

# Global Vaccine Action Plan

## *Secretariat Annual Report 2016*

### *Priority Country report on progress towards*

### *GVAP-RVAP goals*

## UGANDA

### **A. Progress towards achievement of GVAP goals**

#### **1. Summary**

This summary table describes the current situation in Uganda regarding achieving the GVAP goals. Data used to assess progress towards achievement of GVAP goals are included in the annex (Country immunization profile).

Area	Indicator	Data for Uganda
9. NITAG	NITAG established?	Yes (November 2014)

#### **2. Country ownership of the immunization programme**

##### **2.1 Immunization policy decision-making capacity**

In November 2014, Uganda transitioned its Advisory Committee on Immunization (ACVI) into a national independent immunization technical advisory group (NITAG), with technical assistance and training from WHO and the Gates Foundation-funded SIVAC project. Core members come from academia, research institutes and other organizations, with representatives of the MOH, WHO and UNICEF serving as ex-officio members. It currently meets all of the six criteria that WHO has established for a functioning NITAG.

UNITAG has already had an important decision-making role in its short history. First, it raised concerns about the impending introduction of rotavirus and the government's ability to meet its co-financing obligations and cover operational costs for rotavirus and the other vaccines in the immunization schedule. As a result, the introduction of rotavirus and all other new vaccines is currently on hold until a cost analysis of the immunization program and financial sustainability plan are developed (currently underway with WHO support). Second, UNITAG helped to convince the Parliament to add a provision for an Immunization Fund to the 2016 Immunization Act that mandates vaccination of children and women (with TT). The

purpose of the Fund, described below, is to better protect funding for immunization and mobilize additional resources from different sources.

Immunization also enjoys high-level support as a result of the establishment of a Parliamentary Forum on Immunization. The Chairperson of this group was able to block the Parliament's approval of the entire budget in 2012/13 until additional funds were added to the budget to increase the number of health workers and health worker salaries. The Forum also played a key role in the development and government approval of the Immunization Act (described below).

### **2.3 Human resource situation**

Nurses and nursing assistants make up the bulk of health workers who provide immunization services in Uganda. There is a wide range of staffing levels of health professionals by region and district, with the numbers especially inadequate in hard-to-reach and under-served areas, where retention rates are particularly low. Low salaries and a lack of housing in remote areas are key factors making it difficult to recruit and retain qualified health workers. More than 50% of the facilities visited for the Resource Tracking study<sup>1</sup> reported a health worker shortage, while the 2016-2020 Comprehensive EPI Multi-Year Plan (cMYP) reported that 39% of districts reported a health worker vacancy rate of more than 35%.<sup>2</sup> Staff shortages at the health facility level affect morale, as well as the ability of facilities to deliver adequate immunization and other services in the minimum package, including outreach activities.

Concerning immunization-specific staff at the sub-national level, all districts have an EPI focal point, as do 66% of health facilities. Due to staff shortages, this person is often a nursing assistant.<sup>3</sup> Sixty-one percent of districts had no cold chain technician in 2014. Each district also assigns a health officer to serve as the surveillance focal points, who has other responsibilities as well. In addition, there are around 12 surveillance medical officers (SMOs) working at the country's nine IDSR sub-national hubs and in districts. These are government employees who receive additional funding from WHO to enable them to focus on surveillance and supportive supervision for immunization. WHO also supports most technical staff of the national reference laboratory (Ugandan Viral Research Institute or UVRI).

To link communities to local health facilities, Uganda has a system of Village Health Teams (VHTs), made up of several community-based volunteers in each community who assist with disease surveillance, social mobilization, sanitation activities, registering births, distributing anti-malarial drugs and the like. In the area of immunization, these volunteers participate in social mobilization, especially for vaccination campaigns and new vaccine introductions; community-based surveillance; and default tracking. The recent EPI review found that 89%

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<sup>1</sup> Resource tracking for immunization in Uganda, 2013/14, GAVI evaluation. HealthNet Consult Infectious Diseases Research Collaboration, August 4, 2015.

