICIES →	INPUTS →	OUTPUTS →	OUTCOME →	IMPACT
Plans, strategies for best use of resources	Activities	Services provided, documented by reports and surveys	Protected children and women	Reduction in morbidity and mortality

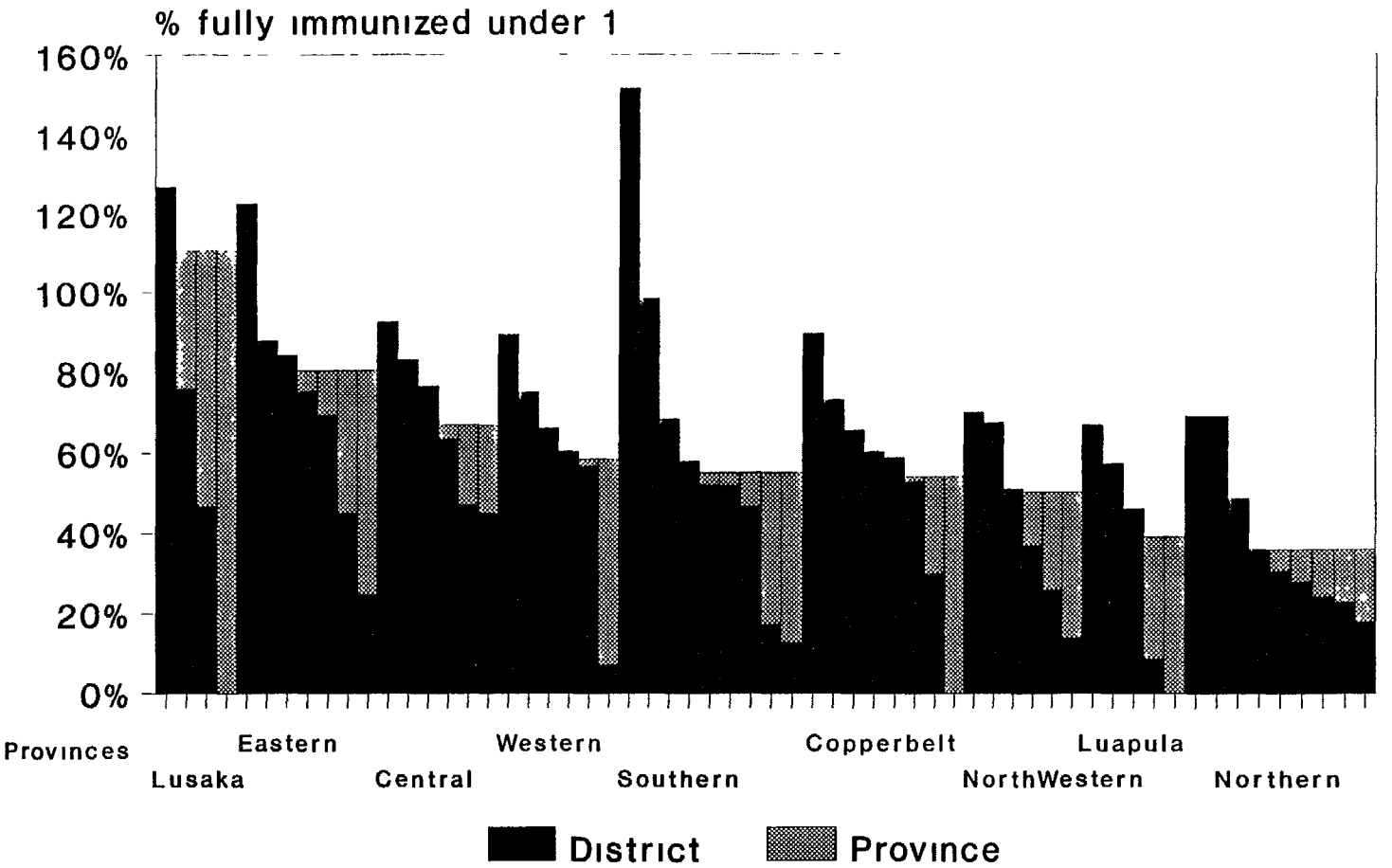
Zambia Proposed funds approved for 1996, and approved funds received by Districts



4-28

OH 17 b

Zambia FIC <1 in 1996, by province & district



4.3.1

Opportunities offered by Health Reform:

General:

