



BMGF

DEVELOPING REGIONAL HEALTH BUREAU CAPACITY TO IMPROVE IMMUNIZATION PROGRAMMING

RHB Assessment Summary Report

The RED-QI approach, implemented by JSI Research & Training Institute, Inc. (JSI) since 2011, has worked to improve the performance of the immunization system in Ethiopia. JSI's RED-QI approach, which has focused on working at the facility and woreda (district) levels to integrate quality improvement (QI) into Reaching Every District (RED), the national immunization strategy, has resulted in immunization system improvements.¹

In 2018, JSI began providing technical assistance (TA) to build the capacity of sub-national immunization staff at the Regional Health Bureau (RHB) and Zonal Health Department (ZHD) levels to implement the RED-QI approach and strengthen the management of immunization services. This brief summarizes the findings from an assessment of the effects of the TA on immunization program management and service delivery.

BACKGROUND AND APPROACH

JSI implements the Universal Immunization through Improving Family Health Services (UI-FHS) project in Ethiopia. Funded by the Bill & Melinda Gates Foundation, UI-FHS focuses on strengthening Ethiopia's routine immunization system through the RED-QI approach.

KEY TAKEAWAYS



- Capacity building of immunization staff at the sub-national managerial level resulted in increased capacity to design, implement, monitor, and supervise immunization services. For example:
 - The delivery of TA on how to develop and implement routine immunization microplans resulted in a marked increase in microplanning. Following TA, over 75% of woredas in four regions developed and were using a microplan, including many that had never done so before.
 - Sub-national staff gained competency in mentoring their supervisees and utilized data from supportive supervision visits to make programmatic decisions.
 - Data review, using multiple sources of available data, became an integral part of staffs' day-to-day activities.
- Sub-national staffs' enhanced skills engendered the confidence they needed to begin to identify implementation gaps, create action plans, and build the capacity of health workers at lower service delivery levels.

¹ J.D. Campbell et al., "Linked vaccination coverage surveys plus serosurveys among Ethiopian toddlers undertaken three years apart to compare coverage and serologic evidence of protection in districts implementing the RED-QI approach," *Vaccine* 39, issue 40, 5802-5813. <https://doi.org/10.1016/j.vaccine.2021.08.071>.

RED-QI is an innovative approach that strengthens the quality of the management of the immunization program and prepares health managers and workers at the woreda and health facility levels to operationalize the RED strategy to reach all children with high-quality immunization services. RED-QI equips health workers and managers with the data and skills they need to identify, analyze, and prioritize problems and support the development of local solutions to improve immunization.

Between 2011 and 2018, UI-FHS developed the RED-QI approach and scaled it to over 100 woredas across six regions of Ethiopia, about two-thirds of which have limited infrastructure and contain remote communities, including nomadic populations. In 2018, JSI began providing TA to build the capacity of immunization staff in sub-national RHBs and ZHDs, focusing on enhancing skills and processes critical to the immunization system.

JSI administered annual self-assessment questionnaires to RHB/ZHD staff to assess their capacities in 14 immunization management competency areas.² Using these results, sub-national staff incorporated action plans into their annual planning processes and JSI supported them with tailored skill-building activities. Some examples of the topics of the TA provided included:

- Introducing new data analysis tools (e.g., RED Categorization tool)
- How to strengthen existing data collection tools (e.g., monitoring charts, stock records, registration books)
- The provision of mentorship and day-to-day support via embedded support staff
- How to analyze data from District Health Information Software 2 (DHIS2) and RED Categorization to assess woreda performance and present the findings at management meetings
- How to provide supportive supervision and guided practice on the job
- How to monitor RHB performance and prepare action plans

EXAMINING SUB-NATIONAL IMMUNIZATION STAFF EXPERIENCES

After three years of providing TA to sub-national staff, JSI conducted a mixed-methods assessment in 2021 to examine how the TA affected immunization program management and service delivery. The assessment (see Box 1) included staff who had worked at the RHB/ZHD for at least one year and had engaged with the UI-FHS project.

