Uganda Country Summary, March 2017

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Uganda—Selected Demographic and Health Indicators			
Indicator	**Data**	**Indicator**	**Data**
Population (1)	40,322,685	DTP3 (2)	79%

Sources: UDHS 2016.

Strategic Objectives

1. Strengthen the Uganda National Expanded Programme on Immunization's (UNEPI's) institutional/technical capacity to plan, coordinate, manage, and implement immunization activities at national level.
2. Improve district capacity to manage and coordinate the immunization program as guided by UNEPI leadership.

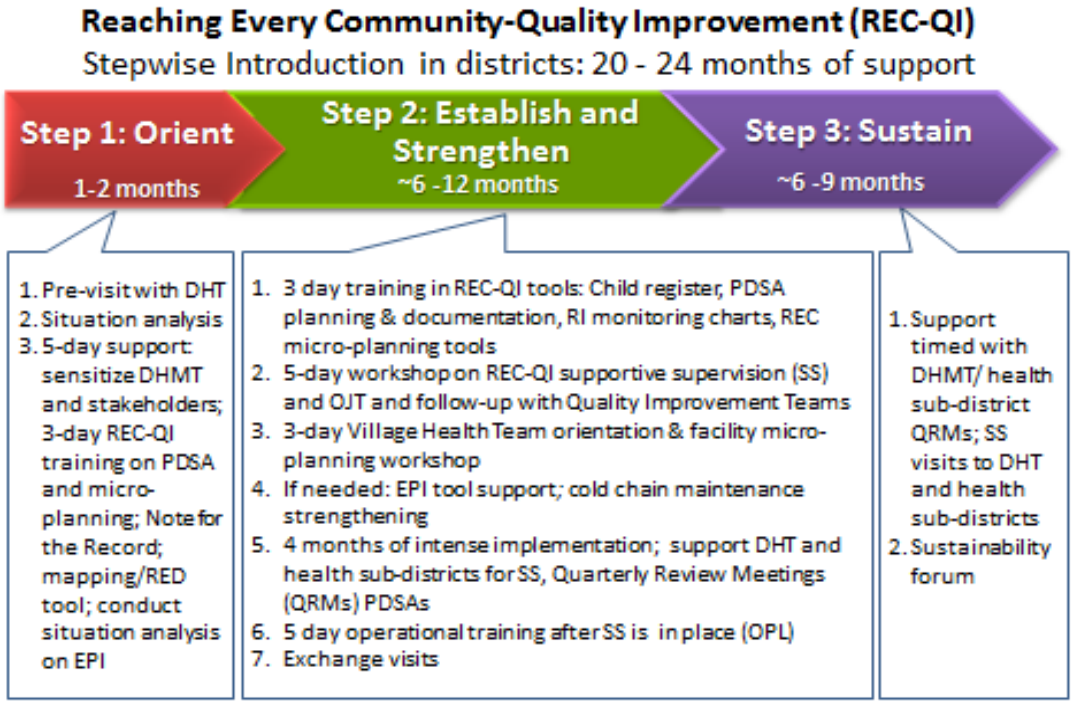
Program Dates	July 2014 - December 2018		
Financial Summary	Expenditures thru PY2 [redacted]; PY3 Budget [redacted]; Total PY1-3 [redacted]		
Geographic Scope	National and district level		
Geographic Presence	**No. of provinces (%)**	**No. of districts (%)**	**No. of facilities/communities (%)**
	Eastern, East Central and South Western Region (30% of the 10 regions in Uganda)	10 districts (9% of 112 total districts)	403 health facilities (100% of health facilities in 10 districts)
Technical Interventions	PRIMARY: Immunization Cross-cutting: Quality, HSS/Equity, Community, Innovation		