- **Awareness**
- **Are we doing the right thing (effectiveness)?**
- **Are we doing the things right (efficiency)?**
- **Identify opportunities through analysis (SWOT)**
- **Creation of new alliances:**
  - **Constructive, proactive approach,**
  - **Dialogue with donors,**
  - **Role of the private sector**
- **Reiteration of local ownership**

Opportunities offered by Health Reform:

Specific:

- **Vaccine procurement with local ownership, government commitment and possible integration into general medical supplies management (VII and VIP)**

- **Storage and distribution with integration into the general medical supplies management system**

- **Revision of HMIS and proper integration with emphasis on district focus and local action (drop out monitoring)**

- **Revision of staffing pattern, competence and curriculum update with emphasis on quality of service with proper organization of services and communication with clients**

Threats:

- **Reform process too fast and ambitious without proper capacity building;**
- **Poor intersectoral communication, planning and action**
- **Competition with other sectors and sub-sectors for scarce resources (outreach and supervision)**
- **Severe shortage of qualified staff (encroachment from the private sector)**

Where to go from here?

- **Enable countries to perform their own analyses (SWOT)**
- **WHO Regions may review the situation in the respective Regions**
- **Revitalize the "EPI" Review and give it a new design suited for assessment of immunization including quality and institutional/managerial issues**

  This may be:

  - **integrated vis-à-vis other health services**
  - **intersectoral**
- **Look for opportunities in times of change**
- **Be patient. . . .**

APPENDIX E

FORMATS AND STANDARDS USED IN UGANDA

Formats and Standards used in Uganda

On the forms, the starred items (*) refer to standards which must be met for a Yes to be coded
The teams are expected to write their comments in the last column

Health Centres

Standards for Service Delivery at Health Centre Level

Health Centre Service Delivery form

Standards for Cold Chain and Logistics

Health Centre Cold Chain, Logistics

Standards for Health Centre Records and Surveillance

Health Centre Records and Surveillance

Community

Immunization assessment at community level

District level

District Planning, Budgeting and Cost Management

District Cold Chain, Logistics

District Records and Surveillance

Standards for Service Delivery at Health Centre Level

S7 Syringe/needle sterilization **ALL POINTS MUST BE CORRECT**

- if pressure cooker used - sterilizables placed in water to soak immediately after use
  - syringe barrel and plunger, and needles all separated on rack
  - fresh water used for each session of sterilization
  - 20 minutes' sterilisation, from time water in cooker comes up to pressure
- if pot for boiling used - sterilizables placed in water to soak immediately after use
  - about 2cm water should cover syringes and needles in pot
  - pot should continue boiling for 20 minutes after boiling starts
  - pot covered with lid throughout boiling
  - fresh water for each sterilization session
- for disposable needles/syringes in cellophane check that package is sealed, and check expiry date

S9 Correct screening for infant immunization **ALL POINTS MUST BE CORRECT**

- health worker asks for infant's immunization card and/or asks caretaker about previous vaccinations
- asks about and verifies vaccines given and dates on card, and looks for scars
- informs caretaker about vaccine(s) needed, when and where

S10 Correct recording in register

- verify record of date, child's names, address, birthdate, sex, weight and vaccination given

S11 Correct recording on card

- verify birthdate, dates of doses, month & child's weight, vaccination, any supplement given

S13 Caretaker checked and referred for TT **ALL POINTS MUST BE CORRECT**

- female caretaker asked for TT card
- if no card, woman asked about number of TT immunizations received during pregnancies
- told whether or not additional TT dose(s) needed, and where and when to get them

S14 Sick children screened and referred

- either in MCH clinic or in OPD where sick children are consulted, verify whether health centre staff screen and refer sick children for immunization

S15 All EPI injections sterile

Sterile needle and sterile syringe for every injection Sterilizables assembled using forceps

S17 EPI injections correct **ALL POINTS MUST BE CORRECT**

- BCG
  - reconstituted with quantity of diluent specified on vial
  - administered intra-dermally with 26 G needle
  - dose of 0 05ml for infants <1yr, 0 1ml for children >1yr of age
- DPT
  - administered IM with 22 G needle
  - 0 5ml for each dose
- Measles
  - reconstituted with quantity of diluent specified on vial
  - administered sub-cutaneously with 22G needle
  - dose of 0 5ml

