REACHING EVERY DISTRICT (RED)

A guide to increasing coverage and equity
in all communities in the African Region

2017 Edition

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ACKNOWLEDGEMENTS

ACRONYMS

- AFRO — Africa Regional Office, WHO
- BCG — Bacillus Calmette Guérin
- CBO — Community Based Organization
- CHW — Community Health Worker
- cMYP — Comprehensive immunization Multi-Year Plan
- CSO — Civil Society Organization
- DEHO — District EPI Health Officer
- DHMT — District Health Management Team
- DHO — District Health Officer
- ·DM — Diabetes Mellitus
- DPT3 — Diphtheria, Pertussis and Tetanus, third dose
- EPI — Expanded Programme on Immunization
- FIC — Fully Immunized Child
- GAVI — Global Alliance for Vaccines and Immunization
- GBV — Gender Based Violence
- GIVS — Global Immunization Vision and Strategy
- GRISP — Global Routine Immunization Strategies and Practices
- GVAP — Global Vaccine Action Plan
- HF — Health Facility
- HPV — Human Papillomavirus Vaccine
- HSAs — Health Surveillance Assistants
- HSS — Health Systems Strengthening
- HT — HIV Testing
- IFA — Iron Folic Acid
- ISCM — Immunization Supply Chain Management
- ISS — Immunization Services Support
- ITN — Insecticide Treated Net
- IYCF — Infant and Yong Child Feeding
- LAM — Lactational amenorrhea method
- M & E — Monitoring and Evaluation
- MLM — Mid-Level Management
- MOH — Ministry of Health
- msls — measles
- MVMH — My Village My Home
- NGO — Non-Governmental Organization
- Penta — Pentavalent vaccine
- PHC — Primary Health Care
- PCV — Pneumococcal conjugate vaccine
- PMTCT — Prevention of mother-to-child transmission
- RCH — Reproductive & Child Health
- RED — Reaching Every District
- RI — Routine Immunization
- SAM — Severe Acute Malnutrition
- SM — Social Mobilization
- SRMNCAH — Sexual Reproductive Maternal Neonatal Child and Adolescent Health
- Td — Tetanus and diphtheria toxoid for children from 4 years and older, adolescents, and adults
- UCI — Universal Childhood Immunization
- UHC — Universal Health Coverage
- UNICEF — United Nations Children's Fund
- VAS — Vitamin A supplementation
- VVM — Vaccine Vial Monitor
- WHA — World Health Assembly
- WHO — World Health Organization

CHAPTER 1

INTRODUCTION

1. INTRODUCTION

1.1 BACKGROUND AND RATIONALE FOR REVISION

Expanded Program on Immunization (EPI) is responsible for vaccines and vaccination to control, eliminate and eradicate vaccine preventable diseases (VPDs). Having strong immunization systems to deliver vaccines to those who need them most will play a significant role in achieving the health, equity and economic objectives of several global development goals. These include the 2030 Sustainable Development Goals (SDGs), the 2011-2020 Decade of Vaccines, the 2030 Universal Health Coverage (UHC) agenda, the 2011-2020 Global Vaccine Action Plan (GVAP), the Global Routine Immunization Strategy and Plan (GRISP), and the Regional Strategic Plan for Immunization 2014-2020.

The Reaching Every District (RED) strategy has played a key role in successfully strengthening African immunization systems to sustainably and equitably increase immunization coverage rates to meet established targets since the early 2000's. RED's five strategies are operationally-focused, and include 1) planning and management of resources; 2) reaching all eligible populations; 3) engaging with communities; 4) conducting supportive supervision; and 5) monitoring and using data for action. In 2007, WHO and partners evaluated the implementation of RED strategies in nine African countries. Results demonstrated improved coverage in eight of the nine countries; an increased number of immunization outreach sessions in all districts visited; and more frequent supervision in seven of the nine countries. These results led to a revision of the RED Guide in 2008, which promoted RED as a platform for improving the delivery of other Primary Healthcare Services, in the spirit of the 2008 Ouagadougou Declaration on Primary Health Care (PHC) and Health Systems Strengthening (HSS) in Africa and WHO's **Global Immunization Vision and Strategy (GIVS)** Goal number 4.

Endorsed by the World Health Assembly (WHA) in 2012, the 2011-2020 **Global Vaccine Action Plan (GVAP)** defines a framework and helps countries set national and district vaccination coverage targets, which are included in **WHO's Africa Regional 2014–2020 Strategic Plan for Immunization**. The RED approach has contributed to increasing DPT3 coverage in Africa from 57% to 80% between 2000 and 2014. However, fewer than 50% of African countries achieved the GIVS or GVAP national targets of 90% DPT3 coverage by 2015 (16 countries)[1] , among which 13* maintained this level for 3 consecutive years. Mindful of this and the need for strong immunization systems to deliver newer vaccines to those who need them the most, in 2016-17, WHO and partners, in consultation with countries, have revised the 2008 RED guidelines to reflect new developments.

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[1] *Algeria*, Bostwana*, Burkina Faso, Burundi*, Cabo Verde*, Eritrea*, Gambia*, Lesotho*, Mauritius*, Namibia, Rwanda*, Sao Tome*, Seychelles*, Swaziland*, Tanzania*, Zambia,*

1.2   PURPOSE AND TARGET AUDIENCES

Aim of the RED Approach

RED aims to strengthen immunization systems by improving planning, managing available resources, service delivery and monitoring, in the context of primary healthcare based on community needs. This in turn improves equitable and sustainable access to vaccines for every age-eligible person and reduces vaccine-preventable diseases (VPDs).

Aim of this Guide

The purpose of the RED guide is to support countries to plan and implement the five components of the RED approach so as to   strengthen immunization systems to *sustainably* and *equitably* increase *access to and use of vaccination services* (as measured by coverage rates and equity indicators).

The 2017 RED guide and the guide's planning and monitoring tools, like earlier versions, are intended for adaptation and use by national immunization programs. It is primarily designed as a resource for *district, health facility*, and *community* teams to improve their immunization services. No single guide can cover all the information, methods, skills, and tools required to improve immunization services. Therefore, other resources which are available to strengthen immunization services are referenced throughout this guide.

TARGET AUDIENCES AND HOW EACH CAN USE THIS GUIDE:

National Immunization Programs:
To help adapt the RED Guide for specific country use or revise existing country RED guides; to help advocate for funding to strengthen immunization systems within the Comprehensive immunization Multi-Year Plan (cMYP), health sector or annual planning process.

Regional/Provincial level: To guide training of district health teams to incorporate budget allocation, development, implementation and monitoring of RED strategies and micro-plans into regional/provincial plans.

District level: To prepare districts to support health facilities by actively promoting micro-planning, using information to monitor progress, detect and solve problems, and ensure the quality of service delivery.

Health facility level: To help guide facilities to develop accurate micro-plans, monitor the implementation of EPI service delivery, and link facilities with communities to improve access, acceptability, appropriateness, and utilization of services.

Community level and eligible populations: To guide community resource persons and leaders on engaging with health facilities in the development, implementation, and monitoring of health facility micro-plans; to promote defaulter tracking, determination of target populations, community registration, and leveraging local resources to support outreach and mobile services.

Technical Partners: To guide key partners on the RED approach for promoting coordination of technical and financial resources to reach every community in every district.

Specific guidance related to the role of each stakeholder in delivering immunization services is described throughout the guide.

1.3   WHAT IS NEW IN THIS GUIDE?

The 2017 RED guide takes into consideration a review of best practices and the emerging issues since 2008. These include various global initiatives that provide new resources and renewed focus on targets for sustainability, address inequities between communities and better integration across health programs. In recent years, immunization stakeholders have both narrowed and intensified their focus on closing gaps in immunization services at the community level. Innovative strategies to reduce these pockets of local inequities are referred to as "Reaching Every Community" or "Reaching Every Child" (REC). The principles behind REC – an approach which reinforces immunization session planning through an "equity lens" – have been woven into the strategies and tools described in this document. This includes more emphasis on community-based interventions at the sub-district level.

This revitalized RED guide emphasizes five important areas for immunization programmes in Africa:

1. reducing *inequity* in immunization coverage,

2. *integration* of health services,

3. delivering vaccines *beyond infancy* using a life course approach,

4. *focusing* on urban, poor and marginalized populations, and

5. *paying special attention* to insecure and conflict areas.

1 INEQUITIES

inequities: Even though national immunization coverage rates have generally increased in many African countries, inequities persist among different communities. These are often driven by differences in ethnicity, income, place of residence, nomadic lifestyle, maternal education, or gender. This guide has additional focus on immunization micro-planning based on addressing identified equity gaps at the community level. The REC approach supports community-based interventions to identify reasons for inequities. Aspects of this approach have been incorporated into RED and include more emphasis on equity analysis at the sub-district level, including context-specific health facility and community-level approaches.

2 INTEGRATION

Integration: Vaccines are often delivered in Primary Healthcare contexts, and vaccine schedules provide an opportunity for contact between the health system and recipient. To avoid missed opportunities, increase system efficiency and maximize health, integrating the delivery of other health interventions at the time of vaccination should be considered. Immunization systems deliver vaccines at relatively high coverage rates, compared to other interventions. Immunization services can be encouraged to deliver multiple interventions to women, children and vulnerable populations at the same time. This RED Guide emphasizes the renewed political commitment for multi-sector, multi-program integrated primary health care, and Chapter 2 provides considerations for integration.

3 BEYOND INFANCY

Going beyond infancy and women of child-bearing age and adopting a life cycle approach: As more new vaccines are introduced, schedules increasingly need to go beyond the first year of life, using a life cycle or life course approach to delivery. Vaccines need to be delivered during the 2nd year of life, as boosters in childhood (e.g., TT or Td), to adolescents (e.g., HPV), to pregnant women, and to other adults. An expanded life course approach to immunization provides a chance to further integrate immunization with other primary healthcare interventions, such as Vitamin A supplementation, nutrition, growth monitoring, de-worming, and family planning.

4 URBANIZATION

Urbanization: Traditional EPI models and RED approaches are based on reaching vulnerable rural populations and overcoming mainly geographical barriers. Increasing numbers of unreached populations are born in Africa's cities or are migrating to them. Urban infrastructures are often not prepared to provide effective services for all eligible populations, and there is a need to address social as well as physical barriers to service access and utilization.

5 INSECURITY

Insecurity: Conflict situations, insecurity, and natural disasters increasingly displace people in many parts of Africa, and there is an emerging need to address the needs of these vulnerable populations. Services for these people often cannot be delivered through traditional government channels. Instead, NGOs or community-based mechanisms may need to plan and implement immunization services for these populations.

1.4   ADAPTATION

This guide contains the principles and tools that can practically be adapted to each country's set of circumstances, and, at the sub-national level, made context-specific, depending on the target populations to be reached. However, no guide can apply to all countries or circumstances. This RED guide is not an instruction manual and may need to be renamed, depending on the administrative structure. Careful preparation and the process of adapting the RED strategies to local circumstances can, in itself, strengthen the overall immunization program. Examples of adaptation include modifying the suggested tools or adding new ones. The guide can be customized by adding new tools to the checklists at the beginning of each chapter.

1.5   STRATEGIES

RED involves the national level, but the five components are implemented at district (or smaller administration units) and health facility levels. As noted, RED prepares districts to support health facilities by actively promoting micro-planning, using information to monitor progress, detect and solve problems, and to ensure the quality of service delivery. RED also promotes linking health facilities with communities to improve access, acceptability, appropriateness and utilization of health services.

1.6 THE FIVE COMPONENTS

The RED approach consists of five components (see Figure 1 below). Although this Guide describes each component in a separate section, it is important to implement the RED approach as an interlinked process, as the content and concepts of each component overlap and link with each other. The process may not be linear, and the components may be implemented at different times.

Figure 1: THE FIVE RED COMPONENTS

For better managing human, material and financial resources

For partnering with communities to promote and deliver immunization services which best fit local needs

PLANNING & MANAGEMENT OF RESOURCES

ENGAGING WITH COMMUNITIES

For regular on-site capacity-building, feedback and follow-up with health staff

The 5 RED components

SUPPORTIVE SUPERVISION

REACHING ALL ELIGIBLE POPULATIONS

MONITORING & USING DATA FOR ACTION

For improving access and use of immunization and other health services by all children, adolescent and adults

For analyzing and using the data at all levels to direct the programme in measuring progress, identifying areas needing specific interventions and making practical revisions to plans

1.7   POTENTIAL PROCESS FOR PLANNING AND IMPLEMENTING RED

It is important to build upon processes that already work, have ownership, and political and financial support. If there is an existing RED approach, review and update it. If not, take time to develop one as an effort to strengthen immunization services, considering the following:

1. ***Establish a Core Team.*** Decide on a core team with an effective leader for adapting or updating your RED strategy. Select staff with field experience in the RED component areas and choose key outside representatives from local government, the community, or partners. The numbers in the team should be as efficient as possible, perhaps up to six members. This core team will also be useful for introducing your RED approach to other areas in the MOH, other health workers, local officials, and the community.

2. ***Define key partners and establish a forum for coordinating RED with other health services.*** This may be the Immunization Inter-Agency Coordination Committee (ICC) or National Immunization Technical Advisory Group (NITAG) or another suitable forum that could include NGOs, community organizations, private sector, academics or parliamentarians. This group should be able to discuss RED ideas and plans with other program managers, coordinating operational, financial and human resources. The RED activities, tools and indicators should contribute to immunization system strengthening and, more broadly, to health systems strengthening.

3. ***Be realistic.*** The RED approach needs to be planned and implemented in coordination with other health services, as well as the available budget, health worker capacity, and other health care activities.

4. ***Consider national policies:*** The RED approach must contribute and refer to the broader context, such as the cMYP, national immunization and health plans and development policies.

5. ***Define terms:*** Defining key terms such as eligible populations, communities, ethnic groups, targets for coverage and others, is important, as they add clarity.

6. ***Use existing systems and resources.*** Consider how RED will fit with existing MOH and district training, planning, financing for health services, communications, logistics and the health information system. It is important to use existing surveys and reports – especially information about local community participation (see Chapter 5).

1.8   CONTENT AND ORGANISATION OF THIS GUIDE

This RED guide is organized according to the five interlinked RED components:

1   Planning and Management of Resources,

2   Reaching All Eligible Populations,

3   Engaging with Communities,

4   Conducting Supportive Supervision, and

5   Monitoring and Using Data for Action.

This guide also provides tools for planning and monitoring the RED approach and addresses some operational issues concerning logistics, communication, and integration. Links to resource materials and country examples are provided at the end of each section. When using the electronic version of this guide, you can click on each resource to jump to the online reference.

There are two icons that highlight specific information in the guide.

This icon points out tools that can help complete a process.

This icon points out tips that can help with the RED approach.

CHAPTER 2

CONSIDERATIONS FOR INTEGRATION

2. CONSIDERATIONS FOR INTEGRATION

In a generic sense, "integration" means: planning, managing, and delivering essential health services together. WHO comprehensively defines integration as: "*The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs, over time and across different levels of the health system.*" In practice, tasks of delivering an intervention can be integrated fully or partially, depending on the complexity of the intervention and existing capacity of the programme with which it is integrated. When considering whether or how to integrate immunization services with other interventions, there are several criteria to consider (see Figure 2.1 below).

Figure 2.1: CRITERIA TO CONSIDER IN LINKING IMMUNISATION AND OTHER INTERVENTIONS

CRITERIA TO CONSIDER IN LINKING IMMUNISATION AND OTHER INTERVENTIONS	
Related to the intervention	**Related to health system context**
A health intervention or service has good potential for combining with routine immunization if it …	Health interventions or services can be integrated effectively if:
☐ Has a similar target group ☐ Requires similar timing or frequency ☐ Has similar logistical requirements ☐ Has a similar level of acceptance among patients, communities and health workers ☐ Involves health workers with a similar skill level	☐ Political will exists to promote integration and coordination among different program managers ☐ National policies support both interventions ☐ Financial support is secure for each intervention ☐ Existing primary health care structures support the delivery of both interventions ☐ Responsibility for supporting and monitoring each intervention is clearly defined among programs ☐ Health workers are "multi-purpose," not designated for only a single intervention ☐ Combining the interventions does not disrupt or create an unrealistic burden for service delivery

In addition, there are fundamental questions to ask when exploring the idea of integrating immunization services with other programs:

1. **What to integrate?** Give preference to high impact interventions while recognizing not all such interventions lend themselves for integration into routine immunization service;

2. **Is it appropriate?** Does integration 'make sense' for the local population and context;

3. **Is it effective?** Monitor results of interventions and employ evidence-based interventions;

4. **Is it flexible?** Is the program able to respond to changes in eligible populations, disease distribution / burden, demography, advances in technology or new policy imperatives?

5. Is it accountable? Monitor operational performance to maximize successful outcomes;

6. Is it acceptable? To providers and clients; provide necessary education and incentives for both; avoid needless overburdening.

Potential benefits and risks of program integration:

Potential benefits: Vaccines delivered on a regular, scheduled basis to eligible populations often achieve high coverage rates. An established immunization service provides an effective platform for delivering other essential maternal and child health services. The five RED components have potential to strengthen systems to increase access to other health care programs and services. For example, RED micro-planning can be used to identify underserved populations, estimate commodity needs, allocate human resources, and to develop service delivery strategies and coordinated supervision for all PHC interventions. RED's supportive supervision and monitoring strategies and tools can be expanded for monitoring and supervising other PHC programs. Delivering integrated health services can be more cost-effective, and consequently more sustainable. Integrated services also help to reduce missed opportunities and to improve the overall health of the community. Financing and managing the logistics of multiple commodities can be more challenging with varying logistics requirements and delivery schedules. However, careful planning and coordination can lower costs of distributing vaccines, drugs, and other health care supplies.

Potential risks: If not thoughtfully planned and based on human resource and health system capacities, integration is more complex and time-consuming and can overburden health workers with too many tasks, leading to poorer quality services. Consequently, integrated activities must be planned with the individual health worker and community needs in mind, prioritizing the most critical program areas and community needs for attention. For example, only attaching every program's supervision checklist into a single document, going from a one-page checklist to six pages, does not effectively integrate supervision. Effective integrated supportive supervision requires quality capacity-building time for the health worker, not only a checklist.