Key Accomplishments

The REC- QI Approach: MCSP is working with the Ugandan Ministry of Health (MOH) and its Expanded Programme on Immunization (UNEPI) at national level to operationalize the Reaching Every Child/ Community using Quality Improvement Approach (REC-QI) in ten (10) districts. REC-QI focuses on district and health facility management processes and applies methods from the field of quality improvement (QI) to help increase coverage and reach every child with immunization services that are effective, safe, responsive to community needs and sustainable. MCSP Uganda continues work started by USAID's predecessor project, Maternal and Child Health Integrated Program (MCHIP) and is implemented side-by-side with the Bill & Melinda Gates Foundation (BMGF)-funded *Stronger Systems for Routine Immunization (SS4RI) Project* in ten additional districts. REC-QI is one of the seven priority "innovations" that MCSP is introducing and studying as part of its global innovations and learning agenda.

The REC-QI implementation process (shown in Figure 1 below) entails: 1) introducing the approach to the district and health facilities (Orient); 2) implementing REC-QI and determining its contributions to the routine immunization system (Establish and Strengthen); and, 3) adding it into the routine operations and plans of districts and health facilities (Sustain). REC-QI implementation from start to finish takes approximately 24 months in each district. Depending on which stage of REC-QI implementation a district is in, it receives differing amounts and kinds of support from MCSP (Figure 1). In general, MCSP supports the training of district managers, health workers and village health teams (VHTs) in immunization, microplanning, EPI management, and the use of key REC-QI tools. The program also trains supervisors in supportive supervision, and supports quarterly review meetings (QRMs) that are led by district health management teams (DHMTs). QRMs are the platform for the DHMTs and district and sub-county political, religious and civic leaders to jointly reflect on the performance of routine immunization and other maternal and child health (MCH) services and to develop action plans to address challenges.

Figure 1: The phases and inputs of the REC-QI model.



QRMs are used to identify challenges with political and civic leaders, analyze root causes of specific challenges using tools adapted from REC and QI, and develop solutions that are tested through the Plan-Do-Study-Act (PDSA) cycle and adopted as routine, once they are proven successful. Successful strategies have included follow-up by district and sub-county leaders to ensure that primary health care funds adequately support the staff and village health teams (VHTs) involved in immunization activities; increasing the involvement of civic and political leaders in supporting immunization activities; and, using health facility data to improve vaccine forecasting, procurement and distribution. All REC-QI activities are district-led, with MCSP and the MOH providing technical and financial assistance. In the last phase of the REC-QI cycle (Sustain), support from MCSP and the MOH continues to reinforce uptake of the REC-QI practices while MCSP's direct support declines. At the end of the "Sustain" phase, MCSP withdraws and the MOH and the districts continue the work without outside support.

Progress on district implementation: Work was initiated in MCSP PY1 with two districts that recently completed the full REC-QI implementation cycle and graduated from direct MCSP support. The four districts added in PY2 are in the full "Establish and Strengthen Phase", and four additional districts were recently selected, in consultation with USAID and the MOH, for support in PY3/4. (See Table 1). Results in PY1 and PY2 districts are described below.

Table 1. Stages of REC-QI implementation in MCSP-supported districts by program year/quarter/month (April 2015 to March 2017).

#	District	2015									2016													2017		
		Apr-June			Jul-Sep			Oct-Dec			Jan-Mar			Apr-June			July-Sept			Oct-Dec			Jan-Mar		
		A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
PY1 Districts																										
1	Kanungu																									
2	Butaleja																									
PY2 Districts																										
3	Ntungamo																									
4	Mitooma																									
5	Kibuku																									
6	Bulambuli																									
PY3 Districts																										
7	Mbarara																									
8	Bushenyi																									
9	Serere																									
10	Mayuge																									