S18 OPV dose correct 2 or 3 drops, as specified on vial

S19 Sterile technique meets standards

- injection site cleaned with sterile water on sterile gauze or cotton wool
- sterile needle/syringe used for injection (see S15), needle remains assembled (not in septum)
- new sterile gauze or cotton wool used to compress injection site

S20 Vitamin A screening and administration

- verify if all ill children to be vaccinated are given Vit A supplements 100,000 units for 6-12 mths
  200,000 units >12 mths

S21 Client-staff interchange

- health worker greets child's caretaker and asks for immunization card in friendly manner
- health worker not rude or impatient when giving information to caretaker
- read client's face

S23 Client told of reactions

- possible soreness, pain and/or swelling on injection site
- fever
- BCG only scar formation

Sustaining Benefits of Immunization - Uganda - October 1997 Service delivery

District _____ Unit_____ Type_____ ☐☐☐☐

Date of visit dd/mm __/__ Urban U Rural R Staff _____ Static S Outreach O None N

Category and Question	Q#	Response	Comment
Number of static sessions scheduled per month	S1		
Number of static vaccination sessions held in Septembr	S2		
Number of outreach scheduled per month	S3		
Number of outreach held in September	S4		
Vaccination session held today? Y/N	S5		
Minutes between scheduled time & starting time	S6		
Syringe & needle sterilizations meet standards Y/N *	S7		
Vaccines in use kept cold and out of sun Y/N	S8		
Screening correct for infant immunization # of 5 *	S9		
Information recorded correctly in register # of 5 *	S10		
Information recorded correctly on card # of 5 *	S11		
Date of today's dose filled in after antigen given # of 5	S12		
Caretaker (F) checked and referred for TT # of 5 *	S13		
Are sick children screened & referred for imm Y/N *	S14		
All EPI injections given w/ sterile needle syringeY/N *	S15		
All clinic injections given w/ sterile needle syringe Y/N	S16		
EPI injections correct reconstit /administr /dose Y/N *	S17		
OPV dose correct Y/N *	S18		
Sterile technique meets standards Y/N *	S19		
Vitamin A screening and administration to <1s Y/N *	S20		
Client-staff interchange friendly and positive # of 5 *	S21		
Client told when to return # of 5	S22		
Client told of reaction to BCG or DPT # of 5 *	S23		
Last visit from supervisor mm yy Comment on followup	S24		
Exit Mothers happy with service # of 5	S25		
Exit Clients know when to return # of 5	S26		
Exit Clients know reactions and what to do # of 5	S27		
Would Team Memb take their child to this clinic Y/N	S28		

Standards for Cold Chain and Logistics

The Vaccine Vial Monitor Questions and Answers

At *the starting point*, the inner square is a *lighter* colour than the surrounding circle As long as the level and/or duration of heat does not damage the vaccine, the inner square remains lighter than the surrounding circle

At *the discard point*, the inner square is the same colour as the surrounding circle This reflects an unacceptable level of heat exposure which will have damaged the vaccine

What are the rules for reading the vaccine vial monitor?

The point to focus on is the colour of the inner square relative to the colour of the surrounding circle

- Rule 1 If the inner square is lighter than the outer circle, the vaccine may be used

- Rule 2 If the inner square is the same colour as, or darker than, the outer circle, the vaccine must not be used

A simple glance at the monitor will be enough to show whether the vaccine can be used or not

Action to be taken when fridge has broken down

1 Place vaccines in a cold box

2 with frozen ice packs

3 and take the cold box to the nearest facility with a functioning fridge

4 Call for the District Technician if you are not able to fix the problem yourself

4 (Check that health unit has a cold box and that there are frozen icepacks in the fridge)

Has DPT been frozen? The Shake Test

[photocopied from the best pictures available]

Sustaining Benefits of Immunization -Uganda - October 1997 **Cold chain, logistics**

District _____ Unit_____ Type_____ ☐☐☐☐

Date of visit dd/mm __/__ Urban U Rural R Staff_____ Static S Outreach O None N

Category and Question	Q#	Fridge	Freezer	Comment
Equipment type E=elec G=gas K=kerosene S=solar	C1			
Days recorded since 1/10/97	C2			
Since 1/10/97 number of days in correct range	C3			
Thermometer in place Y/N	C4			
Current temperature –/+ °C	C5			
Equipment clean with vaccines and drugs only Y/N	C6			