Figure 2.2 below summarizes the opportunities and challenges of integration:

Figure 2.2: SUMMARY OF OPPORTUNITIES AND CHALLENGES OF INTEGRATION

SUMMARY OF OPPORTUNITIES AND CHALLENGES OF INTEGRATION	
Potential benefits and opportunities of integration	**Potential disadvantages and challenges of integration**
Improved effectiveness: increasing the number of health interventions at point of contact could increase chances of reducing mortality and morbidity	*Could decrease coverage of certain interventions:* if a system is not strong enough (integration of two weak systems may not lead to one stronger one). Underlying supply chains, supervision, community engagement and planning need to be in place.
Improved efficiency: reduced redundancy and costs involved with multiple planning and logistics for multiple visits /outreach	*Potential reduction in quality of care:* due to reduced health worker time and availability

SUMMARY OF OPPORTUNITIES AND CHALLENGES OF INTEGRATION	
Potential benefits and opportunities of integration	**Potential disadvantages and challenges of integration**
Improved user satisfaction & convenience: availability to meet clients' multiple health needs at the same place and time. *Improved equity:* increased coverage of a new intervention, cross-promotion and potential increased demand *Reduced missed opportunities for vaccines and other interventions:* Scheduled contacts with the health system reduces chances of missing other vaccine schedules and other health interventions *GAPPD:* specific links between preventive and curative elements of diarrhoea and pneumonia control can increase impact *African Immunization Week:* can act as a catalyst for accessing multiple interventions	*Staff may not accept additional responsibilities* without more pay, training *Clients may not accept integrated services:* if they are stigmatized or if there are confidentiality issues (e.g., HIV prevention or teenage contraception) *Coordination burden:* requires strong communication and diplomacy, and if not done properly can slow implementation *Shared funding sources:* will need careful management.

Bi-directional integration of immunization services with other health programmes:

Integration of EPI and other health programmes should be considered bi-directional, where any immunization contact or visit could be used to deliver other essential Sexual Reproductive, Maternal, Newborn, Child and Adolescent health (SRMNCAH) & Nutrition (N) services, and SRMNCAH & N service contacts could be used to assess immunization status and provide vaccines that are due on the day of the visit. Information about vaccination and VPDs should also be included in existing SRMNCAH & N packages of interventions, training materials, guidelines, job aids and tools to increase vaccination coverage. Please see a series of integration matrix tables below (Tables 2.1-2.5) that describe the potential opportunities for integration of the delivery of SRMNCAH & N interventions during the immunization visits and the inclusion of vaccines into the SRMNCAH & N packages, guidelines, job aids and tools for consideration. For integration to be effective, it needs supportive leadership, management, coordination, joint planning, implementation, supportive supervision, monitoring and evaluation.

Tables 2.1-2.5: Possible opportunities for integrating additional health services into the vaccination schedule, for adaptation

Acronyms: IMNCI = Integrated Management of neonatal and childhood Illness; ICCM = Integrated Community Case management; CHW = Community Health Workers; MUAC = Mid Upper Arm Circumference; AA-HA = Accelerated Action for the Health of Adolescents; VAS = Vitamin A supplementation; NAT = Nucleic Acid Test; DM = Diabetes Miletus; NCD = Non-Communicable Disease

Table 2.1: BIRTH REGISTRATION – UNIQUE ID – (ELECTRONIC) PERSONAL HEALTH RECORD

**BIRTH REGISTRATION – UNIQUE ID – (ELECTRONIC) PERSONAL HEALTH RECORD**				
Age	**Vaccines & Preventive Treatments**	**Additional Services that could be delivered during vaccination visits**	**Contact Points for vaccination and other preventive interventions**	**SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines**
Birth	Hep B birth dose OPV birth dose BCG	**Immediate newborn care** (early initiation of exclusive breastfeeding, skin to skin contact, counselling on neonatal danger signs) Counselling on danger signs Birth notification / registration Entry in Vaccination register Malaria prevention (LLITN) HIV screening and initiation of treatment of infected; postnatal care for mother; postpartum Family planning services for the mother; Counselling on breast care Iron folate supplementation for mother	Delivery / post-natal room Home for assisted home deliveries Home visit as soon as possible for unassisted home deliveries	• Essential newborn care, • Post-natal care, • Home-based newborn care • Birth (NAT) HIV testing • Mother-baby passport/card • Birth register • IYCF guideline and counselling tools • MNH guidelines and tools • PNC guidelines

Table 2.2: FIRST YEAR OF LIFE

**FIRST YEAR OF LIFE**				
Age	**Vaccines & Preventive Treatments**	**Additional Services that could be delivered during vaccination visits**	**Contact Points for vaccination and other preventive interventions**	**SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines**
6 weeks	Penta 1 PCV 1 ROTA 1 OPV 1	Counselling on exclusive breast-feeding (EBF) Growth monitoring & MUAC Counselling on danger signs Contraception (Postpartum FP for the mother including LAM) PNC for the mother Malaria prevention (LLITN) Assess for GBV Iron folate supplementation for mother	Health facility vaccination Out-reach vaccination	• Early Infant Diagnosis of HIV, and initiation of antiretroviral treatment for positives • IMNCI • Infant feeding counselling, • Early childhood development, • Growth monitoring; • Community-based maternal and newborn care • FP guidelines • PNC guidelines

SECOND YEAR OF LIFE – SCHOOL START				
Age	Vaccines & Preventive Treatments	Additional Services that could be delivered during vaccination visits	Contact Points for vaccination and other preventive interventions	SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines
10 weeks	Penta 2 PCV 2 ROTA 2 OPV 2	Counselling on EBF Growth monitoring & MUAC Counselling on danger signs Contraception Malaria prevention (LLITN) Iron folate supplementation for mother	Health facility vaccination Out-reach vaccination	• Early Infant Diagnosis of HIV where missed and initiation of antiretroviral treatment for positives • IMNCI • Infant feeding counselling, • Early childhood development, • Growth monitoring • Community based maternal and newborn care
14 weeks	Penta 3 PCV 3 ROTA 3 OPV 3 IPV	Counselling on EBF Growth monitoring & MUAC Counselling on danger signs Contraception Malaria prevention (LLITN)	Health facility vaccination Out-reach vaccination	• Early Infant Diagnosis of HIV where missed and initiation of antiretroviral treatment for positives • IMNCI/ICCM • Infant feeding counselling, • Early childhood development, • Growth monitoring • Community based maternal and newborn care
6 months	Vitamin A Supplement ation (VAS) 1	Immunization check and catch-up vaccination Growth monitoring & MUAC Counselling on complementary feeding, continued breastfeeding & early child development Malaria prevention (LLITN) Contraception Postnatal care for mother Cervical cancer screening for mother	Health facility visit for VAS Out-reach VAS CHW VAS FP clinic PNC clinic	• IMNCI/ICCM • Infant feeding counselling, • Early childhood development, • Growth monitoring • FP guidelines • PNC guidelines • Cervical cancer guidelines

SECOND YEAR OF LIFE – SCHOOL START				
Age	Vaccines & Preventive Treatments	Additional Services that could be delivered during vaccination visits	Contact Points for vaccination and other preventive interventions	SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines
9 months	MCV 1 YFV Meningitis	Growth monitoring & MUAC Counselling on complementary feeding, continued breastfeeding & early child development Contraception	Health facility vaccination Out-reach vaccination FP clinic	• IMNCI/ICCM • Infant & Young child feeding • Early childhood development • Growth monitoring • Serological HIV test • FP guidelines
12 months	VAS 2 Mebendazole	Check immunization status Catch-up vaccination Growth monitoring & MUAC Counselling on complementary feeding Counselling on early child development De-worming Contraception Cervical cancer screening (if not done)	Health facility VAS Out-reach VAS CHW VAS FP clinic	• IMNCI/ICCM • Infant & Young child feeding • Early childhood development • Growth monitoring • Serological HIV test • FP guidelines • Cervical cancer screening guidelines

Table 2.3: SECOND YEAR OF LIFE – SCHOOL START

SECOND YEAR OF LIFE – SCHOOL START				
Age	Vaccines & Preventive Treatments	Additional Services that could be delivered during vaccination visits	Contact Points for vaccination and other preventive interventions	SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines
15-18 months	MCV 2 VAS 3 Td booster (12-23Mo)	Catch-up vaccination Growth monitoring & MUAC Counselling on complementary feeding Counselling on early child development De-worming		• IMNCI/ICCM • Infant & Young child feeding • Early childhood development • Growth monitoring • Serological HIV test

SECOND YEAR OF LIFE – SCHOOL START				
Age	Vaccines & Preventive Treatments	Additional Services that could be delivered during vaccination visits	Contact Points for vaccination and other preventive interventions	SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines
24 months	VAS 4 Mebendazole	Check immunization status Catch-up vaccination Growth monitoring & MUAC Deworming Malaria prevention (LLITN) Contraception for mother Cervical cancer screening if not yet done Check for GBV		• IMNCI/ICCM • Infant & Young child feeding • Early childhood development Growth monitoring • Serological HIV test • FP guidelines • Cervical cancer guidelines
24-59 months	VAS 5-11 (Every 6 months)	Infant check-up (4 contacts); Serological HIV test IMNCI; Vitamin A; De-worming; Malaria control (LLIN); Nutritional screening (MUAC); SAM identification; Supplementary feeding; Promotion of early childhood development	At health facility; Planned community outreach	• IMNCI/ICCM • Infant & Young child feeding • Early childhood development • Growth monitoring • Serological HIV test if HIV status is unknown.

Table 2.4: SCHOOL ENTRY – PROOF OF CHILDHOOD IMMUNIZATION COMPLETION

SCHOOL ENTRY – PROOF OF CHILDHOOD IMMUNIZATION COMPLETION				
Age	Vaccines & Preventive Treatments	Additional Services that could be delivered during vaccination visits	Contact Points for vaccination and other preventive interventions	SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines
School entry (5-6 yrs)	Check immuniza-tion status Td 2nd booster boys and girls (4-7Y)	Catch-up vaccinations (YF, Men, MCV 2) Deworming	In schools	• School health • Adolescent Job aid • AA-HA

SCHOOL YEARS / PRE-ADOLESCENCE				
Age	Vaccines & Preventive Treatments	Additional Services that could be delivered during vaccination visits	Contact Points for vaccination and other preventive interventions	SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines
10-14 yrs (end of primary school, grade 5-7)	HPV girls (9-14) Td booster boys and girls (9-15)	Check immunization status Catch-up vaccinations (YF, Men, MCV 2) Deworming Health promotion – healthy life-style; Nutrition counselling Menstrual hygiene counselling	In schools	• School health • Adolescent Job aid • AA-HA
Adoles-cents 14-19 years	HPV (catch-up)	Check-up; De-worming; Health promotion – sexuality education, reproductive health, alcohol, tobacco, STD and HIV risks, avoidance early and unwanted pregnancy, risks of unsafe abortions, early marriage, dental hygiene; Nutrition education (including prevention of obesity)	At health facility; At school; Planned community outreach, religious centres (out-of-school adolescents)	• School health • Adolescent Job aid • AA-HA • Weekly IFA supplementation

Table 2.5: ADULTHOOD

ADULTHOOD				
Age	Vaccines & Preventive Treatments	Additional Services that could be delivered during vaccination visits	Contact Points for vaccination and other preventive interventions	SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines
19–65 years	Td booster IPV (catch-up) YF	Counselling on NCD prevention, including obesity prevention and weight loss Screening for health problems Health promotion – healthy life-style HIV testing	At work; At health facility; Planned community outreach	

ADULTHOOD				
Age	Vaccines & Preventive Treatments	Additional Services that could be delivered during vaccination visits	Contact Points for vaccination and other preventive interventions	SRMNCAH & nutrition packages, guidelines, job aids and tools to integrate vaccines
Pregnancy	TTCV Influenza	HIV screening and PMTCT treatment Promotion of exclusive breast-feeding Promotion of birth registration Promotion of vaccination ANC preventive and promotive actions Counsel on danger signs and Individualised birth plan Nutrition counselling for increased food intake	Antenatal care Health facility; Home visits during pregnancy	ANC guideline
Adults >65 yrs	PCV* Men Influenza	Counselling on Healthy Aging Counselling on NCD prevention Screening for health problems including HT and DM type 2	At home; At health facility; Planned community outreach	

*See WHO position paper on this *Weekly Epid. Record (2012, 87: 129-143)*
http://www.who.int/wer/2012/wer8714/en/

For more details on immunization schedules, please refer to the latest versions (March 2017) of the Summary Tables (available in both FRENCH and ENGLISH) can be downloaded from the WHO website
http://www.who.int/immunization/policy/immunization_tables/en/index.html
As these tables are updated several times each year, it is always best to go to the website for the most recent version.

CHAPTER 3

PLANNING AND MANAGEMENT OF RESOURCES

3. PLANNING AND MANAGEMENT OF RESOURCES

PLANNING & MANAGEMENT OF RESOURCES

Steps	RED Tool
1. Preparations	
2. Situation analysis	1a, 1b, 1c, 1d, 2a
3. Set objective & annual activities	
4. Identify problems & plan activities	1e, 1f
5. Estimate resource needs	
6. Select indicators for monitoring	
7. Monitor progress	
8. Use micro-plan as a management tool	

*Comprehensive planning by districts and health facilities **identifies** and **prioritizes** essential activities and resources required for improved performance. Integrated planning strengthens partnerships with district and community stakeholders, which mobilizes resources for a more cost-effective, sustainable program.*

3.1 KEY ISSUES

Planning is a vital management function that helps to systematically improve the effectiveness of the RED approach. It facilitates identification and prioritization of programme needs to improve performance.

Careful planning and focused management of resources by national, district and health facility staff are essential for delivering effective, high quality immunization and other health services. Like management, planning must be active and continuous, not only an annual preparation of documents and spreadsheets for a higher administrative level. **Participatory planning** with key program staff and ministry units, such as finance, from the beginning and with the community partners, promotes ownership. Ownership contributes local information which promotes advocacy for securing budgets, which is a critical step at all levels.

RED micro-planning is an integral part of overall district and health facility planning. An **integrated planning** process helps coordinate approaches to maximize resources and exposes potential problems that might arise from integrated service delivery. This allows development of appropriate strategies for resolving operational and financial problems before they become major barriers. Integrated planning maximizes use of staff time and resources, rather than duplicating staff effort and operational expenditures.

Ideally, the planning process begins at the health facility level with **input from the community**. Community members can help reduce inequities by providing accurate community head counts and assisting with the development of operational and social maps, as well as providing practical and more reliable information for the district plan and budget. In areas of insecurity, input into planning may be needed from non-traditional partners, such as the military.

3.2   MICRO-PLANNING

Definition and benefits: A micro-plan defines how to reach clients, how many people should be targeted for services in the area, and how frequently quality services are provided, and is developed by all stakeholders at each level. An effective micro-plan will support health facilities and district teams to:

Identify which target populations are eligible for immunization services for the next year and calculate required supply needs;

Design data and graphic mapping which illustrates well-defined catchment areas identifying where the eligible populations live. This could include GIS information;

Prioritize plans to reach all target populations with immunization services on a continuous basis, according to the national schedule. For infants this is a minimum of four times a year;

Define realistic local actions (based on available operations, economic and social barriers) for improving and sustaining coverage; and

Reduce inequities and improve quality of services.

Process considerations: Micro-planning is more than compiling information and forwarding it to the next higher administrative level for obtaining funds. The RED micro-planning process uses a periodic review and updating process that includes participation with communities, a problem-solving approach that analyses past achievements, current barriers, and the available human, material and financial resources.

Steps for RED Micro-Planning: Health Facility & District

1.   PREPARATIONS:

The health facility

HEALTH FACILITY

Orientation of the health facility team: the health facility team should be oriented on the RED approach and on the importance and benefits of micro-planning processes.

▶ The HF leadership **calls for an inclusive micro-planning meeting**, including community members and other sectors, with facilitators from the district health management team (DHMT).

The district

D DISTRICT

▶ The district team should conduct a review meeting involving health facilities and other stakeholders as part of the RED microplanning;

▶ During the review meeting, all of the health facilities previous three years' performance should be reviewed and discussed.

2. **SITUATION ANALYSIS:** Before developing the actual micro-plan, planners should know as much as possible about the eligible populations and past immunization trends. Updated catchment area maps, population data, and immunization programme reports are starting points in the micro-planning process.

The health facility

a. Operational map:

The *process* for drafting an operational map should include:

▶ Identification of maps already developed and used by local government administration

▶ Coordination by district level, to ensure no areas or populations are left out;

▶ Use of technology with GIS and digital maps, when possible;

▶ Development by health workers serving the catchment area;

▶ Identification of the high risk and marginalized populations to better understand the underlying barriers to service access and use

An operational map should include:

▶ Defined "catchment area": the geographical area being served;

▶ Villages and communities covered under fixed sites, outreach sites or child health days;

▶ Important landmarks including schools, government buildings, water gathering points, faith-based institutions, hard-to-reach areas, rivers, mountains, roads, transit points such as: nomad meeting points, busy transport and migration routes;

▶ Identification of areas with low coverage, including "high risk communities";

▶ Major climate and geographical barriers to service delivery, such as seasonal flooding and impassable roads;

▶ Distances and travel time between key sites

Urban areas could use existing street maps, Google Earth maps, or polio or measles campaign maps. These can help map out areas of dense populations, migrant populations, slum areas, social structures and NGOs or private sector entities who deliver services.