<sup>2</sup> Government of Uganda. The Uganda national Expanded Programmed on Immunisation multi-year plan, 2016-2020.

<sup>3</sup> Uganda Comprehensive EPI, Surveillance, Immunization Financing Review and Post-introduction Evaluation of Pneumococcal vaccine, 23 Feb – 6 March 2015.

of health facilities visited had established links with VHTs and that these volunteers are the communities' primary source of information concerning immunization.<sup>4</sup>

However, the volunteers receive no salary and only a stipend or allowance, as possible, and they must also juggle immunization activities with other health priorities and programs. As a result, the activism and impact of VHTs varies considerably by area. To improve this situation, the Government has approved plans to create a new position of Community Health Extension Worker (CHEW), who will receive a government salary, have higher minimal qualifications than VHTs, and who will gradually replace the VHTs. To make the program more financially sustainable, one CHEW will cover several (e.g., three) villages.

## **B. Partner support to address remaining challenges to meet the GVAP goals and targets**

Partner support for immunization activities is similar to that in many other GAVI-supported countries, with major partners providing financial support and technical assistance for polio and measles immunization campaigns, new vaccine introductions, surveillance, training, social mobilization, cold chain improvements and so forth (see Table 1). It should be noted that much of the GAVI HSS funding had been on hold for several years due to procurement issues related to the expansion of the cold chain system (including cold room expansion at the national level, construction of district-level cold rooms, and procurement of cold chain equipment), as well as the construction of health worker housing. These issues have recently been resolved and GAVI has approved a second HSS grant (HSS II), with implementation expected to begin in 2017.

**Table 1: Major partners supporting Uganda's immunization program and their main activities<sup>5</sup>**

<b>Donor/partner</b>	<b>Recent key activities funded</b>	<b>Financial contribution to EPI (as a percent of total spending in 2013/14)</b>
GAVI	New vaccine introductions Measles/polio SIAs EPI training EPI outreach activities Supportive supervision Social mobilization HSS (partially implemented): funding for cold chain system expansion, construction of health worker housing, provide private sector health facilities with cold chain equipment and training	27%
UNICEF	Social mobilization (e.g., at community level) Immunization campaigns/SIAs Family Health Days	11.5%

<sup>4</sup> Uganda Comprehensive EPI, Surveillance, Immunization Financing Review and Post-introduction Evaluation of Pneumococcal vaccine, 23 Feb – 6 March 2015.

<sup>5</sup> I got this table from the GAVI Resource Tracking document and expanded upon it, using the PEF and what I know. Not sure of its accuracy and I need some help to complete (e.g., from WCO).

Donor/partner	Recent key activities funded	Financial contribution to EPI (as a percent of total spending in 2013/14)
	Microplanning/RED/REC implementation Cold chain improvements (e.g., remote temperature monitoring system development) Equity assessment	
WHO	Disease surveillance Immunization campaigns/SIAs New vaccine introductions Policy and leadership (development of NITAG, financial sustainability plan) Cold chain improvements (EVM implementation)	8%
USAID/MCSP (in 5 districts)	Support RED strategy and local-level micro-planning Supportive supervision	≈3%
U.S. CDC	Data quality improvements (DITs) NSTOP activities to strengthen surveillance	NA
CHAI	Supportive supervision Logistics management	NA

At the local level, partner support is especially critical to fill in the gaps in funding for both routine immunization and campaigns, given the inadequacy of PHC grant funds from the government and lack of earmarking of these funds for EPI. The GAVI Resource Tracking Evaluation (2013/14) showed that in the seven districts included in the study, if one excludes health worker salaries and the costs of purchasing, storing and distributing vaccines, partners paid for nearly all (97%) of district-level immunization-specific activities – largely SIAs and training – with UNICEF covering 57%, WHO 21%, and GAVI 19%. PHC funding covered only 3% of these expenditures.<sup>6</sup>

Below we describe by objective several partner-supported projects or initiatives that address specific weaknesses in Uganda's immunization program and have made or have the potential to make a significant difference in the program's performance.