BOX 1: ASSESSMENT METHODOLOGY



Qualitative study

- 14 key informant interviews (KIIs) with RHB and ZHD staff
- Respondents from five project regions (Afar, Benshangul-Gumuz, Gambella, SNNPR, and Somali)



Self-assessment

- Survey assessing RHB and ZHD staffs' self-reported capacity in 14 immunization management competency areas
- Data collected annually in five project regions from 2018–2021

FINDINGS: THE IMPACT OF TECHNICAL ASSISTANCE

This section summarizes findings related to how TA affected target setting and performance monitoring, data analysis and the use of data for decision-making, the capacity to train woreda and facility staff, and the provision of supportive supervision.

Target Setting and Performance Monitoring

Sub-national staff reported that learning to develop microplans (MPs) from the “bottom-up” at the kebele and sub-kebele level made it **easier to identify lower-performing zones and woredas and direct support** to them. Respondents noted that they are now better able to **monitor woreda and zonal performance** against their plans. They also reported that microplanning facilitated the development and **implementation of strategies for engaging hard-to-reach populations**.

Respondents indicated that TA on how to develop and implement an MP resulted in a marked increase in the number of woredas with MPs. As of 2021, **over 75 percent of woredas in four regions (Afar, Benishangul Gumuz, Gambela, and Somali) had developed and were using an MP**. Many had never created a microplan before that point.

Before TA, woredas would often request vaccines without knowing the size of the target population, which contributed to elevated vaccine wastage rates. As a result of microplanning, RHB and ZHD staff reported being able to determine a region's target population and use that information to request appropriate quantities of vaccines, thereby **improving vaccine management** and minimizing wastage.

² Competencies were adapted from WHO's [Standard Competencies Framework of the Immunization Workforce](#) draft document. The 14 competencies are: developing technical presentations; building capacity of lower level staff; developing multi-year and annual plans; coordinating stakeholders managing funds; identifying gaps in human resource needs; providing high quality supportive supervision; data analysis, interpretation, and use; conducting data quality assessments; creating a routine immunization microplan; conducting immunization performance reviews; supply and vaccine management; use of quality improvement tools; and immunization safety.



Previously, we used population projection to estimate target population. As a result, some woredas at Kembata Tembaro zone consistently reported performance greater than 100%. However, after we received microplanning training, we used head counts to estimate target children. This...has significantly improved the number of children reached with immunization, and [they] have a short term plan in the region to plan targets using head count in all the zones.

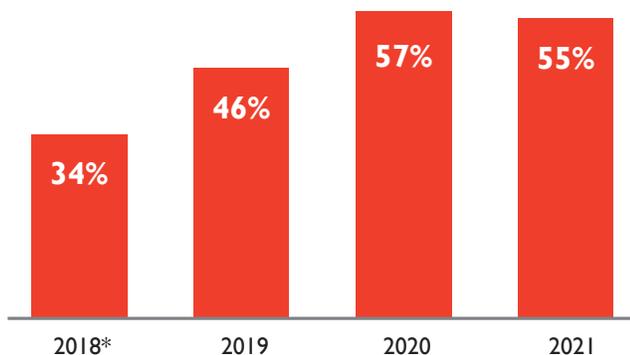
– Respondent from the Southern Nations, Nationalities, and Peoples’ Region



Data Analysis and Use of Data for Decision-Making

Sub-national staff noted that they now **incorporate data review into the day-to-day operations** of their offices. Technical support from UI-FHS enabled staff to **analyze and interpret data from varied sources (e.g., RED Categorization, DHIS2, and supportive supervision data), present their findings at review meetings, and use the findings to prioritize sites to receive supportive supervision.** Figure 1 illustrates the overall increase in staff capacity to analyze, interpret, and use data.

Figure 1. Percent of RHB/ZHD Staff Self-Reporting They Are at “Competent” or “Expert” Level in Data Analysis, Interpretation, and Use



*No data collected in SNNPR at this time point

Analysis note: The staff who completed the self-assessments varied from year to year due to turnover. This graph depicts overall competency in the aggregate for a particular year, rather than individuals’ improvements over time.

Capacity to Train Woreda and Facility Staff

While capacity-building activities for Expanded Program on Immunization (EPI) team members existed prior to UI-FHS (e.g., new staff training and orientation), the UI-FHS self-assessment process **enabled sub-national staff to identify specific capacity-building needs** and create targeted action plans to address them. Respondents said that their enhanced skills in RED-QI, supportive supervision, cold chain management, data quality assessment, and using RED Categorization data for decision-making engendered the confidence they needed to **build the capacity of immunization staff at lower service delivery levels.**

Respondents noted that the cascading of training and skills from themselves to lower-level staff did not always occur consistently, resulting in varying program performance across woredas and health facilities. They emphasized the need for continued support.