See **Tool 1c** in the Annex for several examples of health facility and district **operational maps**. These are graphic representations of catchment areas (urban and rural) showing geography of an area, landmarks & gathering points, key high-risk populations and their attributes, social barriers and delivery strategies.

b. Social map:

A social map is a means of identifying populations at high risk of not accessing or using immunization services and developing program actions to overcome barriers they face to help ensure equity. A social map should include

▶ A list of high risk communities in the catchment area

▶ Names of villages/sites for MNCH services

▶ Populations of these communities

▶ Main barriers to achieving full immunization among these communities

▶ Recommendations for programme actions and strategies

See **Tool 1b** in the Annex for an example of a social map

c. Population data and denominators

A social map is a means of identifying populations at high risk of not accessing or using immunization services and developing program actions to overcome barriers they face to help ensure equity. A social map is a means of identifying populations at high risk of not accessing or using immunization services and developing pro-equity program actions to overcome these barriers. A social map should include estimates of the eligible populations who live in a catchment area. This is a crucial step for micro-planning. The population estimates should align with figures in the Monthly Activity Reports (or equivalent) and the DVDMT (or equivalent).

'Official' estimates of a health facility's catchment population are often provided annually from higher levels. These estimates are based on projections from the latest census and based on averaged population growth rates. These figures may be tied to budget resource allocation and may not be accurate, especially in areas with high rates of migration/immigration or insecurity. It is therefore important to *regularly review population estimates at local levels* and **triangulate information** from district and health facility levels to get the most accurate operational population estimate. These types of information may include:

▶ Total number of children in the target age group in the catchment area (as opposed to the number of children that would achieve a particular coverage target);

▶ Local community head counts at the beginning of the planning cycle;

▶ Community registers from local authorities, polio and measles SIA data or data from other programs. If this data is only available at province level, it may be worth trying to access this for local level planning purposes. To review an example from Uganda: https://www.mcsprogram.org/resource/reaching-every-community-using-quality-improvement-rec-qi-mapping-support-routine-immunization-microplanning-uganda/

▶ Previous census data and local population growth rates;

▶ Information on nomadic or other migrant populations, their routes and timing of movement; and

▶ The immunization register, which may be used as a birth register and therefore estimate infant populations, as well as helping to follow-up infants on the defaulter tracking list. *Immunization in Practice, Module 6 highlights this*.

http://apps.who.int/iris/bitstream/10665/193412/1/9789241549097_eng.pdf

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HELPFUL TIPS

For assistance with determining the denominator, use the *WHO denominator estimation guide*. http://www.who.int/immunization/monitoring_surveillance/data/Denominator_guide.pdf

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d. Analysis of performance, identification of barriers to high-risk populations

An inclusive, participatory review by health, community and political leaders of program performance over the previous three years gives an opportunity to celebrate achieving goals and can highlight areas needing support. **Highlight the vulnerable 'high risk' communities from the operational map, identify barriers to accessing service, and reasons for missed opportunities for vaccination,** and develop plans to address them.

▶ **Analysis of local immunization and disease surveillance data** includes:

✓ Vaccination coverage rates (all antigens and seasonal fluctuations) and dropout rates (DTP1-DTP3, DTP1-MCV1, MCV1-MCV2)

✓ Numbers of unvaccinated target population by health facility/community

✓ Service delivery strategies and results: frequency of fixed, outreach, mobile and other immunization services and results when compared to targets

✓ Management indicators: frequency of supportive supervision visits and monitoring/review meetings, presence of updated monitoring charts in health facilities

✓ Vaccine supply: frequency of vaccine stock-outs, overstocks, and vaccine wastage rates

✓ Cold chain and logistics: health facilities without adequate cold chain, temperature monitoring, transport material, etc.

✓ Surveillance data: cases of VPDs, deaths, locations of epidemics

✓ Community involvement: frequency of review meetings with the community, presence of defaulter and newborn tracking, types of health education materials and activities, quality of health worker communications with communities and families

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See **Tool 1a** on Socio-Demographic Characteristics, **Tool 1d** on Stakeholder Assessment, and **Tool 2a** on Session Planning in the Annex

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The district

- District level data should be analyzed to identify priority areas. There should also be prioritization of HFs using immunization data (**see Table 4.4 in *Immunization in Practice, 2015 Update***).
- Review health facility denominators and overlap between facilities
- For district level coverage calculation: suggest using the district (official) denominator.
    - It is important to regularly review these figures and ensure that differences between official and programmatic denominator estimates are considered.
    - Alternative: at district level, aggregate both the numerator and the denominator of the HFs, in contrast with the official denominator.
    - Alternative: base operational program decisions only on numerators

- Make a map, showing all health facilities and outreach sites, if possible using GIS for catchment area mapping.
    a. The district map should show the same elements as HF maps:
        ▶ the entire catchment area of the district
        ▶ each HF and its catchment area
        ▶ roads, towns, villages and other features and landmarks
        ▶ Use the data from **Tool 2a** to show priority areas and populations.
    b. Show areas with high number of un/under vaccinated children
    c. Ensure no area is left out or appears in more than one health facility catchment area: in case of overlap, HFs should agree on who provides services to each area.

3. SET OBJECTIVE and ANNUAL TARGETS

The health facility

The program goal should be to **reach all eligible populations with each antigen** in their catchment area.

> **HELPFUL TIPS**
>
> Performance should be measured against the total eligible populations, not against an artificially reduced target number. Describe progress in terms of the number of persons reached (numerator) rather than in terms of coverage.

The district

Set incrementally increasing annual target decided by individual district, based on previous year's achievement with the aim of ultimately achieving the national goal as described in the cMYP. However, each district should ultimately be aiming to immunize all eligible populations.

4. IDENTIFY STRATEGIES, DEVELOP ACTIVITIES AND TIMELINE

The strategies should describe how immunization and other objectives and targets will be achieved. The development of strategies requires teamwork and involves the analysis of all the possibilities applicable to each objective.

The health facility

Tool 1e (Problem Identification and Priority-Setting) identifies areas with unimmunized populations as measured by low coverage (based on numbers of unimmunized target population and dropouts) & helps categorize problem areas.

Tool 1f (Root Cause Analysis) identifies underlying problems for poor access and utilization and actions and people needed to address those problems.

Tool 1e provides a useful guide for analyzing access to immunization and dropouts. Maintaining progress in implementing your strategies requires active monitoring to review the progress and update your micro plan.

Identify **special activities for the hard-to-reach and problem areas** and update Health Centre micro-plans to include all "High Risk" communities.

Meet with community leaders to discuss any barriers for immunization. If community leaders are hesitant about immunization, discuss their concerns and find solutions (see Chapter 5: Engaging with Communities).

The district

1. Make a district calendar of events
2. Consolidate all the health facility work plans
3. Prioritize HFs and sessions which will need support based on the highest number of unimmunized and under-immunized children and high-risk populations
4. Plan supervisory visits according to priority facilities/populations
5. Conduct review meetings to monitor progress; review the micro-plan based on the quarterly performance
6. Mark the day on which vaccines, safe-injection equipment and other supplies will be delivered each month to each health facility
7. Make a district activity plan
   ▶ List all the activities that the district is planning to do in the next quarter
   ▶ List by health facility all problem-solving activities for hard-to-reach areas and problem areas for which district support is needed, showing dates and persons responsible.
   ▶ List all district-wide activities, SIAs, meetings, trainings, etc., showing dates and persons responsible.

5. ESTIMATE RESOURCE NEEDS & PREPARE A REALISTIC BUDGET

The health facility

Effective micro-planning requires an accurate estimate of resource needs and a detailed budget. While estimating your resource needs, consider these questions:

▶ Were sufficient funds received last year and what was spent?

▶ Is more or less funding expected next year?

▶ Who will carry out the proposed immunization activities?

▶ What resources are needed to implement the proposed activities?

▶ What resources are available for these activities and from whom?

▶ Are there any opportunities for sharing costs among other MCH services?

To prepare a budget, consider three resource requirements:

Human	Training Meetings for developing and reviewing your micro-plan, as well as meetings with communities and partners.
Material	Transportation costs (fuel, per diem) for distributing vaccines, outreach, supportive supervision, and engaging communities. Vaccines, disposable syringes, waste management supplies, registers, home-based records (HBRs), reporting forms, and coverage monitoring charts.
Financial	Per-diem Remunerations

HELPFUL TIPS   Be sure to also include in-kind contributions from the community and partners.

The budget should fit available resources. If funding and resources are not sufficient to fully implement the plan, increase efforts to raise additional support from government, donor projects, communities, NGOs, and the private sector. Remember to prioritize items in the budget, so that the most critical activities, such as immunizing high-risk communities, will be conducted. A well-prepared budget will help justify the budget request and obtain funding needs.

Ensure that the RED micro-plan budget is included in the overall health facility plan as well as in the district plan.

The district

1. The district budget has two parts:
   ▶ Costs associated with conducting all activities at the health facility level;
   ▶ Running costs, supervision, maintenance costs, training, social mobilization and communication, and program management.

2. The district should prepare its budget based on the requirements of the health facility work plans, and other district level requirements

3. The district EPI micro-plan budget should feed into the whole district health plan

4. Points to consider:
   ▶ A realistic budget is needed reflecting human resources, commodity and financial resources needed for any integration of services
   ▶ Review last year's budget and determine if the money and other resources requested were sufficient and received on time. Were there problems in the flow of funds to the district level or within the district, and if so, how can the situation be improved?
   ▶ Compared to last year, what new activities have been included (e.g., more outreach sessions) for which extra money would be required?
   ▶ Can resources for immunization be mobilized locally (e.g., local partners might provide outreach transport or gas for a refrigerator)?
   ▶ Can certain tasks be done more efficiently to save resources (e.g., combining distribution of vaccines with visits or training)?
   ▶ Explore pooling of resources from different programmes to take advantage of integration (e.g., transport shared with different programs or a minimum package for outreach and/or mobile services which include Vitamin A supplementation, distribution of ITNs, etc.), without compromising service quality
   ▶ Advocate for extra money at provincial or national level
   ▶ Monitor expenditures

6. IDENTIFY STRATEGIES, DEVELOP ACTIVITIES AND TIMELINE:

The health facility

Effective monitoring requires the regular collection of reliable data and its analysis to verify that planned activities are being implemented and that desired results are being achieved. First, determine key indicators, such as coverage and dropout rates, for monitoring the micro-plan and immunization service performance (see Chapter 7 on Monitoring and Using Data for Action for a list of suggested indicators). Active monitoring requires review, feedback, and taking action on documented progress with the DHMT, health workers, stakeholders, and community members.

The district

DISTRICT

Select key indicators for monitoring purposes (see Chapter 7: Monitoring and Using Data for Action). All the monitoring and review activities listed above can lead to short- or long-term corrective action.

Review progress by using consolidated HF monthly reports, HF monitoring charts, quarterly reviews and supportive supervisory visits.

Include the inputs from "monitoring group"; potentially include aspects such as data quality reviews, etc.

7. MONITOR THE PROGRESS MONTHLY

The health facility

HEALTH FACILITY

1. Monitor the process indicators and all antigens coverage and dropout rates monthly (see Chapter 7 on Monitoring and Using Data for Action)
2. Involve all health workers involved in the immunization program and the community representatives in the monitoring
3. Review progress by using: monthly reports, monitoring charts, quarterly reviews and supportive supervisory visit reports
4. Monitor progress within "high-risk communities"

The district

DISTRICT

Review progress to take action and solve problems (see Chapter 7 on Monitoring and Using Data for Action).

8. USE YOUR MICRO PLAN AS A MANAGEMENT TOOL

The health facility

HEALTH FACILITY

The EPI micro-plan is a very effective management tool. Through regular review and routine updating of the micro-plan, one can correct problems and adjust strategies in time to stop major barriers against achieving targets. It can also be used as an advocacy tool for obtaining support from local government, donors, NGOs, CBOs, and the community.

Review and update your micro-plan at least **every quarter**.

The district

DISTRICT

Districts should conduct regular review meetings and review the district micro-plan during the review meeting. The district micro-plan should be updated every six months.

3.3   ROLES IN MICRO-PLANNING

While health facilities develop annual micro-plans and districts create micro-plans based on aggregated facility plans, stakeholders at all levels of the progamme must guide, facilitate, and support the micro-planning process to ensure successful implementation. Stakeholders from national to community level have different and complementary roles, which can be summarized in the table 3.1 below:

Table 3.1 CONTRIBUTIONS OF DIFFERENT LEVELS IN RED MICRO-PLANNING

	Activities	National	Region	District	Facility	Community
Leadership, Coordination and Management	1. Ensure that RED is an integral component of the national strategic health plan, the cMYP and other MoH planning instruments, and that reaching the under-served and most vulnerable is a national priority.	+	+			
	2. Provide, review and improve denominator estimates to increase accuracy of official target populations.	++	+	+	++	++
	3. Conduct situation analysis/equity analysis of programme trends to describe the communities affected by inequities.	+	+	++	+	
	4. Prioritize and provide support to districts/HFs/communities with the most under-immunized populations and communities affected by inequities.	+	++	+++	++	
	5. Conduct a local situational analysis for the micro-plan for improving reliability of information.			++	+++	+
Financial and other resources	6. Allocate budget and disburse government and donor funding and resources to regions/districts in a timely manner.	+	+			
	7. Allocate and disburse resources in a timely manner.	+	+	+	+	
	8. Coordinate health facility and community resources for more cost-effective and sustainable services.			++	+	+
Capacity Building	9. Adapt and update the RED guide and tools according to district and health facility situational analyses.	+				
	10. Train regional/district/health facility managers on the RED approach and relevant EPI technical areas.	+	++	+++		
Monitoring and Supervision	11. Routinely review progress based on process, performance and surveillance data routinely and adjust micro-plans.	+	+	++	++	
	12. Monitor, supervise and assist district/HF micro-planning processes and implementation.	+	++	+++		
	13. Improve the accuracy of the target population (denominator) at HF level, through actions such as registering newborns and finding unregistered families in the community. Compare the number of children in the register with the official target population and with local population records.			+	++	++
	14. Work with the HF to plan optimal scheduling for vaccination sessions.				+	++

Political Advocacy and Community Mobilisation	15. Engage political and community leaders, community health workers and groups, and partners in the micro-planning process.	+	+	++	+++	+
	16. Consult with the community in developing vaccination delivery strategies, particularly in communities that have a large number of unimmunized. These special communities will need additional effort.			+	++	+
	17. Develop a list of community focal points for mobilizing all eligible children and women for vaccination sessions.			+	++	++
	18. Engage community leaders and groups in micro-planning and developing strategies to reduce under-served and dropouts, in particular focusing on those socially hard to reach.		+	++	++	+
	19. Establish regular meetings with community focal points.			+	++	+
	20. Mobilize eligible population for the vaccination sessions.				+	++
	21. Community health workers and leaders participate in RED micro-planning.				+	++

3.4   MANAGING RESOURCES

Increased expectations from the health system and delivering more interventions can often increase resource needs. This comes at a time when financial support may be decreasing and resources are not sufficient for implementing all planned activities. Funds may be limited for vehicle maintenance, per diem and fuel, for example. Consequently, not all activities may be implemented that were included in the micro-plan, and ways of achieving more with less will need to be sought in an effort for more efficient management.

Efficient resource management requires prioritizing activities and coordinating them with other health programs, such as integrated supportive supervision. Managers must carefully and clearly allocate staff to activities. Managers also need to think creatively to find in-kind and collaborative resources from other PHC programs, NGOs, the private sector, and the community. Key issues to consider when allocating human, financial, and material resources follow.

WHAT TO CONSIDER IN MANAGING HUMAN RESOURCES

▶ Capacity building through pre-service, in-service and on-the-job training during supportive supervision. Mentoring and supervision often have more impact on behavior change than more formal trainings;

▶ Staff are motivated by different methods, including supportive supervision; recognition of good performance, including through frequent feedback and sharing practical experiences with peers; appropriate staff placement according to skills and experience; and financial and non-financial incentives, such as: health worker of the month recognition, opportunities to gain new skills, and opportunities to move into more responsible positions;

▶ Innovative ways of motivating health workers include use of technology for recognition and exchanging success stories, better use of review meetings, and reminding health workers of their accountability and importance to the health of the communities they serve.

WHAT TO CONSIDER IN MANAGING FINANCIAL RESOURCES

▶ Review available financial resources by source and identify funding gaps;

▶ Determine how to utilize coordination mechanisms at district level to raise additional funds;

▶ Coordinate resources from different health care activities, such as vitamin A supplementation and ITN distribution, to share transport for outreach and mobile immunization services;

▶ Shared training and communication opportunities;

▶ Determine how activities can be jointly conducted to economize staff time and make services more convenient for mothers.

WHAT TO CONSIDER IN MANAGING MATERIAL RESOURCES

▶ Demand for integrated health interventions including immunization services;

▶ Infrastructure and equipment gaps.
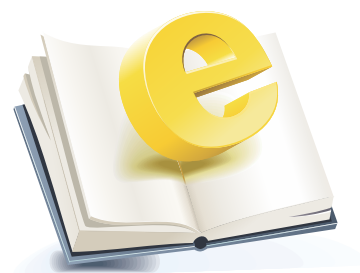
3.5 REFERENCES

WHO/AFRO/EPI, Mid-Level Management Course for EPI Managers. Module 1. *A problem-solving approach to immunization services management.*

WHO/AFRO/EPI, Mid-Level Management Course for EPI Managers. Module 4. *Planning immunization activities at national, provincial and district levels.* http://www.who.int/immunization/documents/mlm/en/

Immunization in Practice. Module 5. *Managing an Immunization Session*, *2015*. WHO/IVB, World Health Organization, Geneva. http://www.who.int/immunization/documents/IIP2015_Module5.pdf

Global Routine Immunization Strategies and Practices (GRISP), *2015*, World Health Organization. http://www.who.int/immunization/programmes_systems/policies_strategies/GRISP/en/

Reaching Every District Using Quality Improvement Methods (RED-QI), a Guide for Immunization Program Managers, Ethiopia; May 2015. http://uifhs.jsi.com/wp-content/uploads/2016/04/UI-FHS_HowtoGuide.pdf

State of Inequality: Childhood Immunization, World Health Organization, 2015.
http://apps.who.int/iris/bitstream/10665/252541/1/9789241511735-eng.pdf

CHAPTER 4

REACHING ALL ELIGIBLE POPULATIONS

4. REACHING ALL ELIGIBLE POPULATIONS

	Steps	RED Tool
REACHING ALL ELIGIBLE POPULATIONS	1. Review the micro-plan and design strategies based on community needs	
	2. Extend immunization to all age groups	
	3. Assess opportunities for integration	
	4. Prepare, conduct and monitor sessions	
	5. Monitor reaching all eligible populations	

"Reaching all eligible populations" focuses on improving equitable access and utilization of immunization and other health services in a cost-effective manner through a combination of service delivery strategies which fit the needs of the community.