		Response	Comment
BCG doses/vial ___ Number of vials of BCG in stock	C7		
Number of diluent ampoules for BCG in stock	C8		
DPT doses/vial ___ Number of vials of DPT in stock	C9		
OPV doses/vial ___ Number of vials of OPV in stock	C10		
Meas doses/vial ___ Number of vials Measles in stock	C11		
Number of diluent ampoules for Measles in stock	C12		
TT doses/vial ___ Number of vials of TT in stock	C13		
All vaccines in fridge & freezer within expiry date Y/N	C14		
VVMs any inner circles same colour or darker? Y/N *	C15		
Opened vials=O Reconstituted vaccine=R Neither=N	C16		
Any vials without labels? Y/N	C17		
Do you collect (C) your vaccine or is it delivered (D)?	C18		
When was your last stockout? month/year Which vax?	C19		
Last stock out of child health cards? month/year	C20		
Last stock out of TT cards? month/year	C21		
Knows shake test Y/N Comment if any frozen DPT *	C22		
Knowledge of VVM correct Y/N *	C23		
Actions to broken fridge meet standards Y/N *	C24		
Syringe type S=sterilizable D=disposable A=autodestr	C25		
Are needles/syringes adequate to meet needs? Y/N *	C26		
Sterilizing eqpt, spares, fuel & supplies available Y/N *	C27		
Waste disposal Bury=1, Burn=2, Pit=3, Garbage=4	C28		
Are all used syringes/needles disposed of safely? Y/N	C29		

Standards for Health Centre Records and Surveillance

R9 Case definition of NNT Two of the following (code all answers in comments) -

1 Sucked normally at birth
2 Stopped sucking
3 Developed spasms
4 Convulsions
5 Died

R11 Response to NNT Two of the following (code all answers in comments) -

1 Report to District
2 Vaccinate mother of case
3 Vaccinate unprotected in neighbourhood

R12 Case definition of AFP acute (sudden) onset of flaccid paralysis in a child

R13 Reasons for AFP surveillance (code all answers in comments)

1 To identify residual foci of paralytic polio essential to eradication
2 To identify areas that need intense mop-up
3 Required (=> ?? cases per year prior to stopping NIDs)

R18 Case definition of Measles Three or more of the following (code answers)

1 Fever
2 Cough
3 Rash
4 Conjunctivitis

R20 Actions in response to an outbreak of measles
Using UNEPI's guidelines, identify actions

1
2
3
etc

Write codes of the answers mentioned by the health worker, multiple codes are expected

and specify how many of these actions must be mentioned by the health worker for a "Yes "

Sustaining Benefits of Immunization -Uganda - October 1997 **Records and Surveillance**

District _____ Unit_____ Type_____ [ ][ ][ ][ ]

Date of visit dd/mm __/__ Urban U Rural R Staff _____ Static S Outreach O None N

Category and Question	Q#	Response	Comment
HC site open Y/N	R1		
HC site clean and orderly Y/N	R2		
Map of catchment area on wall Y/N	R3		
Schedule of outreach sites posted? Y/N	R4		
HC catchment area population	R5		
Target population for under-1s	R6		
Wall chart comparing targets & vaccinations 1997 Y/N	R7		
Does wall chart (R7) include September numbers Y/N	R8		
Knows case definition of NNT (2 or more signs) Y/N *	R9		
How many cases of NNT from 1/1/97 to 30/9/97	R10		
Knows at least 2 actions in response to NNT case Y/N *	R11		
Knows case definition of AFP Y/N *	R12		
Knows reasons for AFP surveillance Y/N *	R13		
Who should detect and report AFP? 1=Hospital, 2=HC, 3=community, 4=others (define) Code all answers	R14		
How do you respond to AFP? 0=nothing, 1=investigate, 2=report, 3=other response (describe) Code all answers	R15		
How many AFP cases were reported in 1996 & 1997?	R16		
Knows case definition of measles 3 or more=Y else N *	R17		
Who should detect and report measles? 1=Hospitals 2=HC 3=community 4=others (describe)	R18		
Number of measles cases needed for you to act	R19		
Response to an outbreak of measles ?? actions correct *	R20		
Number of measles cases reported in 1996	R21		
Number of measles cases reported in 1997 so far	R22		
How often do you submit a communicable disease report? O=only if a case, W=weekly, M=monthly, Q=quarterly	R23		
When was last comm disease report sent to district mm/yy	R24		
Do you submit a comm disease rpt if no cases occur? Y/N	R25		
Is there a children's register Y/N	R26		
If R26=yes What is it used for? N=only registration, L=lost cards replaced, R=report prep, C=coverage, D=drop-outs, F=follow up S=strategic planning, G=growth monitoring, A=Vit A Code all answers Describe other uses	R27		
Total attendance for immunization in September	R28		
How is tally sheet used after the session? N=no tally sheet, R=report prep, D=drop-outs, C=coverage, V=vax utilization	R29		
Do you receive feedback on your reports? Y/N If Yes, From whom, and describe feedback	R30		

