

MOBILIZING LOCAL SUPPORT FOR IMMUNIZATION:

Experience from Uganda and Ethiopia in engaging local stakeholders and leaders



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Vaccines save 2-3 million lives each year¹ when children and other beneficiaries are actually reached with immunization services.

To protect each year's cohort of children and other beneficiaries requires more than vaccines. Routine immunization (RI) programs need several program elements, each of which has associated costs.

These costs are often under-recognized and insufficiently supported, yet must be covered continuously if the public health benefits of vaccines are to be realized (Figure 1).

While vaccines and refrigerators are often funded from national budgets, it is subnational civil authorities and political leaders who decide on resource allocations to cover operational costs for immunization. Collectively referred to as "non-health stakeholders," these influential leaders have a key role to play in supporting immunization. Their decisions can reduce bottlenecks to service delivery and mobilize communities to use vaccination services. But they must first understand their roles and value immunization as an intervention vital to their community's well-being and beneficial to their own leadership.

JSI has worked in Uganda, Ethiopia, and other countries to strengthen sub-national level teamwork between the health personnel typically responsible for immunization and the non-health stakeholders who are in a position to support it. By applying tools and concepts from quality improvement to the Reaching Every District/Reaching Every Child (RED/REC) approach, JSI has

- Experience from Uganda and Ethiopia demonstrates that effective engagement of civil authorities and local political and community leaders is feasible and productive.
- It mobilizes resources for immunization, raises its profile and perceived value, enhances ownership, and stimulates context-appropriate innovations.
- Continuous engagement and a shared commitment from different actors, both within and beyond the health system, is critical to ensuring that all children, every year, are protected from vaccine-preventable diseases.

empowered health personnel to prioritize their main operational problems, identify root causes, and craft solutions appropriate to the local context. These solutions often include mobilizing local resources and fostering ownership by key non-health stakeholders at the local level.

This new engagement of non-health stakeholders has been incorporated into the current structures and processes that health managers are already involved in, such that it is not a major addition to their work. It has also brought benefits that extend beyond immunization to the health system more broadly.

Figure 1: Examples of routine immunization program needs and their associated costs

PROGRAM NEEDS	ASSOCIATED COST
 Skilled health care providers and managers to ensure high quality services	Training and supportive supervision; feedback and review meetings
 Functional supply chain to provide safe and effective vaccines	Transport for vaccine distribution; fuel to run cold chain equipment; maintenance and spare parts for refrigerators
 Services provided to all communities	Transportation for outreach sessions; allowances for health personnel
 Data management systems to manage the program	Supplies of record-keeping tools: tally sheets, registers, stock management tools, home-based records
 Strong partnerships with communities to promote utilization of services	Training and management of community volunteers; community meetings; ongoing communication

¹ <https://www.unicef.org/immunization>

Non-health stakeholder engagement in Uganda: removing last-mile bottlenecks

In Uganda², JSI has actively involved non-health stakeholders in immunization and built the capacity of health personnel to communicate constructively with them. **District health officers regularly share immunization performance data with local leaders and civil authorities** to build their understanding of both the accomplishments and problems and help craft innovative strategies to improve immunization. With guidance from SS4RI and MCSP, **district health staff engage political and civic leaders in quarterly review meetings for immunization and invite them on supervision visits**. This enables the non-health stakeholders to see for themselves the challenges in delivering RI services and recognize the role that they themselves can play to improve them.

The involvement of local leaders and civil authorities with district health teams have led to increased financial, in-kind, and social/political support for RI in more than 20 districts that SS4RI and MCSP support (as shown below).

FINANCIAL SUPPORT

- Otuke district council allocated local resources to procure gas cylinders (fuel) for refrigerators to ensure the quality of vaccines and enable reliable, uninterrupted immunization services.
- Buikwe district provided funding to transport health workers to immunization outreach sites.
- Buikwe town council allocated funds from its local revenue to pay vaccinators' allowances and transport for outreach sessions.
- Wakyato sub-county in Nakaseke district allocated local revenue to extend outreach sessions to formerly unreached villages. It also revised its process for fund requisitions for immunization to ensure accountability.