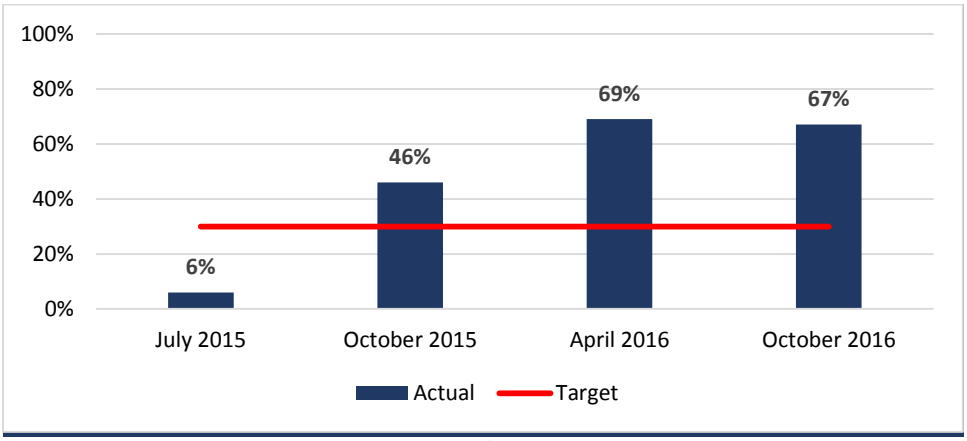
KEY:	Orient		Establish		Sustain		

REC-QI "Sustain" phase completed in PY1 districts (Kanungu and Butaleja): MCSP support to PY1 districts began in April 2015 and was successfully transitioned to the district health teams at the end of February 2017. During this period, MCSP trained a total of 2,379 individuals in these two districts in REC-QI content (see Table 1 below) including health workers, political, religious, and civic leaders, and VHTs from 76 health facilities and sub-counties.

Table 2: Number of individuals trained by MCSP in PY1 districts, disaggregated by gender (April 2015 to January 2017).

Training	Number of individuals	Female	Male
Kanungu District	**1,318**	**812**	**506**
Butaleja District	**1,061**	**491**	**570**
Total PY1 Districts	**2,379**	**1,303**	**1,076**

Figure 2. Proportion of PY1 health facilities with completed REC micro-plan, July 2015-October 2016 (n=76 HFs)