Immunization Assessment at Community Level District _____ Health Unit _____ Team _____

Code 1 =accessible village one kilometre from health unit or outreach site,

Code 2 =accessible village 2/3 of the distance to the furthest point in catchment area of health unit Village _____ Km from Unit/Outreach ____

Is there a Village Committee? Y/N Community Health Worker? Y/N If yes, type _____

Question Mothers	1	2	3	4	5	6	7
1 Age of mother							
2 Age of child in months (0 to 24 months)							
3 Birth order of this child							
4 Child health card							
5 If card seen How many doses were on time? DPT3 by 6/12, Measles by 1 yr							
6 If no card How many doses received? Use site of dose as prompts							
7 BCG scar? Y/N							
8 Where does mother take child for immunizations? (Use codes for Q 8)							
9 Travel time to reach where mother goes for immunization - in minutes							
10 How many times did you go for immunization with this child?							
11 How many times did you find the service there ready for you?							
12 Do you feel welcomed at the immunization session? Y/N							
13 Are you happy with the care you receive? (Use codes for Q 13)							
14 Have you ever been asked to pay for immunization? If Yes How much?							
15 Do you know the names of any diseases prevented by immunization? Code all D=diphtheria, M=measles P=polio T=tetanus TB=TB W=whooping cough							
16 If any of these diseases broke out in the village what would you do about it? (Use codes for Q 16)							
17 Are there any problems with getting your child vaccinated? (Use back of page)							
18 How could these problems be solved? (Use back of page)							
19 Does anyone in village keep track of infants for immunization? If Yes Who?							

Code Q 8 D=DMU, C=Health Centre, O=outreach, M=mission or NGO, P=private, H=hospital

Code Q 13 E=excellent, G=good, F=fair, P=poor

Code Q 16 N=nothing, D=DMU, C=Health Centre, O=outreach, M= mission or NGO, P=private, H=hospital

Sustaining Benefits of Immunization -Uganda - October 1997 **Cold chain, logistics**

District _____ Staff _____ ☐☐

Date of visit dd/mm __/__ Team _____

Category and Question	Q#	Fridge	Vax frzer	Icepack
Equipment type E=elec G=gas K=kerosene S=solar	C1			
Days recorded since 1/10/97	C2			
Since 1/10/97 number of days in correct range	C3			
Thermometer in place Y/N	C4			
Current temperature -/+ °C	C5			
Equipment clean with only vaccines and icepacks? Y/N	C6			

		Response	Comment
BCG doses/vial ___ Number of vials of BCG in stock	C7		
Number of diluent ampoules for BCG in stock	C8		
DPT doses/vial ___ Number of vials of DPT in stock	C9		
OPV doses/vial ___ Number of vials of OPV in stock	C10		
Meas doses/vial ___ Number of vials Measles in stock	C11		
Number of diluent ampoules for Measles in stock	C12		
TT doses/vial ___ Number of vials of TT in stock	C13		
All vaccines in fridge & freezer within expiry date Y/N	C14		
VVMs any inner circles same colour or darker? Y/N *	C15		
Opened vials=O Reconstituted vaccine=R Neither=N	C16		
Any vials without labels? Y/N	C17		
Is stock book up to date for all antigens? Y/N	C18		
When was your last stockout? month/year Which vax?	C19		
Last stock out of child health cards? month/year	C20		
Last stock out of TT cards? month/year	C21		
Knows shake test Y/N Comment if any frozen DPT *	C22		
Knowledge of VVM correct Y/N *	C23		
Actions to broken fridge meet standards Y/N *	C24		
Syringe type S=sterilizable D=disposable A=autodestr	C25		
Are needles/syringes adequate to meet needs? Y/N *	C26		
Sterilizing eqpt, spares, fuel & supplies available Y/N *	C27		
Waste disposal Bury=1, Burn=2, Pit=3, Garbage=4	C28		
Are all used syringes/needles disposed of safely? Y/N	C29		
Number of functioning cold boxes	C30		