4.1   KEY ISSUES

Achieving and sustaining high levels of equitable coverage requires service delivery strategies which are appropriate to the needs of the people and which make additional efforts to immunize communities affected by inequities. In addition to geographical considerations, reaching target populations includes bridging socioeconomic and other inequities. To develop the most effective strategy or combination of strategies, the health team must identify and locate all immunization-eligible children and adults. Then the health team determines which groups are at high risk for not completing their required immunizations, and thereby at high risk for VPDs. Effective service delivery strategies are based on clearly defined reasons for low vaccination coverage, including logistical, cultural, or financial barriers, and inadequate performance of immunization services.

HELPFUL TIPS

A **high-risk population or community** is a group of individuals who are at high risk of being under-served with vaccination services, and therefore susceptible to vaccine preventable diseases. These high-risk groups can include but are not limited to nomadic populations, migrants, refugees, certain faith-based or ethnic communities, the urban poor, or individuals displaced by insecurity, natural disaster or conflict situations.

Reaching All Eligible Populations is not just a task for the health facility, but all levels in the Ministry of Health. **National policies** must support implementation of the RED micro-planning for all programs. Well-planned, integrated services use scarce resources more effectively. The process of **Reaching All Eligible Populations** begins at the national level and with coordinated policies, projects, and budgeting which support integrated management and delivery of services.

Regions and Districts must also be involved. They ensure adequate resources for health facility micro-plans and that accurate target populations (denominators) are included, mapping is consolidated, and that all communities are clearly defined and reached appropriately. Action-oriented district communication and advocacy plans which fit the needs of communities are vital for effectively finding and reaching the unimmunized and the under-immunized.

At the **health facility** RED focuses on three basic Routine Immunization delivery strategies: **fixed, outreach, and mobile.** Fixed services refer to services offered in the health facility. Outreach means services delivered in the community by health workers who go to the community and return to the health facility in the course of the working day. Mobile services refer to sessions that are conducted by teams that travel to places distant from any health facility. The teams usually stay out at least one night. Mobile sessions are scheduled when needed; teams often go to homes, fields, workplaces and schools, wherever the population is living.

4.2 HOW TO REACH ALL ELIGIBLE POPULATIONS

The definition of "eligible populations" has greatly expanded. The immune response to new vaccines, the need for booster doses, and disease patterns of emerging infections all require vaccine delivery schedules that go beyond infancy and use a life cycle approach. To maximize health benefits and return on investments, health systems need to deliver to more pregnant women, school children, adolescents and vulnerable adults. This requires a change in thinking beyond traditional vaccine schedules and, in the context of a primary healthcare approach, be more aligned to a life cycle or continuum of life approach to delivery (see Figure 4.1 below). This should encourage innovative delivery mechanisms to reach all eligible populations (in schools and in places where mothers gather, for example).

Figure 4.1: THE LIFE CYCLE APPROACH
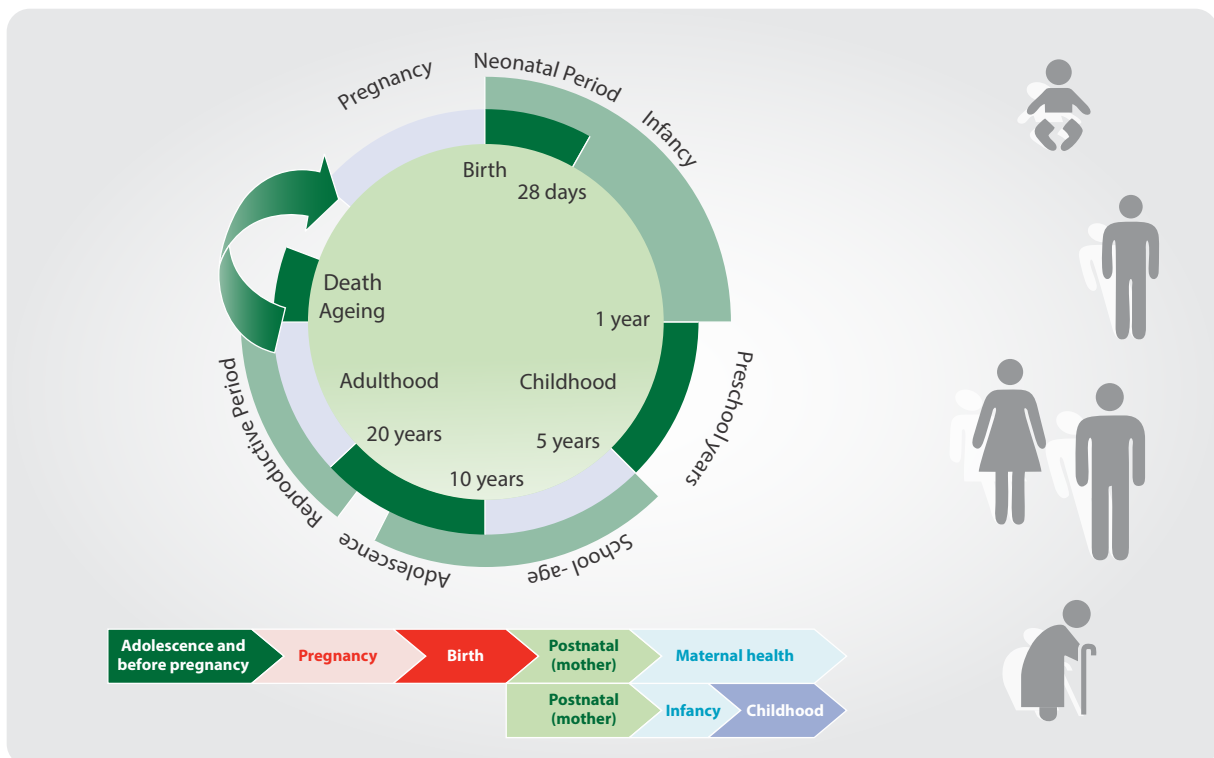
Looking at health needs of populations by age can stimulate links between the life cycle approach and integration. For example, HPV introduction can provide opportunities for health interventions targeted at adolescents, such as Td/TT vaccination, menstrual hygiene education, sexual and reproductive health education and HIV prevention. Consider the life cycle approach when planning for reaching all eligible populations.

Five major steps to reach eligible populations :

1: Review the Micro-Plan and Design Strategies

Develop the most effective strategy or combination of strategies for **Reaching All Eligible Populations**. Use the information in the health facility micro-plans and perform the following tasks:

▶ **Review** the micro-plan and the frequency of immunization sessions in the past 3-6 months, in particular in those areas that are previously underserved, to sustain and raise coverage.

▶ **Identify** the groups that need special attention and secure the resources needed to reach them (e.g., coordinate with the agriculture sector to reach nomads, political authorities or NGOs to reach insecure areas, etc.).

▶ **Monitor** efficiency of the immunization sessions (i.e., ensure all targets are being reached, and if not, work with communities to reorient strategies)

▶ **Regularly meet** with leaders of communities that resist or are reluctant about immunization; discuss the issues and find solutions.

▶ **Plan** for additional opportunities to boost coverage through Periodic Intensification of Routine Immunization (PIRI), Child Health Days (CHDs), African Vaccination Week (AVW) and campaigns. These are planned efforts to reach populations that are not reached systematically using the RED approach.

◆ **PIRIs** are organized in areas where the systematic RED approach is not possible (e.g., for nomadic populations, in seasonally inaccessible areas, during humanitarian crises, etc.).

◆ **CHDs** are integrated events for delivery of immunizations, Vitamin A, deworming and other high-impact interventions typically to children under five and pregnant women for broader MNCH, but the age range is tailored to the target population of the interventions that are delivered.

◆ **AVW** is a week to advocate for and deliver immunization. It also promotes delivery of other high-impact life-saving interventions.

2: Extend Immunization to All Age Groups

According to national immunization policies:

▶ Implement the principles outlined in the life cycle approach

▶ Catch-up children who did not complete their series in the first year of life, after their first birthday.

▶ Include children in their 2nd year of life for second dose of measles/rubella-containing vaccines, DTP booster and other vaccines, as appropriate, and provide immunization and preventive care sessions for children under five.

◆ Find out why children beyond 1 year are not being immunized (this may include issues related to health worker or caregiver's knowledge). These reasons may differ from infant immunization barriers.

- Organize sessions for school age children, adolescents, and adults.

  ◆ Adolescents: in addition to immunization in schools, develop strategies to reach out-of-school adolescents. Adapt strategies to their ways of living, workplace programs and informal workplace settings.

- Consider special mobilization strategies for adults, by group.

3: Assess Opportunities for Integration

- Numerous potential opportunities exist for integrating additional health services into the vaccination schedule. Review what interventions can be integrated (see Tables 2.1-2.5 in Chapter 2 "Considerations for Integration"). Session plans should contain strategies to reach populations and can integrate services to immunization, as appropriate.
- Use contact points at the heath facility for curative and preventive care and at community level to identify

The WHO *Planning Guide* http://www.who.int/immunization/programmes_systems/policies_strategies/MOV/en/ to Reduce Missed Opportunities for Vaccination (MOV) is intended for use by decision-makers and programme managers at national and sub-national levels. The MOV strategy includes assessment of the magnitude and causes of missed opportunities (for people visiting health facilities when they are sick and being vaccinated and vice-versa), and tailored health system interventions to reduce such missed opportunities, leading to an increase in vaccination coverage and timeliness of vaccinations and other health interventions.

Deliver other interventions with immunization (see Tables 2.1-2.5 in Chapter 2):

  ◆ Add on interventions and referrals according to the criteria described in Chapter 2

  ◆ Bring commodities for other interventions during outreach sessions

  ◆ Ensure systematic referral in fixed sites for other programs

  ◆ Offer all immunizations with other interventions

4: Prepare, Conduct, and Monitor Sessions

There are numerous steps for preparing, conducting, and monitoring immunization sessions. These can be found in Module 5 of WHO's *Immunization in Practice (2015 Update)*. Below are a few of the key steps:

  Assign community focal points to mobilize target population for fixed, outreach and mobile sessions.
- Take the right quantity of vaccines and other supplies and maintain vaccines at the proper temperatures at all times.
  Assure the safety of immunization, including reconstitution of vaccines, vaccine administration, discarding
- reconstituted vaccines within six hours and proper waste management.
  Correctly record the doses administered on tally sheets, registers, and child and mother cards.

▶ Provide caretakers with key information: date, time, and place for next immunization, number of visits still needed for the child or a woman.

▶ Inform mothers and caretakers about what to do for an Adverse Event Following Immunization.

▶ Regularly monitor immunization sessions to assure effective delivery of vaccinations to all eligible populations.

5: Monitor "Reaching All Eligible Populations"

The best way to monitor whether all eligible populations are being reached is by measuring vaccination coverage by strategy: fixed, outreach or mobile. Suggested indicators can be seen in Section 7: Monitoring and Using Data for Action.

4.3 REFERENCES

WHO/AFRO/EPI, Mid-Level Management Course for EPI Managers. Module 5. *Increasing Immunization Coverage.* March 2004 – Draft2.

Increasing immunization coverage at the health facility level.
http://www.who.int/immunization_delivery/systems_policy/www721.pdf
WHO/V&B/02.27, World Health Organization, Geneva, December 2002
USAID, Immunization Essentials: a Practical Field Guide. *Chapter 3. Delivery of Immunization Services, pp. 43-59.*
http://pdf.usaid.gov/pdf_docs/PNACU960.pdf

USAID, RED - Reaching Every District Strategies.
http://www.immunizationbasics.jsi.com/Resources_Immunization.htm#Outreach

WHO: Recommended Routine Immunization Schedule
http://www.who.int/immunization/policy/Immunization_routine_table1.pdf?ua=1

Immunization in Practice Module 4: *Micro planning for reaching every community*
http://www.who.int/immunization/documents/IIP2015_Module4.pdf?ua=1
and *Module 5: Managing an immunization session.*
http://apps.who.int/iris/bitstream/10665/193412/1/9789241549097_eng.pdf

Micro-Planning for Immunization, *How to strengthen every step of your process*; ELearning module 4:
https://agora.unicef.org/course/info.php?id=6730&utm_campaign=Immunization+eLearning+Initiative&utm_source=hs_email&utm_medium=email&utm_content=32135821&_hsenc=p2ANqtz--U5PqpF2twofZNe_QrBcMK0WtdxMeJ0aksthAdWvC0qdWVViQHnwcPhMoGq5DC245bdw9OnIngjnLIKGxaWpkyiECcQ&_hsmi=32135821

WHO Immunization in Practice: *Partnering with Communities*. Module 7.
http://www.who.int/immunization/documents/IIP2015_Module7.pdf?ua=1

UNICEF: *Achieving Equity in Immunization Coverage by Reaching Every Community - An Operational Guide for National Immunization Programs.*

WHO: *Increasing coverage at health facility level;*
http://apps.who.int/iris/bitstream/10665/67791/1/WHO_V%26B_02.27.pdf

UNICEF: *Narrowing the gap to meet the goals.*
http://www.unicef.org/media/files/Narrowing_the_Gaps_to_Meet_the_Goals_090310_2a.pdf

Reaching Every Community Using Quality Improvement (REC-QI): *Mapping to support routine immunization micro planning in Uganda*; August 2016; https://www.mcsprogram.org/resource/reaching-every-community-using-quality-improvement-rec-qi-mapping-support-routine-immunization-microplanning-uganda/

CHAPTER 5

ENGAGING WITH COMMUNITIES

5. ENGAGING WITH COMMUNITIES

ENGAGING WITH COMMUNITIES

Steps	RED Tool
1. Building community partnerships	
2. Supporting trust and friendly services	
3. Delivering services to disadvantaged communities	
4. Working with community health workers and mobilizers	
5. Using effective communication	
6. Monitoring community participation	3a

RED encourages health workers to partner with communities for the planning, promotion, delivery and monitoring of immunization and other primary health care services. Engaging with communities results in more accommodating and user-friendly services, increases utilization and promotes accountability. This chapter describes techniques and approaches for engaging with communities.

5.1 KEY ISSUES

Effective community participation is built on partnerships with communities through supportive and coordinated actions by District Health Management Teams (DHMTs), health facility committees, health workers and community members. When communities are involved as allies in planning, promoting, implementing and monitoring services, they develop a stronger trust and ownership in the health service. It is therefore easier for health workers and health planners to analyze and address reasons for low uptake, drop-out, and underserved populations when the communities are active partners.

Communities are groups of people who share common socio-demographic characteristics or living conditions, for example rural villages and urban poor neighborhoods. There are faith-based and ethnic communities and communities which have common practices and livelihoods, such nomadic tribes and fishing communities. Other mobile communities include refugees and internally displaced people. People who share the same socio-economic living standards, such as the poorest segment of a population, also make up communities. Communities are not limited to people who live in the same place. It is important for health managers to recognize community differences and dynamics, and to interact with the various sections within the communities as well as their influencers and partners.

The sense of "belonging" in a community can be a determinant of the likelihood of being vaccinated, and immunization acceptance or use of services can differ substantially between communities. When some communities have lower immunization uptake, it puts their members at risk, impacts on herd immunity and increases the risk of outbreaks. Communities with low vaccination coverage tend to be disadvantaged in multiple aspects that increase the risk of infectious diseases: crowding, lack of safe water, poor sanitation, and geographic or economic barriers to accessing health care.

The poor consistently have lower vaccination coverage in surveys. Evidence has shown that increasing immunization coverage in the poorest communities is cost-effective and generates more health per vaccinated child compared to vaccinating more children in better off communities. Under-vaccinated communities can be identified at national and regional levels through surveys such as DHS, MICs and through equity assessments (including with local communities). It is important that DHMTs and health facility staff are aware of who the underserved communities are at national level and apply this knowledge to local planning. Local pro-equity interventions should be designed and implemented in partnership with the high-risk communities and as an extension of national strategies and initiatives to reduce disparities.

Social and behavior change communication (SBCC) are activities conducted with communities which can reinforce positive health practices, discourage dangerous practices and foster community involvement in service delivery such as resource mobilization, integration, and accountability. Effective SBCC is critical for reducing disparities in vaccination between communities.

5.2   BUILDING COMMUNITY PARTNERSHIPS

Effective community partnerships

Effective community partnerships are based on engaged communities which are supported and facilitated by DHMTs, health facility teams and CHWs. Community trust and ownership in public services and immunization are fostered when communities are part of the planning, promotion, implementation and monitoring. This is more than a local responsibility. The roles and responsibilities of the national program, district health team, and health workers in linking the community with health services should be clearly stated in plans and strategies at all levels.

Engaged communities

Engaged communities are better positioned to claim their right to vaccination and to hold the health system accountable for the delivery of friendly and convenient services. **Demand promotion** and **SBCC** are critical activities when engaging with communities. Some examples include: community dialogue on the value of immunization; mobilization of faith leaders to reach all segments of communities; and collaboration with community-based organizations (CBOs) and schools for disseminating key messages and tracing those in need of vaccination.

Community engagement activities should be clearly outlined, budgeted and tracked in cMYPs and national and local level annual work plans. Monitoring and reporting tools and review meetings should capture the frequency as well as the content and progress of community engagement activities, linking their contributions with improving coverage, identifying and reaching target populations, and reducing drop-outs. Districts need to integrate their community engagement activities in the area of immunization with those of other health programs and work closely with locally active NGOs and other partners.