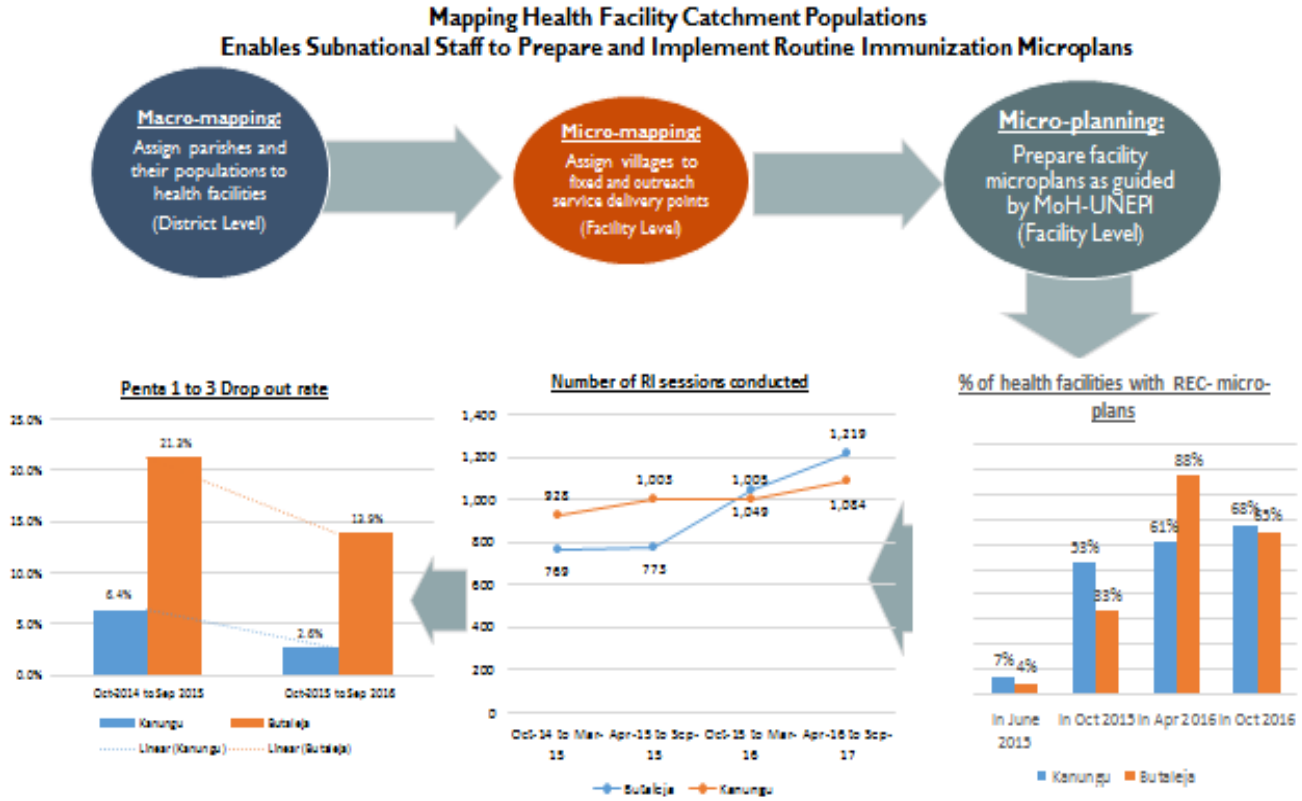


Source: Health facility assessments conducted since April 2015

As of October 2016, 67% of health facilities in the PY1 districts had reviewed and completed new health facility micro-plan; this was greater than a tenfold increase over the baseline level of 6% in July 2015. (Figure 2) There was also an increase in the absolute number of RI sessions conducted in Butaleja and Kamungu by January 2017, as compared to the period prior to REC-QI introduction. The Penta 1-3 dropout rates for these two districts also dropped from 6.4% to 2.6% between PY1 and PY2 in Kanungu and from 21% to 13% in Butaleja. (Figure 3)

By the end of the "Sustain" phase, 37% of health facilities in the PY1 districts were implementing all of the key REC-QI practices (e.g. had a micro-map, micro-plan, and a functional Quality Work Improvement Team (QWIT) that met at least once in the past 3 months). Again, this was more than a tenfold increase over the 3% the baseline, in June 2015. All of the health facilities were also found to have completed at least one PDSA cycle each during REC-QI implementation.

Figure 3. Mapping and micro-planning inputs linked to outputs and decreased immunization dropout rates in PY1 districts.



Four PY2 districts in the "Establish and Strengthen" phase of REC-QI activity (Ntungamo, Mitooma, Kibuku and Bulambuli): In April 2016, MCSP enrolled four new districts in REC-QI support--Ntungamo and Mitooma in South West Region, and Kibuku and Bulambuli in Eastern Region. Over the past 11 months of support in the PY2 districts, MCSP has trained 6,542 participants, mainly health workers, political, religious, civic leaders and VHTs, from all 112 health facilities and sub-counties in the four districts. In general, health staff training covered planning for REC-QI implementation; supportive supervision; and the use of REC-QI tools. Village Health Teams were also trained with a focus on REC micro-planning. On-site supportive supervision is used by the district and regional health teams to work with health staff on their individual challenges. A total of 98 district supervisors have been trained since the start of the program, using the WHO Mid-Level Manager's (MLM) module on supportive supervision. In an attempt to match the size of the supervisory checklist to the time that supervisors realistically have with health facility staff and their backgrounds, a shorter supervisory checklist was developed which allows more time to analyze available data and work with the health facility to address their specific challenges.

Table 3: Number of individuals trained by MCSP in the PY2 districts, disaggregated by gender (April 2016 to January 2017).