Sustaining Benefits of Immunization -Uganda - October 1997 **Records and Surveillance**

District _____ Staff _____ ☐☐

Date of visit dd/mm __/__ Team _____

Category and Question	Q#	Response	Comment
Map of District catchment area on wall Y/N	R1		
Schedule of static and outreach sites posted? Y/N	R2		
District population	R3		
Target population for under-1s	R4		
Wall chart comparing targets & vaccinations 1997 Y/N	R5		
How often imm data reported to Entebbe? W/M/Q/A	R6		
Knows case definition of NNT (2 or more signs) Y/N *	R7		
How many cases of NNT identified in 1996 & 1997 to date	R8		
Knows at least 2 actions in response to NNT case Y/N *	R9		
Knows case definition of AFP Y/N *	R10		
Knows reasons for AFP surveillance Y/N *	R11		
Who should detect and report AFP? 1=Hospital 2=HC 3=community 4=others (define) Code all answers	R12		
How do you respond to AFP? 0=nothing 1=investigate 2=report 3=other response (describe) Code all answers	R13		
For how many days do you carry out (response to R15)?	R14		
Within how many days of onset must you collect stool?	R15		
How many AFP cases were reported in 1996 & 1997?	R16		
Knows case definition of measles 3 or more=Y else N *	R17		
Who should detect and report measles? 1=Hospitals 2=HC 3=community 4=others (describe)	R18		
Number of measles cases needed for you to act	R19		
Response to an outbreak of measles ?? actions correct *	R20		
Number of measles cases reported in 1996	R21		
Number of measles cases reported in 1997 so far	R22		
How often do you submit a communicable disease report? O=only if a case W=weekly, M=monthly, Q=quarterly	R23		
How many negative comm disease rpts submitted in 1997?	R24		
Do you estimate coverage using doses and all <1s? N=no if Yes How often? M=monthly Q=quarterly Y=yearly	R25		
Drop-out rates calculated? 0=none 1=BCG-DPT1 3=BCG-DPT3 4=BCG-measles	R26		
If R25 or R26=yes How do you use the data? R=reports, P=performance monitoring F=follow up feedback to units S=strategic planning Code all answers	R27		
How many units provide immunization services? Answer for each category Count government hospital OPD & HCs & DMUs as Govt	R28		Govt Mission/NGO Private
Do you receive feedback on your reports? Y/N If Yes From whom and describe feedback	R29		

District _____ **Planning, Budgeting & Cost Management**

Job position of respondent _____ Team _____

Date _____

1 When did you first prepare a plan for health services? _____

2 What does the budget with which you work cover? [Y/N]

Routine immunization services? _____

Primary health care? _____

Hospital services _____

Other? _____

2 1 Does this budget include campaigns (NIDs)? _____

2 2 Does it include outbreak response? _____

3 1 What is the budget based on? (e g district priorities? a workplan? population?)

_____

_____

3 2 What is the process for approval (e g DHT prepares and presents to whom? What discussions took place, what issues vis a vis District Council priorities?

4 1 How much was the proposed budget <u>last</u> year? U Sh _____

4 2 How much was the final approved budget? U Sh _____

4 3 How much of your final approved budget did you actually receive <u>last</u> year? U Sh _____

5 How much of your budget <u>last</u> year was for

health centres? U Sh _____

hospitals? U Sh _____

DHT expenses? U Sh _____

[if not yet equal to 4 3] Other _____ U Sh _____

_____

6 1 How much is the approved budget for <u>this</u> year? U Sh _____

6 2 How much have you received this year? U Sh _____

6 3 Number of months into the budget cycle _____

7 How much of <u>this</u> year's budget is allocated to the essential health services? U Sh _____

8 Have there been any financial constraints which limited immunization services in the district over the last three years?

1995 _____

1996 _____

1997 _____

9 1 What is the biggest problem connected with managing health costs in this district?

9 2 What is the cause of this problem?