IN-KIND RESOURCES

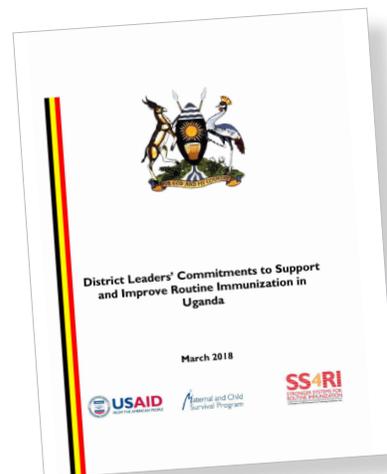
- Otuke district allowed use of the town council mayor's motorcycle to transport health workers to immunization outreach sites.
- Kalungu district's town council donated a megaphone to mobilize communities for RI.

POLITICAL/SOCIAL VISIBILITY

- Kole district's Resident District Commissioner dedicated part of his regular radio airtime to mobilize communities to use immunization services.
- Kalungu's Resident District Commissioner engaged with resistant communities to encourage their use of vaccination services.

While sometimes modest in monetary value, the various types of support outlined represent allocations that are doable within the context of the local resource envelope and address identified bottlenecks to higher immunization performance. Equally important, **the allocation of local resources by leaders enhances their ownership of the program: they look for accountability in the form of increased coverage and reach of services to all children**. For example, some administrators now request to review DTP3 coverage every month, noting that lack of funds is no longer an excuse for low performance.

In 2017, JSI brought the grassroots experience with non-health stakeholder engagement to national attention by convening a peer learning forum with health and non-health stakeholders from 18 districts in Uganda. These teams shared innovative ways in which non-health stakeholders provided additional resources from their local revenue to supplement national allocations for RI. They exchanged experience on strategies to strengthen RI leadership and mechanisms to improve accountability, such as performance contracts with health facilities. They discussed local administrators' experiences with monitoring program performance, identifying underserved communities, and sensitizing hesitant families on the importance of getting their children immunized. Through this forum, they agreed to key, specific commitments that they themselves would make to support immunization.



A key outcome was a national Ministry of Health document that formally stipulates the commitments to be made by different types of stakeholders to support routine immunization.

Engaging administrative leaders in Ethiopia: the case of Itang woreda

In Ethiopia³, JSI is liaising with district level leaders in geographically diverse and widespread areas that face challenges with health access. A key lesson learned is that securing commitments from non-health stakeholders to support RI operational costs is beneficial but requires continued engagement with leaders over time.

In Gambela region's Itang district (or "woreda"), the Woreda Health Office (WoHO) had experienced many challenges with its RI program. This WoHO lacked clearly defined plans and strategies to reach children with immunization services at clinics or community outreach sites. Scheduled vaccination sessions were frequently cancelled due to budget constraints.

² Stronger Systems for Routine Immunization (SS4RI) project and its sister project, the USAID-funded Maternal and Child Survival Program (MCSP)

³ Universal Immunization through Improving Family Health Services (UI-FHS) project

Table 1: Selected key activities in RI microplan for Itang woreda

	IMMUNIZATION OUTREACH SESSIONS	SUPERVISION VISITS	DATA REVIEW MEETINGS
Total number needed annually	276	4	4
Number supported by woreda health budget and NGO partners	120	3	3
Number supported by additional budget from woreda administration	156	1	1
Remaining gap	0	0	0



Woreda staff review immunization planning documents

Over the course of several months, JSI worked with WoHO staff to develop a detailed immunization microplan. This plan estimated the budget needed to deliver vaccination services throughout the district.

However, plans are only as good as their implementation and this requires resources.

Once the microplan was fully developed and budget gaps were clearly identified, Itang’s WoHO staff advocated for increased immunization funding

with the district’s civil authorities. After continued engagement over several months, the WoHO staff were able to present the microplan to the Itang woreda administration council, which is the body responsible for budget allocation to government services including health in the district.

This process of engagement with Itang’s health staff resulted in the woreda administrative council approving funding to cover budget gaps for key immunization program activities, including 156 outreach immunization sessions at 13 outreach sites that provide services to remote populations (Table 1).

By building woreda health staff capability to advocate effectively with key stakeholders responsible for local budgeting, UI-FHS helped Itang woreda to expand outreach immunization services to reach and vaccinate more children. This continuous and intensive process succeeded in closing a critical gap, improving the availability of vaccination services in the district.

Conclusion

Experience from Uganda and Ethiopia demonstrates that effective engagement of civil authorities and local political and community leaders is feasible and productive. It mobilizes resources for immunization, raises its profile and perceived value, enhances ownership, and stimulates context-appropriate innovations. Continuous engagement and a shared commitment from different actors, both within and beyond the health system, is critical to ensuring that all children, every year, are protected from vaccine-preventable diseases.