Training	Number of individuals	Female	Male
Ntungamo District	**2,170**	**1,296**	**874**
Mitooma District	**1,242**	**867**	**375**
Kibuku District	**584**	**246**	**338**
Bulambuli	**2,546**	**1,236**	**1,310**

Training	Number of individuals	Female	Male
District			
Total PY2 Districts	**6,542**	**3,645**	**2,897**

Although it is too early to analyze results in the PY2 districts, there has been progress on some of the process indicators that MCSP tracks including the percentage of planned outreach sessions that are conducted each month and the number of health facilities with up-to-date microplans. However, at least one of the districts—Bulambuli—has problems that go well beyond the mandate of MCSP or of the district health team. In this district, up to 7 sub-counties have no health facilities at all, which stands in contradiction to national policy, and there is a religious cult that opposes Western medicine and has had a serious negative impact on service utilization. MCSP is advocating with the MOH/UNEPI for special support for this particular district while continuing to provide the normal package of support.

Learning shared and PY1 & PY2 districts and health facilities recognized (Kanungu, Butaleja, Ntungamo, Mitooma, Kibuku and Bulambuli): MCSP organized learning workshops with health workers from the PY1 and PY2 REC-QI districts to bring the best performing and some of the under-performing health facilities together to learn from each other. Specifically, participants identified actions that had contributed to consistent recording of children vaccinated in the child register, continuous vaccine availability, and increased utilization of immunization services in their catchment areas. The findings from these learning workshops are guiding the roll out of REC/QI more broadly in other districts.

Four new PY3 districts selected and "Orient" phase of REC-QI under way (Mbarara, Bushenyi, Pallisa and Mayuge): MCSP, USAID and the MOH selected and then conducted visits to sensitize district leadership to the REC-QI approach in the four new PY3 districts of Mbarara and Bushenyi in South West Region, Mayuge in East Central Region, and Pallisa in Eastern Region. Baseline data were collected to facilitate planning and set the stage for monitoring and evaluation; all four districts are currently completing the "Orient" phase of REC-QI.

"Learning": In the process of REC-QI implementation, an extensive evidence base is being built from multiple data sources including baseline data, plan-do-study-act (PDSA) cycle data, supportive supervision reports and the national HMIS. The Uganda team is also working to streamline the REC-QI approach so that the most successful elements of it can be taken by UNEPI to other districts. As one of MCSP's global "innovations", the program has a robust learning agenda centered on two important study questions:

- REC/QI Assessment - What are the tangible results of the REC-QI approach and the principle enablers/drivers of change along the REC-QI continuum from "Orient" to "Sustain"?
- Doer/Non-Doer Assessment – In Kapchorwa District, which is challenged in its ability to improve the RI immunization program, even after the introduction of REC-QI, what are the factors that allow some health facilities and their catchment areas to successfully implement REC-QI, while other health facilities are less successful?

These two studies are approved by USAID, data collection is on-going and they will be completed in 2018.

New national policies and standards: MCSP has provided technical and limited financial assistance to MOH/UNEPI for development of the first-ever national Uganda Immunization Policy 2014; updating and printing the Uganda Immunization in Practice (IIP) manual, which now incorporates some REC-QI lessons and tools and is used as a field guide and reference material for pre- and in-service training of health workers. updating Uganda's EPI standards, which now include essential REC-QI elements including health facility catchment area mapping and steps to enhance utilization of the child register; and adapting and incorporating the WHO EPI prototype curriculum with the Ministry of Education and Sports' (MOE&S) training curricula. MCSP also supported the MOH's introduction of inactivated polio vaccine (IPV) and the switch from trivalent OPV (tOPV) to bivalent OPV (bOPV), and took steps to improve vaccine supply chain

management from district to lower levels, using REC-QI mapping data. Using the revised IIP Manual, MCSP and SS4RI supported UNEPI to conduct a Training of Trainers (TOT) for 39 national trainers. MCSP also continues supporting publication of a newspaper pull-out with district and regional immunization coverage data that has generated political interest and additional resources for routine immunization services.