Participatory community mapping

Participatory community mapping is when health workers and community members together identify community structures and resources, vulnerable and under-vaccinated groups and influential community members and local leaders. Engaging influential community members and leaders for immunization is critical for reaching the unreached and increasing coverage overall. An important practical step in community mapping is to list, by name and contact information (mobile number, address), community members and leaders who can help promote immuni-zation—such as government officials, traditional healers, businessmen, and opinion leaders as well as contacts in institutions like schools, faith-based institutions, NGOs, and women's groups. Visualizing the results on actual maps can be helpful when planning.

An example of effective participatory community mapping for reaching every community can be found at http://www.mcsprogram.org/resources/reaching-every-community-using-quality-improvement-rec-qi-mapping-support-routine-immunization-microplanning-uganda/.

5.3   BUILDING TRUSTED and FRIENDLY SERVICES

Public trust in vaccination is an immunization program's most valued asset. Studies in Africa and elsewhere consistently show that health workers are the most trusted source of information for caretakers, but they are not the only source. Rumors and misinformation about vaccinations can spread quickly through community networks, as well as via mobile phones or media, and over the internet. Frontline health workers need to know well the communities they serve and be prepared to respond to their concerns.

The interaction between health workers and caretakers is at the center of maintaining trust. Mothers who are treated respectfully and who perceive that their children's health and safety comes first are more likely to come back for the next vaccination. Vaccine shortages, rude reception, lack of interpersonal communication, cancelled sessions and closed health facilities are effective ways of losing a community's trust. Friendly, convenient, safe and reliable immunization services should be at the center of work plan development and micro-planning processes.

How to maintain trust:

▶ **Know your community and listen to them**. If a particular community in a catchment area has lower immunization coverage, engage with them and find out why. Perhaps they are unaware of the immunization services, or the scheduled times or locations are inconvenient to them. Perhaps they feel left out from the health care system (social distancing), or they may fear immunizations or have incorrect beliefs about vaccines.

▶ **Participatory dialogue.** This requires regular meetings with the communities to discuss and resolve issues around planning, possible misconceptions about vaccines, follow-up of unvaccinated and the quality of services. Regular mobile phone contact with the community workers and leaders in between meetings ensures that health facility teams are on top of developments.

▶ **Engage the community.** Communities that are actively involved in planning and supporting immunization are more likely to use the services and to contribute resources. Propose and discuss with community members how they can contribute to improving facility and outreach sessions. Examples include:

◈ Motivating friends, family and neighbors to come for vaccination

◈ Arranging clean and convenient outreach sites

◈ Transporting vaccines and health workers to outreach sessions

◈ Reminding the community about scheduled outreach sessions

◈ Helping to keep the community register up-to-date

◈ Giving health education messages

◈ Following-up with caretakers who do not bring their children back for immunization

5.4   DELIVERING SERVICES to DISADVANTAGED COMMUNITIES

Urban poor communities

The urban poor is a community that often miss out on vaccinations. Although they may live close to health facilities, social distancing and discrimination often prevent them from using their services. Other barriers include unfamiliarity with the health facilities, lack of trust in authorities, inconvenient service hours and high opportunity costs. Urban poor parents often work long hours away from where they live and may have prohibitive transportation costs to health service points.

Urbanization offers new opportunities to deliver immunization. High population density means that it is possible to reach many in a short time. Good radio, TV and printed media coverage are opportunities for mass-media promotion of vaccinations. Mobile phone ownership is higher in urban areas, including among the poor, and this opens the possibility for SMS alerts, reminders and recalls, and for more individualized tracking with caretakers of children in need of immunization. Arranging alternative service hours may be easier in urban areas where distances are shorter and where there is public transport. Social mapping with urban poor communities is important and can inform immunization providers about when and where caretakers are more likely to bring children for vaccinations and help with communication strategy design. Health facility staff can engage with partners in immunization, such as faith-based organizations, health care and social service providers, schools, private sector, humanitarian organization and community volunteer networks, to identify and understand the behavioral and social determinants of the urban poor community.

Refugees and Internally Displaced People

Every child and adult in district and health facility catchment areas should be immunized. Do not leave out unexpected or newly established communities, such as camps and settlements for refugees and internally displaced people. Populations who are displaced by emergencies are at increased risk of VPDs and should be prioritized for vaccinations regardless of their origin or reason for arriving in the area. The DHMTs and health facilities need to coordinate the work with partners assisting the displaced communities and make sure that they have access to vaccine and vaccination supplies as needed, and that immunizations are administered safely and correctly recorded. All relevant partners should be involved in the planning, implementation, and monitoring of immunization services.

Mobile populations

Mobile communities such as pastoralist herdsmen, hunters, and fishing communities may not be accessible at all times of the year or may turn up unexpectedly in the catchment area. They can easily be missed during work planning unless their movements are known and predictable. It is important to be aware of their social patterns and migration routes in order to plan for their immunizations at places and times when they can be reached. Communication with mobile and nomadic communities about the location and timing of immunization sessions may require the identification of their community and faith-based leaders. Collaborating with agencies that work on animal health, environment and emergency preparedness can facilitate access to these

5.5   WORKING WITH COMMUNITY HEALTH WORKERS (CHWs) and COMMUNITY MOBILIZERS

In countries with formally trained and paid CHWs, the health facility teams and DHMTs should foster effective communication channels with the CHWs. This includes scheduling regular meetings and, wherever possible, frequent mobile phone contact. Community representatives and CHWs should be invited to the health facility micro-planning sessions. The health facility team should also engage with other community structures that can support immunization service delivery, such as health extension agents for nutrition, HIV/AIDS, TB, and malaria, as well as community health committees, schools, local media, women's groups, youth groups, faith-based organizations, NGOs, CBOs, and the private sector.

CHWs often have multiple responsibilities and may have competing priorities based on their sources of compensation or training. The involvement of CHWs in immunization service delivery, including supervision and coordination, should be part of micro-planning. Community health committees can be used to support this process. CHWs should be able to understand and communicate the information on the home-based vaccination cards.

CHWs, health extension workers, community mobilizers and health volunteers can assist with:

- Providing caretakers with correct information on the importance of vaccines and vaccination schedule
- Identifying and entering pregnant women, newborns and children < 5 years of age in community registers
- Generating "due lists" and tracking people in need of vaccinations and inform health facilities about missed children and missed communities
- Arranging and conducting home visits as needed
- Assisting with the organization of outreach sessions and mobile clinics
- Promoting demand and encouraging caretakers to attend immunization sessions

Community registers

Community registers of pregnant women and children up to 5 years of age are important for keeping track of the eligible population and for achieving high coverage with vaccinations and other scheduled health interventions. Health facility teams should work closely with CHWs to keep the community registers up to date and use them to recall and track children and pregnant women who are due for vaccination. Health facilities should link and compare these registers with the existing immunization or child health register and tracking system at the facility and ensure that recorded vaccinations for individual children and mothers correspond with home-based records and the information in the community registers. The registers should record contact information (such as mobile phone numbers, village/address, and name of responsible CHW) that allow for tracking and recalling unvaccinated children and those due for services.

5.6   USING EFFECTIVE COMMUNICATION

Effective communication is based on dialogue and respect. It entails listening, understanding, encouraging and working with caretakers and communities to increase vaccination uptake and other services available to them.

Health workers who counsel caretakers should ensure that they understand:

▶ What vaccine(s) are being given and what they protect against

▶ The possible side effects for each vaccine and how to manage them if they occur

▶ When to return for the next immunization and the next Vitamin A supplementation dose

▶ That only fully immunized children are fully protected and the importance of returning for all scheduled vaccinations and Vitamin A doses

▶ That ill children can be vaccinated and should be brought to vaccination sessions when they are due for vaccination

▶ The importance of handwashing and sanitation for prevention of diarrhea

▶ Danger signs and when to bring a sick child for care

HELPFUL TIPS

To improve community understanding and utilization of services, districts should:
1. Include strategic communication and advocacy activities in their annual work plans and budgets
2. Ensure health workers are trained on interpersonal communication and community partnering
3. Conduct advocacy by routinely communicating with district and community leaders and partners on the performance and challenges/needs of the immunization program

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5.7   MONITORING COMMUNITY PARTICIPATION

The core indicators below are used to monitor progress of involving communities in immunization and other PHC services. In addition to recording the frequency of community meetings, it is valuable to document attendance and to take notes from the meetings, including actions to be followed up.

Adapt and use the following **core process indicators for monitoring community participation:**

▶ Proportion (%) of <u>districts</u> that conduct at least one meeting per quarter in which immunization and other PHC services were discussed with leaders of CBOs, local authorities, religious leaders, etc.

▶ Proportion (%) of <u>health facilities</u> that conduct at least one meeting per quarter in which immunization and other PHC services were discussed with representatives of CBOs, political leaders, religious congregations, etc.

▶ Proportion (%) of health facility micro-plans that include a costed community engagement component.

5.8   REFERENCES
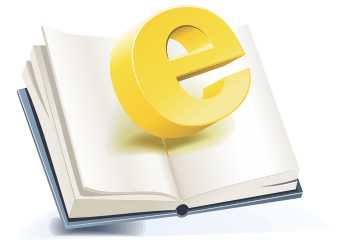
Technical

Immunization in Practice: A Practical Guide for Health Staff, 2015

http://www.who.int/immunization/documents/training/en/

MLM WHO/HQ Community module http://www.who.int/immunization/documents/mlm/en/

WHO/AFRO MLM Communication Module

WHO, *The Guide to Tailoring Immunization Programs*. http://www.euro.who.int/__data/assets/pdf_file/0003/187347/The-Guide-to-Tailoring-Immunization-Programmes-TIP.pdf

Immunization Advocacy Tool kit for CSOs. http://advocacy.vaccineswork.org/

Community engagement to reduce inequities in health. http://www.ncbi.nlm.nih.gov/books/NBK262817/

USAID, *Immunization Essentials: A Practical Field Guide* (Chapter 9). http://pdf.usaid.gov/pdf_docs/PNACU960.pdf

WHO, *Strengthening Immunization Programs: The Communication Component*

http://who.int/immunization/hpv/communicate/strengthening_immunization_programs_usaid_2004.pdf

The 'What' and 'How' of Communication for Immunization

http://healthcommcapacity.org/communication-immunization-part-two/

Engaging Communities with a Simple Tool to Help Increase Immunization Coverage

http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15494&lid=3

Immunization Partners' Meeting on Advocacy, Communication, and Community Engagement for Routine Immunization (March 2016 report): http://www.comminit.com/unfpa/content/immunization-partners-meeting-advocacy-communication-and-community-engagement-routine-im

WHO *Health Equity Assessment Toolkit (HEAT)*: http://www.who.int/gho/health_equity/assessment_toolkit/en/

JSI, NOTES FROM THE FIELD; *Bringing Immunization Closer to Communities: Community-Centered Health Workers*

http://3qvw4sd8qlr2o7003493odw1.wpengine.netdna-cdn.com/wp-content/uploads/2012/11/Arise_NotesfromTheField3_CommCenteredHealthWorkers_final5082.pdf

Reaching Every Community Using Quality Improvement (REC-QI): Mapping to support routine immunization micro-planning in Uganda. August 2016 http://www.mcsprogram.org/resources/reaching-every-community-using-quality-improvement-rec-qi-mapping-support-routine-immunization-microplanning-uganda/

Resources and guidance related to card (Home-Based Record) design, availability and use - to improve community and caregiver linkages with immunization services, contacts, and tracking.

http://jsi.com/homebasedrecordsproject

Country Examples

Madagascar Community Mobilization experience (English).http://www.immunizationbasics.jsi.com/Docs/IMMbasics_Madagascar_Community_mobilization_experience_(English).pdf

Madagascar Community Mobilization experience (French).

http://www.immunizationbasics.jsi.com/Docs/http://www.immunizationbasics.jsi.com/Docs/IMMbasics_Madagascar_Community_mobilization_experience_(French).pdf

WHO Bulletin. Community Health Workers after Ebola. http://www.who.int/bulletin/online_first/BLT.15.164020.pdf

Malawi My Village My Home for name-based immunization infant tracking.

http://www.slideshare.net/jsi/my-village-my-home-in-malawi

Adapted from India My Village My Home.

http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15243&lid=3

CHAPTER 6

CONDUCTING SUPPORTIVE SUPERVISION

6. CONDUCTING SUPPORTIVE SUPERVISION

SUPPORTIVE SUPERVISION

Steps	RED Tool
1. Prepare for the supervision	
2. Designate supervisors	4.b
3. Prepare tools & checklists	4.a
4. Plan site visits	4.c
5. Conduct constructive visits	

Supportive supervision is a process of helping staff to improve their own work performance continuously. It is carried out in a respectful and non-authoritarian way with a focus on using supervisory visits as an opportunity to improve knowledge and skills of health staff.

*Supportive supervision encourages **open, two-way communication**, and building **team approaches** that facilitate problem-solving. It focuses on **monitoring** performance towards goals, and **using data** for decision-making, and depends upon regular follow-up with staff to ensure that new tasks are being implemented correctly.*

6.1 KEY ISSUES

Supervision is a key function of management and is process of continuous assessment and improvement. It can be done by using self-assessment, interactions with peers or supervisors through remote means, and review meetings, as well as the in-person visit by a supervisor.   Health workers can use analytical supervision tools to continuously monitor their performance.

When done well, supportive supervision catalyzes the effective delivery of immunization services. It requires experienced staff who are trained in both immunization and as supportive supervisors. Such supervisors are able to routinely assess staff performance and system functioning in a non-threatening manner and identify problems on-site, such as low coverage or high dropout rates, and cold chain and waste disposal deficiencies. Once problems are identified, supportive supervisors address system barriers and provide on-site capacity building to improve staff performance or address gaps in knowledge and skills.

Not all deficiencies can be solved at the service delivery level. Therefore another role of supportive supervisors is to serve as a liaison with district, provincial, and national managers to make them aware of needed support and follow-up to improve local performance. This may be through the provision of essential commodities, job aids, in-service training, and exchange visits. Supportive supervisors also can help instill a sense of accountability among service providers for implementing EPI as planned and serving the community.   Ideally, supportive supervision can lead to a better-run program and therefore more fully-immunized children and women.

Regular supportive supervision improves the safety, efficiency and the effectiveness of immunization services. **Supportive** supervision adds more to traditional supervision by emphasizing the following:

- **On-site capacity building** to answer health workers' questions, correct problems before they become major obstacles, and provide on-going refresher training for health workers;
- **Participatory performance and quality improvement** through interactive and non-threatening dialogue with the health worker;
- **Documentation** with regular and constructive feedback;
- **Appropriately scheduled visits**, according to the health facility's workload and to avoid inconveniencing the health staff, mothers or caretakers;
- **Application of the findings** from supervisory visits in micro-planning and strategy development.

See **Tools 4a, 4b, and 4c** in the Annex.

Supportive supervision can also be enhanced by additional performance improvement strategies, such as those listed in **Resources** at the end of this chapter, and those described in **WHO MLM module 4, WHO AFRO MLM Module 21**.

6.2 MAKING SUPERVISION SUPPORTIVE

Supportive supervision involves observation of performance with constructive oral and written feedback. It includes collaborative problem-solving between the supervisor and the health worker, and with the community. To be effective, supervisors need to have good technical and observational skills, as well as good interpersonal communication skills. Where integrated supervision is in place, the district should train supervisors in all of the necessary PHC areas. Developing trust between the supervisor and health staff is essential.

6.3 PLANNING AND CONDUCTING SUPPORTIVE SUPERVISION

Use these five steps when planning and conducting supportive supervision:

1. Prepare for the supervision

Decide whether the supervision will be **specific to EPI** or **integrated**. If you conduct integrated supervision, determine the most critical factors to review during the visit for each health intervention. It is important not to overload your visit with too many items, such that the visit becomes rushed, only to complete a very long checklist. On the other hand, you do not want to exclude any critical areas that must be checked. Refer to national guidelines about the type of supportive supervision to conduct.

Supervision is more effective and more frequent when indicators are streamlined and prioritized. It is more cost-effective when funding for supervision is coordinated with other health interventions. Ideally, integrated supervision involves supervisors experienced in multiple interventions who have technical expertise in more than one area. Sending several supervisors, each with expertise in only one intervention, may not be the most efficient or the most productive use of a health worker's or supervisors' time.

Integrated supervision needs to be well-planned and timed so that the interventions are assessed adequately and without disruption to health services or inconvenience to mothers and caretakers. The district health team must determine how many interventions/services can be effectively assessed during a single visit. Health workers can only internalize a limited number of recommendations. If a lengthy list of areas to address is the result of a supervisory visit, it will be discouraging and demoralizing to the health worker. More frequent, focused feedback is key to assuring performance improvement.

2. Identify/designate effective supervisor(s)

It is important to assign supervision to well-trained staff with good field experience and rapport with health workers. At **national, regional, provincial** or **district levels**, supportive supervision should be conducted at least **quarterly**. Ideally, **health facilities** should be visited **monthly**.

Remember: supervision is continuous. Health workers can routinely assess health facility performance through self-supervision. They should not wait for the next visit from the district officer to assess their performance or reveal problems with service delivery. (See **Tool 4.b** in the Annex and Section 6.1 above.}

3. Prepare tools & checklists

Supervision without a checklist will not be effective; it can be revised depending on the situation. The checklist includes some of the following items: quality of vaccine, supply management, and the cold chain; immunization service performance, such as measles, Penta/DTP3 coverage, and dropout rates; service delivery, such as planned versus conducted sessions and missed opportunities, available human resource and capacity, data quality issues, the manner in which health workers treat clients and community engagement activities.

An effective supervision tool guides staff through a constructive, participatory process aimed at identifying problems and weaknesses and at measuring progress. It allows national, provincial, and district teams to track indicators of service delivery and thereby make decisions on corrective actions, training needs, and issues for updating micro-plans. Review and follow up on the recommendations from previous supervision visits. (See Tool 4.a in the Annex for a generic supportive supervision tool.)

4. Plan site visits

▶ **Plan/prioritize where to go:** When human and financial resources are limited; prioritize visits according to those facilities needing the most help, such as those serving high-risk communities. Do not limit your supervision only to the nearest facilities.

▶ **Inform the supervisee** of the date and time of supervision; be sure to let the health facility know when you are coming. Plan your supervision schedule together.