9 3 Do you have any suggestions for solving this problem?
[Use back of page for answer]

9 1 [biggest problem]

_____
_____
_____
_____

9 2 [cause of that problem]

_____
_____
_____
_____
_____
_____

9 3 [suggestions for solving that problem]

_____
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APPENDIX F

PRESENTATION TO UNEPI IN ENTEBBE, UGANDA

Annex 6 Presentation to UNEPI in Entebbe, Uganda

DEBRIEFING MEETING ON THE FINDINGS BY THE CONSULTANTS FROM WHO, GENEVA AND UNEPI OFFICIALS ON IMMUNISATION AND DECENTRALISATION IN JINJA AND SEMBABULE DISTRICTS, 15/10/1997

OBJECTIVE

- TO HAVE AN INSIGHT ON HOW IMMUNISATION SERVICES ARE DELIVERED WITHIN THE CONTEXT OF DECENTRALISATION IN UGANDA
- TO PRETEST A SUPPORTIVE SUPERVISION CHECKLIST AND CONSIDER ITS APPLICABILITY DURING THE NATIONAL EPI REVIEW

PREPARATION

DMO MASAKA WAS BOOKED FOR AN APPOINTMENT TO RECEIVE THE TEAM AND PREPARE FOR THEIR JOURNEY TO SEMBABULE DISTRICT

DMO JINJA COULD NOT BE BOOKED FOR AN APPOINTMENT DUE TO FAILURE OF COMMUNICATION BOTH ON TELEPHONE AND RADIO-CALL

AT THE DISTRICT MEDICAL OFFICE

Dr Nyanzi and his Staff, DMO Masaka received the team well and proceeded to Sembabule in the company of the District Cold Chain Assistant

Mrs Kisigwa Florence, Nursing Officer , District Medical Office Jinja received the team (DMO was at a two-day seminar in Kampala)

PROCEDURE

THE JINJA TEAM PAID COURTESY CALLS ON

- ACAO, I/C HEALTH
- ARDC, I/C HEALTH
- MEDICAL SUPERINTENDENT, JINJA HOSPITAL

THE TEAM TO SEMBABULE WAS NOT ABLE TO MEET THE NEWLY POSTED DMO BUT CALLED ON MINNESOTA INTERNATIONAL NGO, INVOLVED IN CHILD SURVIVAL ACTIVITIES

FIELD FINDINGS

Units visited

Jinja	Children s Ward at Jinja hospital, Busede H/C
Sembabule	Lwebitakuli Dispensary NGO, Community survey-5 mothers

Observations at the immunisation session

- Adequate staff for urban hospital
- Shortage of staff for rural units
- Sponge method is practiced in Sembabule but not in Jinja (use shallow tray)
- Steam sterilisation is used correctly (NGO) Sembabule, Jinja (Children's Ward Jinja Hospital)
- Weighing of children is irregular but well done Plotting of the data on the graph is not properly done
- Session observed in Sembabule started late whereas that observed in Children s Ward had just ended, but still receiving late comers
- Shortage of CHC and poor retention of TT cards

Communication with mothers during lesson

[*At this point the presenters moved into a role play illustrating the style of communication*]

- Physical distance between mother and vaccinator is long
- Health education - when to bring back the child, side effects, etc is not communicated to the mother

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COLD CHAIN

- Fridges in Units visited were in working condition
- Tempe ature recording is done though not done on weekends and public holidays in Children's Ward Jinja Lwebitakuli had run short of temperature charts
- No Unit lacked vaccines
- Vaccine records were not readily available at Children's Ward Jinja They reported having no vaccine control book
- VVM is correctly interpreted
- The VVM on 18 vials of OPV had changed colour in the fridge at Children's Ward Jinja. [*This was illustrated by dropping all 18 vials onto the table - quite percussive*]
- The daily static immunisation activities plus outreach on Wednesday and Friday afternoons for Busede Health Centre does not allow proper freezing of icepacks in the RCW42

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Assessment of Immunisation concept in the Community

- The community is aware of immunisation services but did not know the age group that should benefit from the service
- Retention of Child Health Card is poor
- Mothers claiming to have got their children (<2 years) immunised, had no trace of BCG scar
- Tracing of children for immunisation is not done, nor is follow-up of drop-outs

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DISEASE INCIDENCE (MEASLES)

SEMBABULE DISTRICT -LWEBITAKULI DISPENSARY-NGO

- 1996 240 cases
- 1997 360 cases (September alone had 40 cases)

JINJA DISTRICT- BUSEDE HEALTH CENTRE

- 1996 50 cases (January - July 1996)
- 1997 175 cases (most cases reported May-September 1997)
  June alone had 49 cases

Note Some children in Jinja caught measles even after measles vaccination

SUPPORT SUPERVISION

- Lwebitakuli - last visit was made in April 1997

- In general there is lack of budget for DHT visits due to lack of priority