Adapting REC-QI for other maternal and child health programs: Immunization has advanced significantly in developing simple tools and refining REC-QI processes to achieve improved results. These tools and processes, with some adaptation, could be used to estimate more accurately health facility target populations and to set targets for other population-based health programs (e.g., number of TB cases or pregnancies expected in a given community) And tools like the enhanced RED categorization tool could be adapted and used for regular monitoring of program performance and use of data for action.

Challenges

Competing MOH/UNEPI priorities have at times caused delays in implementing REC-QI activities including supplementary polio immunization activities (SIAs), IPV introduction, and the tOPV to bOPV switch in April 2016. Understaffing at UNEPI makes it difficult to carry out all planned activities. MCSP overcomes these challenges by continuously reviewing the activity timelines with the UNEPI team and maintaining a high degree of flexibility in terms of scheduling. Critical inputs are lacking in some districts (e.g., health facilities, human resources, cold chain equipment, vaccines and other supplies). Vaccine stock-outs can be attributed to challenges of communication, coordination and distribution from the district vaccine stores to health facilities. MCSP, the Clinton Health Access Initiative (CHAI) and other partners on the MOH EPI Technical Working Group (TWG) have raised the supply chain issues and MCSP is developing policy and technical briefs for advocacy with UNEPI and the Minister of Health/Primary Health Care. Finally, poor data quality makes the use of administrative data for monitoring and evaluation impossible, including for the evaluation of REC-QI. Concern over the persistent inaccuracy of Uganda's administrative data for routine immunization has led to the extraordinary decision by UNEPI and its partners to carry out district-specific coverage surveys in every district of the country in early 2017. Data quality issues within the control of health facility staff--recording details of children immunized in the child register, completing and submitting reports on time, etc.—are addressed at district level through data quality assessments, PDSA cycles, re-allocation of qualified staff to support immunization sessions, etc. MCSP shares data quality assessment results during QRMs and the program is supporting continuous monitoring of data quality at district level and seeing improvement in most cases.

Way Forward

MCSP will support the MOH/UNEPI to roll out revised frontline health worker training materials and to finalize and disseminate the new EPI standards with essential REC-QI components included. The program team will also document and share lessons learned on REC-QI implementation with USAID and other partners; and continue to explore solutions to bottlenecks by answering the two learning questions and working with other partners and stakeholders, including civil society organizations (CSOs), to address them. At the district level, MCSP will complete the roll out of the REC-QI approach in all eight districts by the end of the program in early 2018, improving district capacity to manage and coordinate their immunization activities and strengthening UNEPI's leadership and ability to support REC-QI at district level. MCSP will also continue to monitor district performance and provide technical assistance upon request to the two PY1 districts that have already completed the REC-QI cycle. In PY3/4, MCSP anticipates producing a series of technical briefs that highlight "best" RI practices and some of the proven solutions to common bottlenecks; the MOH/UNEPI, district health teams and other partners will be the target audience. Process documentation will also continue, and with greater and greater attention to the analysis and use of routine EPI data to refine the REC-QI approach. Also, before the end of the program, MCSP will document the REC-QI process in a revised *REC-QI How to Guide* and begin exploring it potential to improve the coverage and quality of other MNCH services, beyond immunization.

Expansion of MCSP's Uganda program to include child health in PY3: In mid-2016, USAID requested MCSP to expand the current scope of the Uganda RI program to include other EPCMD interventions. In early 2017, USAID requested that MCSP narrow the scope of the proposed technical assistance to focus on child health and support to USAID/Uganda's Regional Health Integration to Enhance Service (RHITES) South West and East Central bilateral programs. MCSP is in the process of developing a two-year workplan for child health technical assistance to RHITES that will build on the REC-QI approach.