To increase government funding for immunization and improve advocacy and decision-making:

- **Support to a high-level immunization lobbying group:** Through a Gates Foundation-funded project, the Sabin Institute, along with WHO and other partners, has assisted the Parliamentary Forum on Immunization in advocating for increased government spending on immunization. The Forum's efforts led to the drafting and enactment of the Immunization Act that includes a provision for an Immunization Fund. The Forum also encourages politicians to promote immunization amongst their constituents.
- **Support for the NITAG:** Partners, especially WHO and the SIVAC project, supported the country in establishing a NITAG and making it operational. UNITAG, as described

<sup>6</sup> Resource tracking for immunization in Uganda, 2013/14, GAVI evaluation. HealthNet Consult Infectious Diseases Research Collaboration, August 4, 2015.

above, has already played a critical role in making decisions about new vaccine introductions – adding the criteria of affordability and sustainability – called for a financial sustainability plan to be conducted, and was instrumental in getting an Immunization Fund provision added to the 2016 Immunization Act.

To improve EPI coverage and program performance:

- **Implementation of EPI Revitalization Plan:** This plan was enacted by the Government from 2012 to 2014 with funding from UNICEF, WHO, USAID, CHAI, CDC, and other partners to fill in gaps in immunization service delivery in poor-performing districts. The infusion of funding, along with technical assistance, was used to strengthen the role of VHTs in promoting immunization and in organizing outreaches; purchase vehicles and fuel to increase outreach activities and to pick up vaccines from district stores; increase supervisory visits; and implement RED/REC and microplanning. As shown in the Annex, the number of districts meeting the target of 80% coverage with three doses of DPT-containing vaccine increased significantly from 2010 to 2015, with informants attributing these gains to this Plan.
- **Assisting private health facilities in providing quality immunization services:** One objective of the GAVI HSS grant that is being implemented is to improve immunization services in private sector health facilities, which make up an estimated 19% of all health service providers in the country.<sup>7</sup> This is being done by procuring refrigerators and other cold chain equipment for around 90 private clinics in Kampala, as well as providing immunization training and supportive supervision to health workers in these facilities. The equipment procurement was delayed due to the lack of involvement of key stakeholders in selecting the health facilities and to other issues, but is now being implemented.
- **Establishment of Regional Supportive Supervision Team:** Partners, including WHO, CHAI and UNICEF, have assisted the Government in establishing these teams to increase the regular supervision of health workers, a critical element in improving and sustaining the performance of the immunization program and other components in the minimum health care services package. The teams – made up of regional EPI and IDSR supervisors, and other health professionals – operate from the regional reference hospitals and are each responsible for providing integrated supervision in to the districts in their region. Begun in 2003 with polio funding, teams have already been established in 11 of the country's 14 regions.

To improve the quality of EPI and other health data:

- **Establishment of Data Improvement Teams (DITs):** The quality of immunization and other health data in Uganda needs to be strengthened, as evidenced by the 11 or 12 point difference in immunization coverage estimates between the government's administrative data and the WHO/UNICEF estimates (e.g., 89% vs. 78% for pentavalent 3 and 94% vs. 82% for measles). Several partners, including the U.S. CDC, WHO and UNICEF, are supporting the establishment and training of district-level teams, each consisting of the district biostatistician, immunization focal point, surveillance officer and other relevant district health team members. The teams are responsible for mentoring

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<sup>7</sup> CMYP.

and training health facility staff in data management and harmonization, with an focus on immunization data and using DHIS2 software. Training of trainers and district-level trainings have taken place and teams are currently operating in 13 of the country's 14 regions. The DITs are envisioned to have regular meetings to review data, such as part of surveillance meetings. A major gap is that there is at present little supervision and follow up of the DITs.

## **ANNEX: Country immunization profile**

- Planning and management:
  - Stockouts events in 2015: 1 month for BCG
  - cMYP: 2012-2016
  - Annual Plan: Yes
- Country decision making: A NITAG was established in 2014 and meets five of the six minimum criteria defined by WHO for a functioning NITAG.