5. Conduct constructive visits

Supportive supervision is not an evaluation or an exam for the health worker, but rather a mutual understanding on the importance of the standards necessary for high quality services. It is important for the supervisor and health workers to discuss the standards and the supervision tool. Agree upon the most critical areas and

Steps in conducting supportive supervision

▶ **Introduction of the team to the health facility**: the supervision team should introduce itself to the in-charge of the health facility and when feasible ask the in-charge to join the team.

▶ **Observation of services**: the team should observe services without interruption of the service and in a way not affecting the privacy of clients.

▶ **Exit interview of caretakers**: a minimum of five caretakers should be interviewed after vaccination.

▶ **Interview/dialogue with the supervisee**: use the checklist for the interview and provide feedback to the supervisee on what you observed. Acknowledge good performance and correct errors in techniques and procedures in private.

▶ **Provide verbal feedback/on-the-job training/mentoring**: Provide on-the-job capacity building, including skill-building and updating on current policies and technologies, and identify future training needs for staff.

▶ **Visit the community**: when time and capacity permits, the supervisor and the health center staff should visit high-risk communities in the health center's catchment area. They should discuss with the community leaders and community members about immunization and observe their perception of the immunization service. Health center staff should apply their feedback to improve services. When feasible the supervision team should identify and visit a priority community and conduct house-to-house visits of houses with 10 children of 0-23 months old and assess their vaccination status.

▶ **Provide written feedback**: Document observations and suggested follow-up actions in a supervision logbook. See Tool 4.a for a generic supportive supervision format.

▶ **Share observations and findings**: Discuss the results of supportive supervision visits with the DHMT at every opportunity, such as routine staff meetings and review meetings. Knowledge of the needs and obstacles for delivering immunizations by the local administration and community can lead to increased support for the health facility.

Conducting internal supportive supervision at health facilities

Supportive supervision at a health facility can be conducted internally by the facility health management team members, including the in-charges of the health facilities and the Quality Improvement (QI) team, if any. The facility health management team can support and motivate health care providers; provide training and recognition to staff; form and build teams and promote team-based approaches to problem-solving; foster trust and open communication; and collect and use data for decision-making. In addition, they can ensure that follow-up actions recommended by district supervisors are implemented.

Conducting supportive supervision at the community level

The success of community health workers (CHWs) is directly tied to the training, support and supervision they receive. Therefore, the health facility in-charge and the relevant focal persons should ensure that supportive supervision is also provided at the community level. This can be conducted on a monthly basis or as the need arises, and the supervisor should act as a mentor, advocate, and counselor to the CHW. During each supervisory visit, the HF team pays a courtesy call to the village leader, such as Village Executive Officer, then meet with a CHW to review their work, discuss their needs and upcoming events, provide feedback on how the program is progressing, and problem-solve any issues that have come up. Such visits can include a review of standard operating procedures (SOPs), equipment and supplies, service delivery based on guidelines, patient satisfaction, training needs, referral systems and community linkages.

6.4   CORE INDICATOR FOR SUPPORTIVE SUPERVISION

Supervisory visits should be as regular and frequent as resources allow, in accordance with national policies. Coordinate with other programs to increase opportunities to conduct supervision. When resources are scarce and health facilities are difficult to reach, **promote self-assessment and supervise remotely** (by telephone or e-mail). The core indicator for supportive supervision below can be adapted by countries.   In addition to this indicator, written reports or logs documenting problems detected, solutions, and capacity building needs, are valuable for monitoring supervision in districts.

CORE INDICATOR FOR "SUPPORTIVE SUPERVISION"

Adapt and use the following process indicator—taken from the RED MonitoringTool—to monitor supportive supervision across districts:

"% of DISTRICTS conducting at least (minimum number) of supportive supervisory visits to each of their health facilities per (quarter)."

This core indicator is intended to remind districts teams (and inform those at higher levels of the health system) of the importance of conducting regular supportive supervision at each health facility according to national guideline frequency. In addition to determining whether or not supportive supervision visits are conducted at the minimum frequency, districts and those supervising them will also want to review the frequency of visits to health facilities above minimum standards, the quality of visits (sufficient time, observation of sessions, on-the-job-training, etc.), and written feedback and follow up. This can be tracked by districts (self-assessment) and through supportive supervision visits to districts from higher levels of the system.

REFERENCES

Technical

WHO/AFRO/EPI, Mid-Level Management Course for EPI Managers.
Module 4. Supportive Supervision by EPI Managers. 2008.
http://apps.who.int/iris/bitstream/10665/70184/4/WHO_IVB_08.04_eng.pdf

McNamara, C. "*Free Basic Guide to Leadership and Supervision*."
Free Management Library. 1997-1998. http://www.managementhelp.org/mgmnt/prsnlmnt.htm

Children's Vaccine Program at PATH. *Guidelines for Implementing Supportive Supervision: A step-by-step guide with tools to support immunization*. Seattle: PATH, 2003.
http://www.path.org/vaccineresources/files/Guidelines_for_Supportive_Supervision.pdf

Country Examples

PATH and National EPI, Vietnam. "*Improving Immunization through Supportive Supervision*." Seattle: PATH, 2007.
http://www.path.org/publications/detail.php?i=1443

National Primary Healthcare Development Agency, Nigeria. 2009. *Supportive Supervision, a practical guide for State and LGA routine immunization managers.*
http://www.immunizationbasics.jsi.com/Docs/IMMbasics_Nigeria_Support_Supervision_2009.pdf
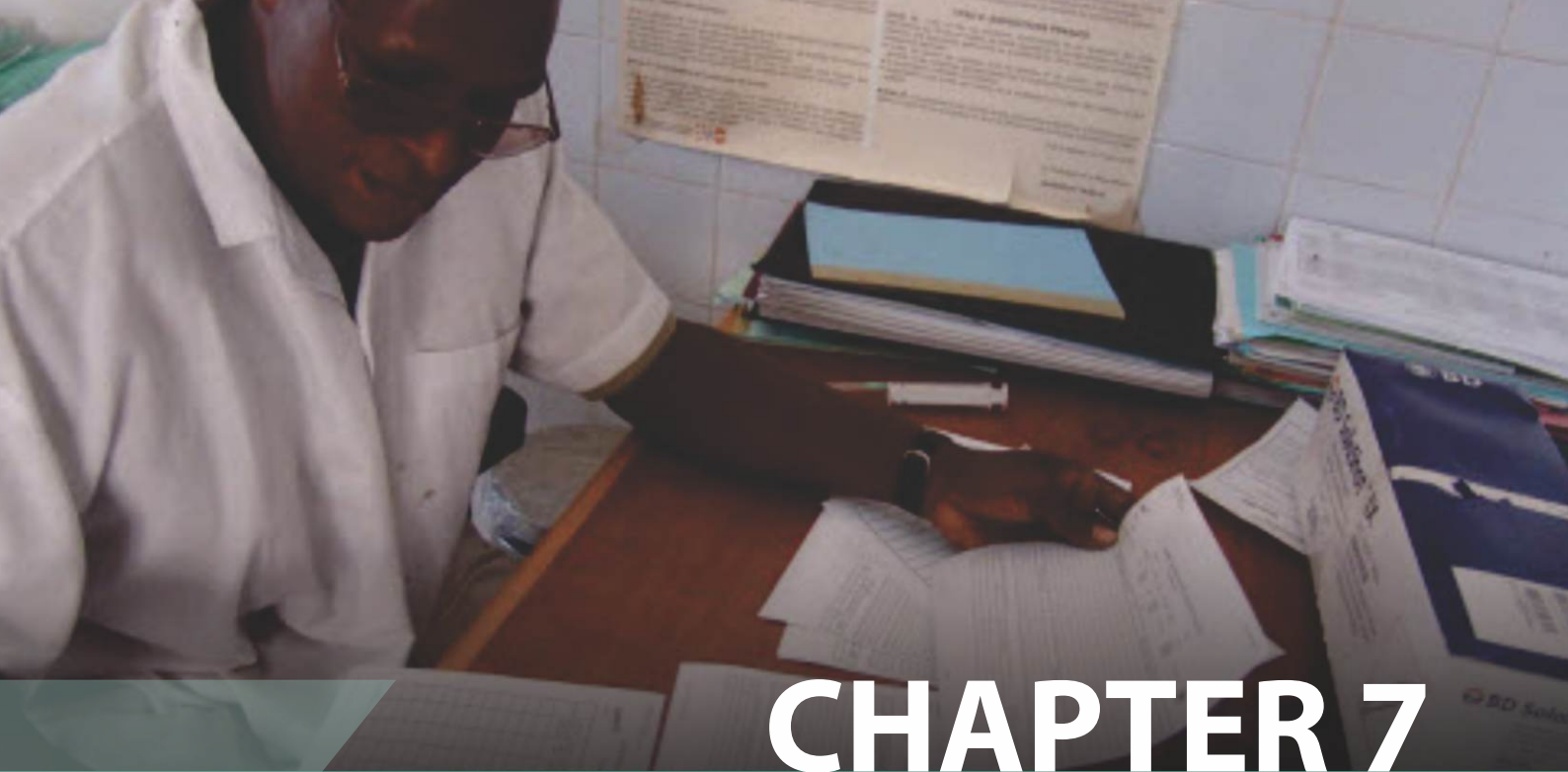
CHAPTER 7

MONITORING & USING DATA FOR ACTION

7. MONITORING & USING DATA FOR ACTION

	Steps	RED Tool
	1. Define the monitoring process	OP. Monitoring Session Schedules
	2. Select indicators & targets	
	3. Collect data & submit reports	5a; OP. due list; OP. My Village, My Home; OP Defaulter Tracing
	4. Analyze & interpret data	5a, 1f
	5. Take action	

Monitoring for Action is more than collecting data, making reports and analysing data. Active monitoring continuously uses information at all levels for: measuring progress, identifying problems, and developing practical solutions and realistic work plans. Monitoring for Action involves everyone: managers, supervisors, health workers, local officials, and the community.

7.1 KEY ISSUES

Monitoring of the immunization programme is a **continuous active process for the entire health team** and is an essential component of effective management. An effective programme monitoring system reinforces accountability of those who contribute to its implementation. A programme can be monitored by using a combination of passive data collection (standardized monthly reports) and active data collection (supervisory visits).

District and health facility staff need to continuously generate and collect a flow of reliable information that describes the quality and effectiveness of their health services, in order to make informed decisions on the direction of programme strategies (see Figure 7.1 below). Rather than wait for an annual review or work planning, staff should be aware on an ongoing basis if their performance is on track. Quarterly or monthly reviews can investigate a range of issues. For example, are targets being achieved? Are the unreached being reached? Are delivery strategies working? Is there confidence that injections are being given safely? What are the bottlenecks to reaching targets: dropout rates, missed opportunities, vaccine stock-outs?

Figure 7.1: STEPS IN EPI MONITORING & USING DATA FOR ACTION

Often, managers consider only their own program's reporting needs. As a consequence, combining all reporting requirements for all health programs, district and health facility staff can lead to staff being overburdened with forms and data. Because of this, health workers lose sight of the importance of using the information which they are collecting. Active and effective monitoring requires selecting only the most essential information for management that can be used and analyzed to improve programme strategies. Examples of essential information for immunization include: vaccinations given by location and by delivery strategy, dropout rates, and immunization sessions held versus planned.

The accuracy and effectiveness of monitoring is greatly influenced by the choice of measurement indicators, and the quality of data collection. Data for indicators should be easy to collect, easy to understand and linked to corrective actions. **Attention to reports and use of information lead to better quality information**. When staff who compile reports know that their work is important and is being used by managers, quality improves. When up-to-date information is **visually displayed**, and when supervisors **review, cross-check and provide feedback** on reported versus recorded information and **discuss** health facility reports, the quality of information can improve.
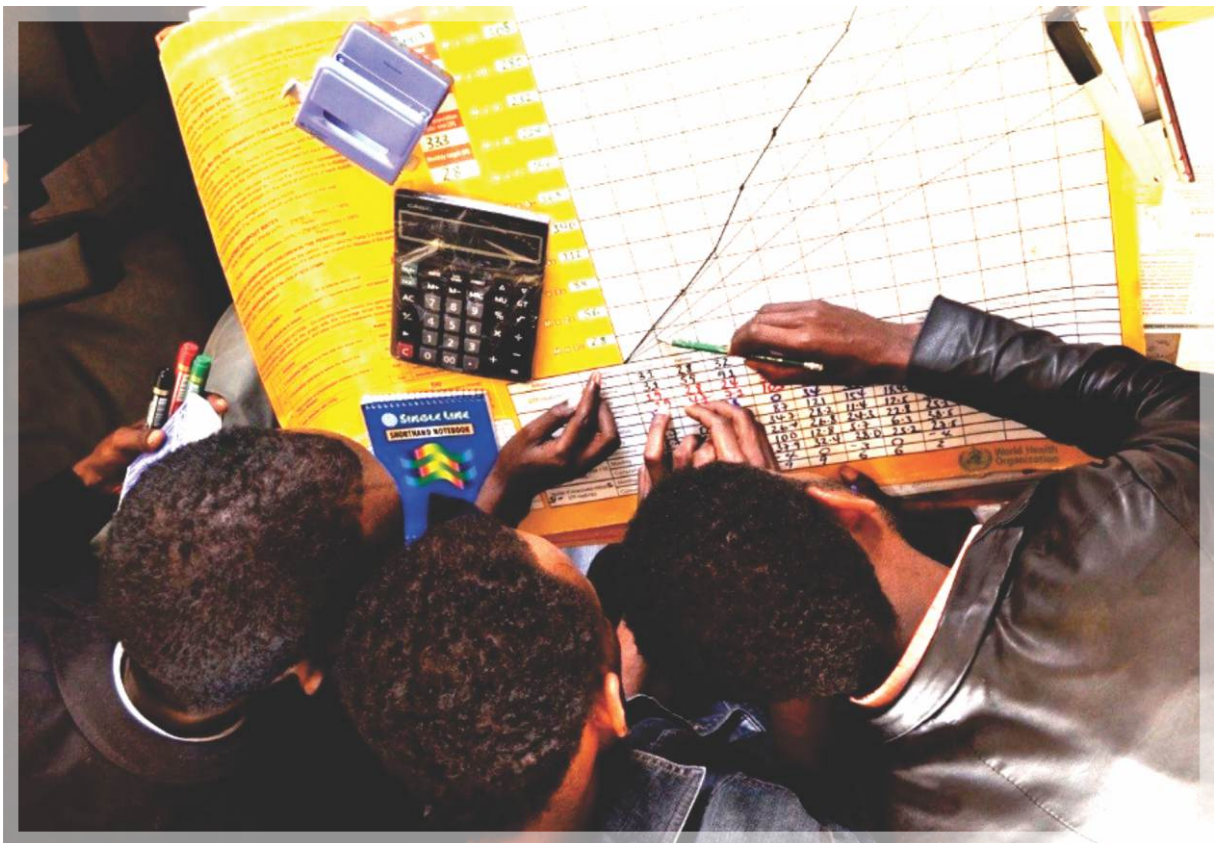
The five RED components provide a useful framework to help organize and structure the monitoring of core indicators selected for reviewing programme performance. Supplementary indicators may be used depending on country context. The monitoring tools used and the approach should be standardized, but also remain flexible and adapt to national, district and local situations.

7.2 THE MONITORING FOR ACTION PROCESS

There are five major steps to immunization programme monitoring.

1: Define The Monitoring Process

Based on the national policy and standards, the district health management team and health facilities can design a monitoring process that will be effective for their district. This can be accomplished during micro-planning. Jointly decide with health workers the most effective approach and persons responsible at district, health facility and community levels, according to human and financial resources. Develop a schedule that includes a monthly review of **process indicators** (sessions conducted per plan, stock-outs, for example), **performance indicators** (coverage, dropout rates, and VPD trends) and **quality indicators** (administered/ vaccine used, doses given at the same time, etc.). Time should be allocated for development and monitoring of coverage improvement plans at least quarterly for those facilities or areas in need.

2: Select Indicators and Targets

Today, immunization programs operate in a rapidly changing environment. They have gone well beyond only measuring immunization coverage, which is heavily reliant on the accuracy of denominators. In addition to adding new vaccines, programs now focus more on specific quality issues and targeting the under-served. Consequently, there is more variation in indicators for monitoring. Although targets and indicators are usually set at the national level, district and health workers should review their targets and indicators and decide how and when targets will be achieved.

A limited number of core indicators (process, performance or quality) can be chosen to measure key activities over time and reinforce performance standards. This helps managers make better and more focused decisions, without over-burdening service providers with data collection. In certain settings, it may also be useful to select supplemental indicators that can be tracked.   Core indicators measure critical immunization processes for adjusting service delivery strategies, strengthening community linkages, fine-tuning logistics, and updating micro-plans. Supplemental indicators measure additional aspects of the programme that may enable good performance, or that may be showing levels of integration with immunization (e.g., existence of written guidelines, levels of TT2+ and antenatal care). Although progress against indicators is monitored by supervisors, the same indicators can also be used for "self-assessment" by health facilities and district health teams.

Table 7.1 below gives examples of core indicators and performance standards expected of each of the RED components, and the suggested frequency of collection. The intent is to stimulate national and district health management teams to use and adapt those indicators that are most relevant locally.