Selected Performance Indicators for PY2— District performance during the periods of support by MCSP			
MCSP Global and Country PMP Indicators	**PY1 Achievement**	**PY2 Achievement**	**PY2 Target**
Number and percent of children who at 12 months have received three doses of DTP/Penta vaccination from a USG- supported immunization program.	**Overall: 101**% *(20,295 / 20,106)*	**Overall: 86%**[1]*(39,966 / 46,449)*	**90%**
	Kanungu: **111%** (11,292 /10,178) Butaleja: **91%** (9,003 /9,928)	Kanungu: **88%** (10,075 / 11,502) Butaleja: **92%** (10,280 / 11,138) Ntungamo: **84%** (9,239 / 11,036) Mitooma: **82%** (3,416 / 4,184) Kibuku: **95%** (4,363 / 4,608) Bulambuli: **65%** (2,593 / 3,981)	**90%**
Number of people trained in child health and nutrition through USG-supported programs	**Overall: 316**	**Overall: 8,711**	**8,388**
		REC-QI tools training: 307 VHT training: 8,117 Planning for REC-QI Implementation: 287	REC-QI tools training: 300 VHT training: 7,536 Planning for REC-QI Implementation: 312
% MOH/UNEPI TWG coordination meetings held where RI was discussed in a year	**83% (10/12)**	**50% (6 / 12)**	**92% (11 / 12)**
% of planned RI sessions that were conducted in the year	Kanungu: **91%** Butaleja: **92%**	Kanungu: **81%(**1,335 / 1,654) Butaleja: **100%** (1,084 / 1,083) Ntungamo: **74%** (1,597 / 2,143) Mitooma: **78%** (380 / 798) Kibuku: **52%** (791 / 1,039) Bulambuli: **46%** (398 / 2,081)	**91%**
% of planned quarterly review/coordination meetings held where RI was discussed in a district per year	Kanungu: **8%** (1 /12) Butaleja: **38%** (3/8)	Kanungu: **50%** (6 / 12) Butaleja: **25%** (2 / 8) Ntungamo: **6%** (2 / 6) Mitooma: **25%** (1 / 4) Kibuku: **25%** (1 / 4) Bulambuli: **0%** (0 / 4)	**20%**
% of health facilities with complete REC micro-plans	Kanungu: **17%** (2 /12) Butaleja: **50%** (4/ 8)	Kanungu: 67% (35 / 52) Butaleja: 67% (16 / 24) Ntungamo: 39% (19 /49) Mitooma: 57% (16 / 28) Kibuku: 38% (6 / 16) Bulambuli: 63% (12 / 19)	**30%**

[1] *Date of DHIS 2 download: October 15, 2016 for months: Oct. 2015–Sep. 2016. Note that improved data quality often results in a short-term decline in reported coverage because of greater care in recording and reporting service delivery results. Coverage should begin to improve again after such a decline, as health workers begin to measure their performance with more accurate numbers.*

% of planned integrated supportive supervision visits conducted in a district in a year	Kanungu: 7% (3 / 42) Butaleja: 4% (1/ 24)	Kanungu: **25%** (3 / 12) Butaleja: **13%** (1 / 8) Ntungamo: **13%** (2 / 16) Mitooma: **25%** (2 / 8) Kibuku: **25%** (2 / 8) Bulambuli: **13%** (1/8)	**20%**

Notes:

- These data reflect PY1 and PY2 achievements only. Partial PY3 data are reflected in the narrative portion of this summary, but not in the PMP tables above.
- Kanungu and Butaleja are PY1 districts, which means that MCSP began its support (e.g., "Orient" phase) in PY1. Data reported in the PMP tables represents MCSP support to the PY1 districts from April 2015 to September 2016.
- Ntungamo, Mitooma, Kibuku, and Bulambuli are PY2 districts, which means that MCSP began its support (e.g., "Orient" phase) in PY2. Data reported in the PMP tables represents MCSP support to the PY2 districts from April to September 2016.