I can confidently provide any technical support regarding EPI at the regional, zonal, woreda, and facility level. As an example, I can build capacities of staff on RED-QI approaches like microplanning and supportive supervision.

– Respondent from Benshangul Gumuz

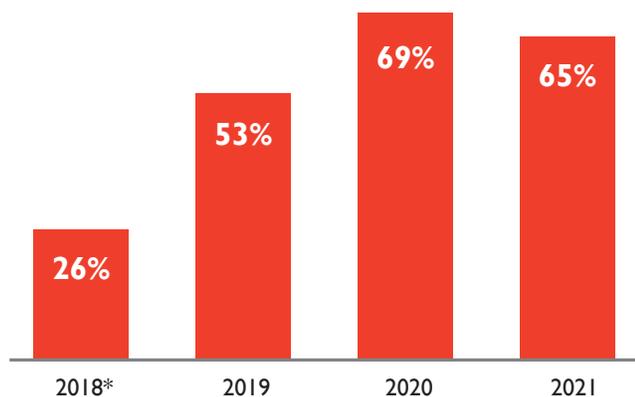


Provision of Supportive Supervision

Prior to receiving TA, sub-national staff used supportive supervision primarily to pinpoint program weaknesses. As a result of UI-FHS TA, **supportive supervision evolved into a collaborative process focused on improving program implementation**, where sub-national staff presented supervision findings to technical working groups, provided feedback to facilities, and identified and implemented action items based on supervision results. When supportive supervision findings required the involvement of more senior managers, ZHD and RHB staff communicated them to national-level staff. Figure 2 illustrates the overall increase in staff capacity to provide supportive supervision.

In the SNNPR and Somali regions, respondents noted that this collaborative approach to supportive supervision created a “friendly working environment” and **improved staff motivation and morale.** Respondents observed that health workers felt more supported as a result of receiving quicker follow-up and assistance for the challenges they face.

Figure 2. Percent of RHB/ZHD Staff Self-Reporting They Are at “Competent” or “Expert” Level in Providing Supportive Supervision



*No data collected in SNNPR at this time point

Analysis note: The staff who completed the self-assessments varied from year to year due to turnover. This graph depicts overall competency in the aggregate for a particular year, rather than individuals' improvements over time.

All EPI partners in the regions now use a standardized supportive supervision checklist. As a result, **supportive supervision data are entered into a single database, which greatly facilitates data monitoring, the use of data for decision-making, and reporting of findings** to higher-level officials.

STUDY IMPLICATIONS

A key to a strong, decentralized health system is building the capacity of sub-national health staff. The processes and systems that UI-FHS introduced to support staff were durable, so that even with staff turnover, they remained strong and most improvements were sustained. Simultaneous investments in individuals and systems are critical. Additional research is needed to understand whether/how changes at the management level affect service delivery.



RECOMMENDATIONS

The findings of this assessment suggest the following actions for the Ethiopian government to consider to continue enhancing and sustaining the capacity of RHB and ZHD immunization staff:

- **Institutionalize annual self-assessments as a means to measure staff capacity and identify areas for staff support.**

The KII findings demonstrated the substantial impact of UI-FHS TA in developing the capacity of health staff across multiple levels to plan and manage immunization services. To continue to assess and strengthen immunization staff skills, it is recommended that the self-assessment process be repeated at the regional and zonal levels annually and that capacity building action planning based on self-assessment data be incorporated in annual planning processes.

- **Mitigate the negative effects of turnover among sub-national staff.**

To help ensure that staff capacity remains strong over time despite turnover, more systematic handover processes should be in place for RHB and ZHD staff leaving their position as well as standardized onboarding processes for new staff. For example, the procedures might include requiring staff to provide a certain amount of notice before leaving their post, establishing or strengthening simple knowledge management systems for training materials, assigning new hires a “buddy” to support the orientation process, and defining the handover and orientation procedures as standard practice in a manual for staff.