Table 7.1: EXAMPLES OF CORE INDICATORS FOR RED COMPONENTS FOR HEALTH FACILITIES AND DISTRICTS

RED Component	Indicators	
	Health Facility	**District**
Planning and management of resources with a similar skill level	☐ Stock out of vaccines, diluent, or syringes in the past month ☐ Stock out of tally sheets, immunization registers, immunization cards, or other EPI tools in the past month ☐ Functional refrigerator with normal temperature ranges recorded in the past month ☐ EPI micro-plan updated (quarterly) ☐ Received operation funds for immunization activities on time (quarterly)	☐ % of HFs in district with stock-out of any vaccines, diluent, or syringes in past month ☐ % of HFs in district with stock-outs of tally sheets, registers, immunization cards, or other EPI tools in the past month ☐ % of HFs in district with functional refrigerators with normal temperature ranges recorded in the past month ☐ District EPI micro-plan updated (quarterly) ☐ % of HFs in district receiving disbursed operation funds for immunization activities on time (quarterly)
Reaching All Eligible Populations	☐ At least 80% of planned sessions were conducted in previous month	☐ At least 80% of planned sessions in all HFs in district were conducted in previous month ☐ Activity plan for outreach immunization sessions in all HFs in district is updated annually
Engaging with Communities	☐ Documented meeting at the community level held monthly	☐ Documented meeting at the community level held monthly
Conducting Supportive Supervision	☐ Received at least one supportive supervision visit from the district with written feedback per quarter	☐ % of all HFs in district receiving at least one supportive supervision visit with written feedback per quarter
Monitoring and Using Data for Action	☐ Coverage of Penta1, Penta3, and MCV reached at least 90% for each antigen in the previous month ☐ Drop-out rate of Penta1-Penta3 less than 10% for previous month ☐ Immunization monitoring chart is up-to-date, accurate, and visibly displayed	☐ Coverage of Penta1, Penta3, and MCV reached at least 90% for each antigen in the previous month ☐ Drop-out rate of Penta1-Penta3 less than 10% for previous month ☐ Monthly review meeting conducted for HF staff

**3:
Collect Data
and Submit
Reports**

Data should be collected through the MOH health information systems and/or the immunization programme information system.   Using the RED framework to organize and consolidate data is a useful way for managers to observe trends and take corrective action on key priorities.   In addition to monthly reporting forms that may include tables and charts, using visual dashboards or a 'traffic' light method to monitoring helps facilitate interpretation of the information.   Showing data in a graphic manner is a good approach to illustrating the overall programme performance in different areas. There are many tools and techniques that show progress on targets and give early warning on potential problems. Below are two examples of easy-to-use tools that display monitoring information.th management teams to use and adapt those indicators that are most relevant locally.

Figure 7.2. INTERPRETING ACCESS AND UTILIZATION

Districts A and B both have 20% DTP1-3 drop-out rates. However, District A has a major problem with "left outs." Sixty per cent of children in District A are not being reached for immunization. District B, on the other hand, is doing better by reaching the 80% of children with the first dose of DPT, but still 20% of these children "drop out" and do not complete the required 3 doses. Thus, only 64% coverage is fully protected against diphtheria, pertussis and tetanus.
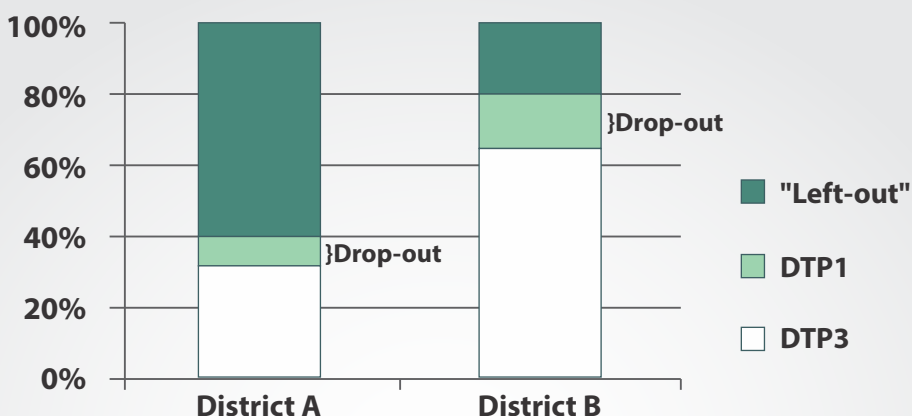
Left-out = 100% - DTP1% coverage
Drop-out = DTP1 coverage - DTP3 coverage x 100%
                          DTP1 coverage

District A: Left-out = 100% - 40% = 60%
Drop-out = 40% - 32% = 20%
                     40%

District B: Left-out = 100% - 80% = 20%
Drop-out = 80% - 64% = 20%
                     80%

Districts A and B both have 20% DTP1-3 drop-out rates, but these rates mean very different things in each case. If District A wishes to improve coverage. it should address the large number of children that have not received DTP1 (left-outs). District B. on the other hand, could increase its coverage by taking action to reduce both drop-outs and left-outs.

 Source: Immunization Essentials: page 50

An immunization monitoring chart (Figure 7.3) is another very useful visual tool for showing progress on reaching the target. It illustrates progress on reducing dropout from immunization and in reducing the children "left out" from immunization services. In areas with poor quality data, one can monitor the number of children immunized compared to the total number of children from health facility records who need to be immunized, rather than by coverage rates (%). This chart provides a constant, up-to-date reminder for staff on how well they are doing on reaching their target. It is also a good tool for discussing with the health team about the changes needed to improve the effectiveness of immunization services, including defaulter tracking (see "*Immunization in Practice*," 2015 update , http://apps.who.int/iris/bitstream/10665/193412/1/9789241549097_eng.pdf).

Figure 7.3: EXAMPLE OF AN IMMUNIZATION MONITORING CHART FOR PENTA1 AND PENTA3

Fill in at the end of each month	Jan	Cum Total	Feb	Cum Total	Mar	Cum Total	Apr	Cum Total	May	Cum Total	Jun	Cum Total	Jul	Cum Total	Aug	Cum Total	Sep	Cum Total	Oct	Cum Total	Nov	Cum Total	Dec	Cum Total
Total Immunized pentavalent1	6	6	4	10	6	16	6	22	7	29	7	36	5	41	5	46								
Total Immunized pentavalent3	4	4	3	7	6	13	6	19	6	25	6	31	5	36	5	41								
Drp-out (DO) (Penta1-Penta3)		2		3		3		3		4		5		5		5								
Drp-out % (DO/Penta1)*100		33		30		19		14		14		14		12		11								

Using data for action in a meaningful way requires that the reporting is timely, complete and accurate. Improvements can only be achieved through regular review and analysis of reported data and active use and feedback of the data collected.

4: Analyse and Interpret Data

Monitoring data for action is a participatory approach involving the district health management team, health facilities, communities and partners who routinely review and discuss the programme information and its interpretation. Information that is only collected, compiled, and sent up to the next hierarchical level and then put away in a file is not useful for taking action.

Effective monitoring involves regular analysis and participatory feedback with health staff, partners, local officials and communities. Communities that actively participate in planning and monitoring are more likely to assist with improving access and utilization of health services. At district level, review of process, performance and data quality indicators is important to do at least every quarter. The best way to improve the validity of data is for the district and health facility staff to continuously and critically review the information which they are collecting and report observations or concerns to higher levels.

When the information is being analysed, it is important to identify the problem causing the poor outcome. Asking multiple layers of questions based on the immunization data can help identify the underlying reasons or 'root-cause' behind why there are performance gaps. Ask questions and discuss potential solutions about findings, such as:

- If you are not reaching your targets, what are the critical reasons or root causes?

- How and who can correct these problems? What are the local solutions?

- Are there communities without access to health services? If so, how can they be reached?

- Are there communities or groups who are not fully utilizing the available services? Why?

- What additional available resources are needed to implement solutions?

- Which areas, groups, communities are at highest risk for low coverage?

- Are cold chain and supply management adequate for meeting the demand?

- How can you revise your micro-plan to better fit the findings from your active monitoring?

Including others such as community leaders, community health workers, community volunteers, and relevant private sector representatives, NGOS, and CBOs, in the review and discussion about the findings leads to better strategies and effective solutions.

Tool 1f helps conduct a root-cause analysis to identify the causes of problems.

To ensure reaching all target populations and reducing inequities, additional efforts are required in problem areas, which can be conducted during campaigns or regular supervision visits:

▶ Identify areas with low performance indicators (e.g., low coverage, high drop-out rates, vaccine stock-outs) or high-risk communities (e.g., vulnerable communities or communities that oppose immunization)

▶ Investigate reasons for low coverage and drop-outs, in particular in vulnerable and 'high risk' communities by visiting households and doing an immunization card check

▶ Determine reasons for missed vaccination and understand the issues in the community

▶ Address the issues in the next sessions or integrate additional actions in the next microplanning cycle, as appropriate

Asking questions about immunization monitoring data results in **action**.

5: Take Action and Update the Micro-Plan

Once immunization data has been reviewed and a root-cause analysis is conducted, potential solutions can be discussed among the team. The appropriate actions that need to be taken should be discussed collaboratively and an action plan drafted. This final step is about linking data analysis to practical, actionable interventions.

The action plan is a simple way to describe actions, name responsible parties, set timelines and track progress. The speed at which actions are taken depend on a combination of the seriousness of the problem and the ease of implementing solutions.

Tools in the Annex for monitoring and using data for action:

Tool 5a: Monitoring Chart
Tool 1f: Root Cause Analysis
Optional Tool: Due List
Optional Tool: My Village, My Home
Optional Tool: Defaulter Tracing
Optional Tool: Monitoring Session Schedules

7.3   REFERENCES

Mid-Level Management Course for EPI Managers. Module 5. *Monitoring the immunization system.* http://www.who.int/immunization/documents/mlm/en/

Increasing immunization coverage at the health facility level.
http://www.who.int/immunization_delivery/systems_policy/www721.pdf

WHO/V&B/02.27, World Health Organization, Geneva, December 2002
Immunization in Practice, 2015 Update. Module 6. Monitoring and surveillance.
http://apps.who.int/iris/bitstream/10665/193412/1/9789241549097_eng.pdf

WHO/IVB. *Increasing coverage at health facility level, WHO/UNICEF*;
http://apps.who.int/iris/bitstream/10665/67791/1/WHO_V%26B_02.27.pdf

WHO/IVB, World Health Organization, Geneva, 2014. *My Village is My Home*. http://www.mchip.net/node/3214

Engaging communities with a simple tool to help increase immunization coverage. Global Health: Science and Practice. 2015: (3)1. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4356280/pdf/117.pdf

Using data to make a difference; ARISE.

The immunization data quality self-assessment (DQS) tool. March 2005. WHO/IVB/05.04.
http://apps.who.int/immunization_monitoring/routine/DQS_tool.pdf

Community Problem Solving and Strategy Development, Uganda. http://pdf.usaid.gov/pdf_docs/PNACW611.pdf

JSI, Notes from the Field; *Regular Review of Program & Health Worker Performance: Using Data to Make a Difference.*
http://3qvw4sd8qlr2o7003493odw1.wpengine.netdna-cdn.com/wp-content/uploads/2012/12/ARISE_NotesfromTheField2_Using-Data_EN_final508.pdf
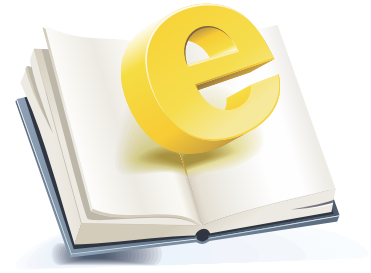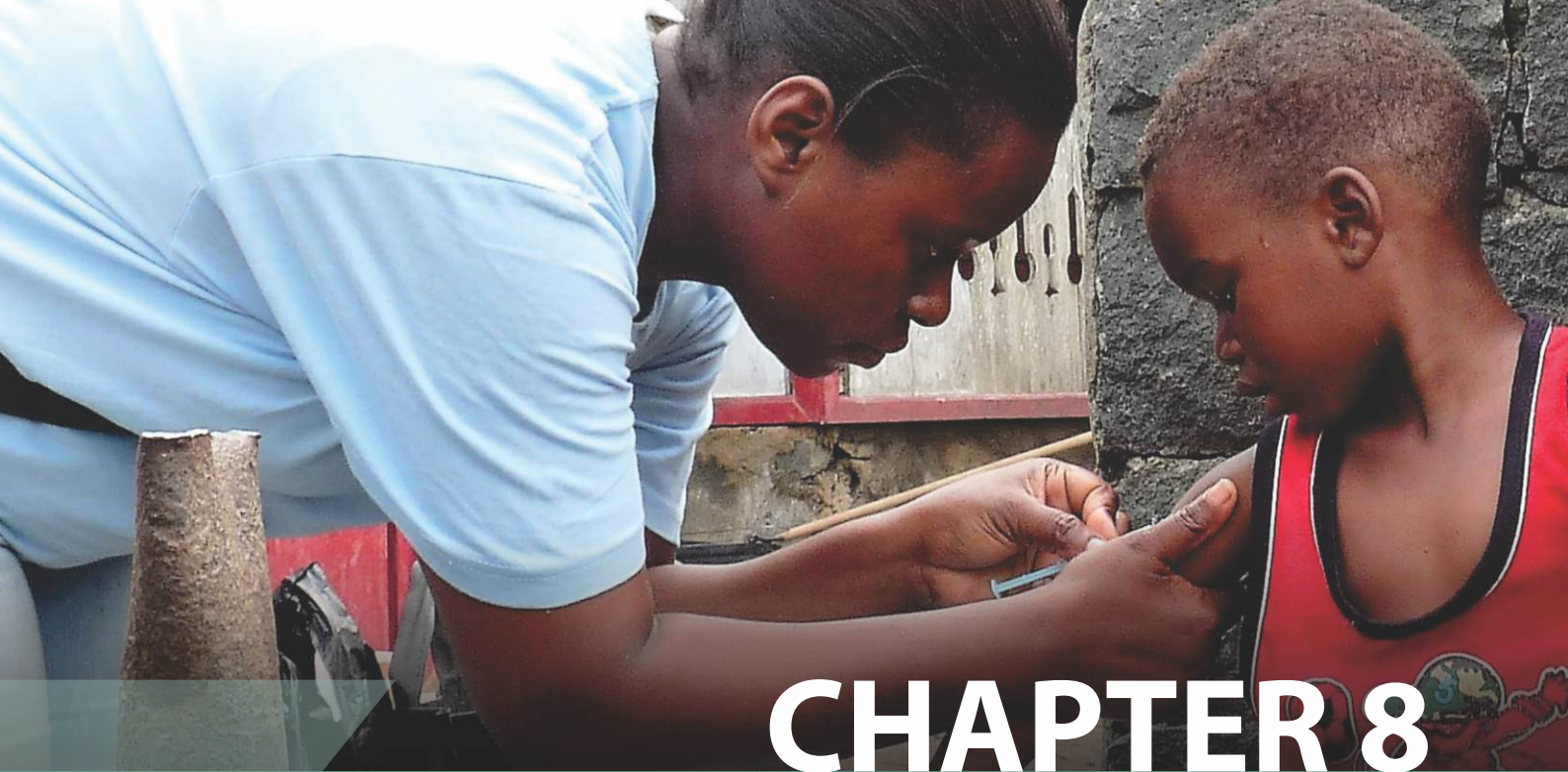
CHAPTER 8

OPERATIONAL CONSIDERATIONS WHEN IMPLEMENTING RED

8. OPERATIONAL CONSIDERATIONS WHEN IMPLEMENTING RED

8.1 THE MONITORING FOR ACTION PROCESS

RED is not a separate plan in itself and should ideally be embedded in district and health facility planning processes to build upon what already works. The RED tools and examples are not exhaustive or prescriptive and can be considered as a menu to be adapted and used as needed. They can be adapted to local contexts when addressing inequities by increasing access and utilization of immunization and other MNCH services.

This RED guide and related tools can be used alongside WHO and WHO AFRO's Immunization in Practice (IIP), Immunization Training for Mid-Level Managers (MLM), and Immunization Supply Chain and Management (ISCM) resources. Training opportunities should be considered for adapting to local contexts and selecting tools that could strengthen immunization systems.

Operationalizing the RED approach and tools needs an enabling environment, which requires support from communities, health workers, district managers, province and national officials. Drawing attention to discrepancies in data, high-risk populations needs, communities facing social and geographical barriers, and offering practical program-based solutions can help advocate for resources during the planning process. Resources are mainly domestic and need close collaboration with broader health planners and financiers. The RED approach and tools could also be an attractive investment for GAVI's Health Systems Strengthening (HSS) portfolio as countries explore ways of addressing inequities. The RED approach therefore needs to be part of the regular national, province, district and health facility planning and resource allocation processes, including a country's five-year planning cycle, annual planning, or monthly activity planning processes.

If used effectively, the RED approach and tools can help prioritize resource allocation for high-risk communities and geographic areas. The process can also encourage dialogue about more efficient use of existing resources and strategies. This includes leveraging resources from other pro-equity approaches such as Periodic Intensification of Routine Immunization (PIRI), Child Health Weeks/Days, and vaccination campaigns. The RED approach can be an important part of polio transition plans and measles-rubella control efforts, delivering vaccines in more sustainable ways.

8.2 ACCOUNTABILITY, LEADERSHIP AND OWNERSHIP

Implementing the RED approach and tools requires accountability to communities and strong leadership at all levels to provide an enabling environment focused on the needs of high-risk populations. Accountability to communities needs active participation by key community stakeholders and encouraging their participation in planning, implementing and monitoring services. Other aspects of accountability are highlighted in the Addis Declaration on Immunization that ensures that partners are contributing to well-recognized Government plans and targets and not duplicating efforts.

Authorities need to be engaged at national, district, health facility and community levels. Good leadership encourages ownership by involving managers of other PHC programs, key district and community leaders, and partners in planning, resource mobilization, and budgeting. Ownership in turn promotes transparency and accountability, which are critical for obtaining resources. Community ownership and health facility transparency are also important in areas where the population may be losing interest or trust in immunization

8.3   COORDINATION

Coordination among Ministry of Health programs, such as immunization, malaria, nutrition, and maternal health, and also with the community, leads to a more cost-effective and more sustainable healthcare system.
It is also important to coordinate with donors, NGOs and communities to maximize and not duplicate efforts. Coordination goes beyond the health sector to other sectors such as Ministries of Finance, Social Welfare, Agriculture, Education, Culture and Sports, as well as the private sector. Such coordination with other sectors is needed at all administrative levels, including the district and health facility levels.

8.4   LOGISTICS (& iSCM AND TRANSPORT)

Logistics includes: planning, procurement, and delivering vaccines and supplies; and managing and maintaining transport and cold chain equipment.

RED energizes strengthening all of the components of an immunization program. Successful immunization services also depend on effective and efficient logistics, including:

- accurate forecasting, ordering, storage and distribution of vaccines and vaccination supplies, and other health services supplies such as: Vitamin A, de-worming medication, and ITNs
- reliable cold and dry store management
- availability of transportation for outreach for each health facility
- maintenance and repair of transport and cold chain equipment
- safe management of injection and biomedical waste

These needs are interlinked and reinforced throughout all of the five RED components. For example, your cold chain strategy needs very careful attention during your situational analysis and strategy development during **Micro-Planning**. The reliability of your cold chain depends on continuous and accurate **Monitoring for Action**. By C**ommunity Engagement** and **Reaching the Target Population** you can extend the cold chain to unreached communities and target groups. Regular **Supportive Supervision** detects your cold chain and supply management problems before they disrupt your program.

8.5   COMMUNICATION

Communication strategies integrated into other health services can be more effective in reaching your target audiences. Communication with partners should be included in RED planning and implementation. Your immunization team needs expertise in communication. They should work with communication professionals, including communication program managers, multimedia and advertising specialists, community leaders, as well as experts in social science and behavior change.

Effective communication relies on a strategic approach based on **community engagement, social mobilization, social behavior change, health worker capacity building**, and **advocacy**. Your communication strategy should be:

▶ **Data-driven** with objectives and indicators.

▶ **Community-oriented** and planned according to the needs of the people who are being served, as well as monitored and evaluated with the communities.

▶ **Results-based** with evidence based on your planning and implementation and using information from your monitoring.

▶ **Ownership oriented which** activates the community to take control of their own health and development.

▶ **Developed from input** at provincial and district levels with comprehensive advocacy, information, and communication strategies which encourages investment and support for immunization and other health services.

▶ **Technically supported** to strengthen the quality of communication plans and to facilitate their implementation and to promote an integrated approach.

▶ **Coordinated with** government, partner agencies, and communities for communication.

▶ **Integrated into work plans** including realistic objectives, activities, targets and indicators.

▶ **Integrated communication** with other health services and monitoring.

▶ **Documented and shared** (e.g., lessons learned, tools, and successful activities).

8.6   REFERENCES

WHO Training for Mid-Level Managers (MLM)
Module 1 *Cold Chain, vaccines, and safe-injection equipment management* and **Module 3** *Immunization Safety*
http://www.who.int/immunization/documents/mlm/en/

Immunization in Practice
Module 2, *The Vaccine Cold Chain*, **Module 3**, *Ensuring Safe Injections, and* **Module 5**, *Managing an Immunization Session.*
http://apps.who.int/iris/bitstream/10665/193412/1/9789241549097_eng.pdf

ANNEX 1

REFERENCES FOR IMPLEMENTING RED

ANNEX 1 : REFERENCES FOR IMPLEMENTING RED

WHO Mid-Level Management Modules

http://www.who.int/immunization/documents/mlm/en/

Module 7:   World Health Organization vaccination coverage cluster surveys: Reference manual

WHO AFRO Mid-Level Management Modules

https://www.unicef.org/supply/files/1.UNICEF_Equity_for_SD.pdf

Module 1:   A Problem-Solving Approach to Immunization Services

Module 2:   The Role of the EPI Manager

Module 3:   Communication for Immunization Programs

Module 4:   Planning Activities at National, Provincial and District levels

Module 5:   Increasing Immunization Coverage

Module 8:   EPI Cold Chain Management

Module 9:   Vaccines Management

Module 10: Immunization Safety

Module 15: New Vaccines Introduction

Module 20:   Monitoring Routine Immunization and Data Management

Module 21: Supportive Supervision by EPI Managers

Module 23: Conducting Assessment of the Immunization Program

Module 24: EPI Facilitators Guide for Priority Mid-Level Management Modules

WHO Immunization in Practice, 2015

http://www.who.int/immunization/documents/training/en/

Module 1: Target Diseases

Module 2: The Vaccine Cold Chain

Module 3: Ensuring Safe Injections

Module 4: Micro planning for reaching every community

Module 5: Managing an immunization sessions

Module 6: Monitoring and surveillance

Module 7: Partnering with communities

WHO Guidance on adding HPV to your vaccination schedule

http://www.who.int/immunization/hpv/plan/en/

UNICEF

Achieving Equity in Immunization Coverage by Reaching Every Community; an Operational Guide for National Immunization Programs. https://www.unicef.org/supply/files/1.UNICEF_Equity_for_SD.pdf

ANNEX 2

REACHING EVERY DISTRICT TOOLS

ANNEX 2 : REACHING EVERY DISTRICT TOOLS

These tools are examples that can be adapted to local contexts when improving tools that already work.

Situation Analysis:

1a) Demographics and delivery strategy (health facility or district use):
Population numbers, identify "high risk" populations, village or health facility names, health worker or village head names and contacts, and vaccine delivery strategy per location.

1b) Social mapping of vulnerable populations (health facility or district):
Equity assessment identifying "high risk" population numbers, attributes, main social barriers to immunization, and reasons for being high risk, and program actions to overcome these barriers.

1c) Map (health facility or district):
Diagrammatic representation of catchment area (urban or rural) showing geography of area, landmarks and gathering points, key high risk populations and their attributes, social barriers and delivery strategy.

1d) Stakeholder assessment:
Identifying influential stakeholders who have power or can make decisions, their strengths and what they can do to benefit the program

1e) Program analysis and prioritization:
Identifying problems and prioritizing areas and populations on basis of access, utilization, VPD cases, high number of unimmunized or high number of high risk populations

1f) Root cause analysis:
Identifying underlying problems/reasons for poor immunization access/utilization and actions and people needed to address these problems.

Session planning:

2a) Session planning:
For the upcoming year, process and tables required to plan number of sessions, delivery strategies and key resources to reach target eligible populations, with focus on high risk populations

Engaging with communities:

3a) Engaging communities:
Planning monthly/annual activities for each stakeholder identified in Tool 1d. Stakeholder assessment to strengthen links with communities.

Supportive supervision:

4a) Supportive supervision checklist:
Generic comprehensive example of a supportive s

4b) Health facility supportive supervision & self-assessment record:
A brief assessment for HF review either by district staff or self- assessment by HF staff

4c)   Supportive supervision activity schedule:

A planning tool for scheduling HF visits by month for the district staff

Monitoring:

5a)   Monitoring chart

A chart used at health facility level for tracking monthly cumulative immunization performance by month

Supply chains and injection supplies:

6a)   Logistics and supply chains

6b)   Injection supplies

Optional tools and examples:

Optional monitoring tools:

OP. Due list

List of children and mothers (before a session) who are due for vaccination

OP. My Village, My Home (example from Malawi)

Chart for community tracking of immunization coverage

OP. Defaulter tracing

List of children and mothers (after a session) who need following up as they did not attend a session. Needs to be used in conjunction with a tickler box.

OP. Card check

Community-based monitoring sheet to help assess why children were not vaccinated; can be compared with the accuracy of the immunization register in the health facility.

OP. Monitoring session schedules

To help plan for vaccination sessions in each village/settlement/neighborhood in the catchment area of the health facility.

Optional session planning:

OP. Calculating session sizes

Alternative method of calculating session size (involving injection numbers)

OP. Summary activity plan

A useful sheet that summarizes activities to budgets

OP. Annual RI work plan

1a. Demographics and delivery strategy (health facility or district use)

Population #'s, identify 'high risk' populations;village or Health Facility names, health worker or village head names & contacts and vaccine delivery strategy per location

Could be adapted for district or health facility levels. Example here is Health Facility

Date filled in: _____ Name of Zone / Province: _____ District: _____ Health Facility: _____

Sl. No	Name of the attending villages /Sites for MNCH services (if no data by villages, use Health facility data)	Name of village head / representative & contact / phone number	Identify and name any 'high risk communities' (e.g. access, poverty, religion, language, occupation, nomads, religion, language, urban	Community Health Worker (name and contact / phone number)	Distance or time to health facility (km or minutes)	Total Population	Target eligible populations, for current year: Source of data:								Mode of service delivery Fixed site (F), Outreach (O) or Mobile (M)
							Live births	Surviving Infants	12-23 months	12-59 months	Pregnant Women	Women of child bearing age (15-45)	TTCV target population	HPV target	Other MNCH interventions	
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																
13																
14																
15																
Total																

1b. Social mapping of vulnerable populations (health facility or district)

Equity assessment identifying 'high risk' population #'s, attributes, main social barriers to immunization and reasons for being high risk and program actions to overcome these barriers

Could be adapted for district or health facility levels. Example here is Health Facility

Date filled in: _____ Name of Zone / Province: _____ District _____ Health Facility: _____

Sl. No	High Risk Communities identified (some examples given)	Name of the attending villages /Sites for MNCH services (In cases no data by villages use Health facility data)	Population total	Main barriers identified to full immunization – Access and Use (social and geog barriers, consider asking why five times)		Recommendations for Program strategies and Actions
				supply	demand	
	urban poor settlements					
	migrants					
	ethnic minorities					
	rural remote					
	new urban or rural settlements					
	other					
	other					
	other					

1c.   Map (health facility or district)

Diagrammatic representation of catchment area (urban or rural) showing geography of area, landmarks & gathering points, key high risk populations and their attributes, social barriers and delivery strategy per site

Could be adapted for district or health facility levels. Example here is Health Facility

Date filled in: _____

Name of Zone / Province:_____ District _____ Health Facility: _____
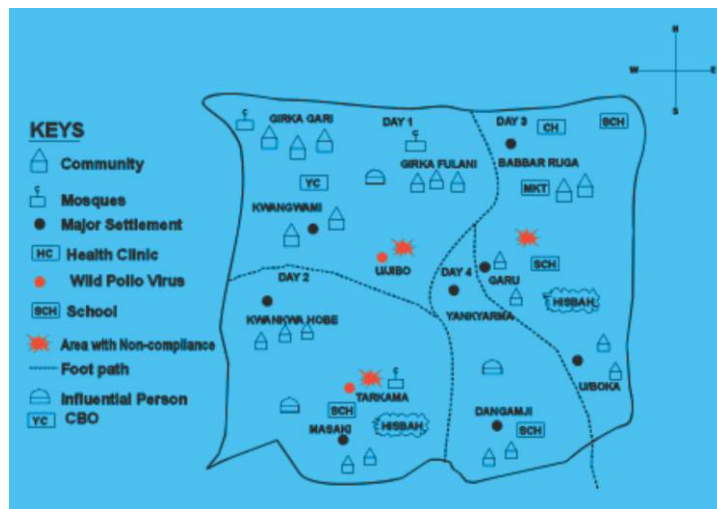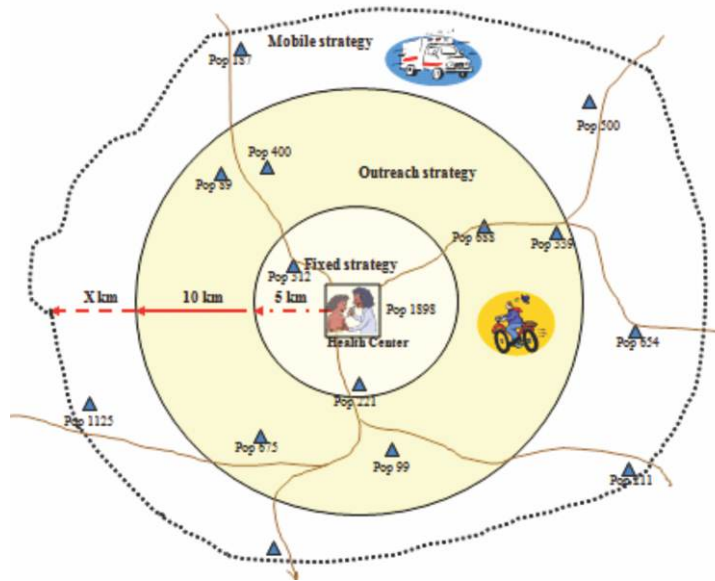
Diagramatically represent the catchment area to help better understand populations.

Use existing maps and build upon these a map either by hand or using GIS data that reflects broader aspects than health:
    a) geography (such as roads, transport, key landmarks, schools, gathering points, markets)
    b)   aspects of social distance.
    c) strategies and outreach sites

Urban and rural maps may be significantly different.

Distinction of distance for outreach needs to include mapping social barriers / distance to include: presence of 'high risk communities'. THis should include mapping of special characteristics (including access, religion, language, occupation for example).

Map should be complemented with problem analysis and session planning tool highlighting main population characteristics and demographics in catchment area and contact number of community health worker.

1d.   Stakeholder assessment

Could be adapted for district or health facility levels. Example here is Health Facility and some examples of stakeholders are given

Date filled in: _____   Name of Zone / Province: _____   District: _____   Health Facility: _____

Name of Village / Health facility	School Details		Opinion Leaders		Faith based Institutions Details (Churches, Mosques etc.)		Traditional Authority		Non Governmental Organisations, Faith based Organisations or community Based Organisations etc.		Other influencers, name _____		Strengths and opportunities for each group	Potential contribution and action for program
	Name of School	Head Master name and contact details	Name of leader	Contact details	Name of institution	Name of Pastor/ Sheik and contact details	Name of TA head	Contact details	Name	Contact details	Name	Contact details		

Current strengths of key partners:

Opportunities and threats:

1e. Program analysis and prioritization

Identifying problems and prioritizing areas and populations, on basis of access, utilization, VPDs cases, high # of unimmunized or high # of high risk populations

Mainly a district based tool, but could be adapted for health facility as well

Date filled in: _____ Name of Zone / Province: _____ District _____ Health Facility: _____

	Target Population	Compile data on population & vaccine doses administered & coverage in the previous 12 months																				Analyse problem															
		Surveillance data (any significant confirmed VPD cases in last 12 months)				Doses of vaccine administered							Immunization coverage (%)							# Un-immunized children / women							Drop-out rate (%)		Identify and categorize problems						
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	**N**	**O**	**P**	**Q**	**R**	**S**	**T**	**U**	**V**	**W**	**X**	**Y**	**Z**	**AA**	**AB**	**AC**	**AD**	**AE**	**AF**	**AG**	**AH**	**AI**	**AJ**
Name of the Health Facility (HC, Dispensaries etc.)	Surviving Infants	Measles confirmed or suspected	any AFP reported in last 12 months	Neonatal Tetanus	Others (eg. Diphteria, Pertussis, Yellow Fever, polio, tetanus)	birth dose Hep B	Penta1	Penta3	MCV1/MR1	MCV/MR2	Other vaccines (e.g. HPV)	TT2+/TTCV	Birth dose Hep B	Penta1	Penta3	MCV/MR1	MCV/MR2	Other vaccines (e.g. HPV)	TT2+/TTCV	Birth dose Hep B	Penta 1	Penta 3	MCV/MR1	MCV/MR2	Other vaccines (e.g. HPV)	TT2+/TTCV	Penta1-Penta3	MCV1-MCV2	Access	Utilisation	Category 1,2,3,4	Are there significant # VPDs?	Are there significant # of high risk populations?	Are there significant #'s of unimmnized?	Prioritization of area / ranking
Sub-Total																																			

Q = POOR (Penta1< 80%) OR **GOOD** (Penta1 ≥ 80%).

R = POOR (Penta1-Penta3 >10%) OR **GOOD** (Penta1 - Penta3 <10%))

S = 1 = No problem (low Penta1 - 3 dropout rate < 10%, high Penta 1 coverage ≥ 80%);

2 = Utilization problem (high Penta 1 - 3 dropout rate ≥ 10%, high Penta 1 coverage ≥ 80%);

3 = Access problem (low Penta 1 - 3 dropout rate < 10%, low Penta 1 coverage < 80%);

4 = Utilization and Access problem (high Penta 1 - 3 dropout rate ≥ 10%, low Penta 1 coverage < 85%).

T = (1) VERY HIGH or **(2) HIGH** or **(3) MEDIUM** or **(4) LOW**, based on the No of Un-immunized Children and Category of problem

1f.   Root cause analysis

Identifying underlying problems / reasons for poor immunization access / utilization and actions and people needed to address these problems

Mainly a district based tool , but could be adapted for health facility as well

Example of table given here along with fishbone analysis. Other possibilities include asking why 5 times, assessing supply / demand or enabling factor issues or problem tree

Date filled in: _____ Name of Zone / Province: _____

District: _____ Health Facility: _____

System Components / link to social barriers	Problems Identified	Root cause of the problem	Solution with limited resources	Solution needing additional resources and assistance from the district	Responsible Persons and Possible Timeline
Reaching the target population (issues with sessions, reaching special populations (vulnerable populations), 2nd year of life, girls (HPV), Women (TT/Td) etc)					
Supportive supervision					
Engaging communities					
Monitoring and use of data for action					
Planning and management of resources					
Cold chain & vaccine management					
Integration with other programs (eg. MNCH or nutrition)					
Surveillance					

Use a Fishbone Diagram to Help Find Real Solutions

What it is: A fishbone diagram helps team members to visually diagram a problem or condition's root causes, allowing them to truly diagnose the problem rather than focusing on symptoms.

Why do it: "Solutions" that only address the surface aspects of a problem are not likely to succeed. Identifying the sources of a problem – the root causes – helps teams develop lasting solutions. The more often you do fishbone diagrams, the easier and faster it becomes!

Who: A small, focused team should conduct the fishbone analysis. This might include, for example:

- HEWs, Vaccinators, EPI focal persons, and others experiencing or affected by the problem
- Supervisors or managers who might have insight into the problem, a role in solving the problem, or good facilitation skills to help move the process along
- QIT members, including community leaders/members

How to Construct a Fishbone Diagram:

Draft a clear problem statement, on which all team members agree

1.   Problem statement

Write the problem statement on the right side of your paper, at the head of the "fish." Draw a line with an arrow toward the head of the fish—this is the fish's "backbone." In the example shown here, the problem is low coverage.

2.   Categorization

Brainstorm major categories that might be part of the problem. Connect them to the backbone, in "ribs." Some common categories are listed below. (Other examples include health system, geography, materials, policy, environment, culture/tradition, methods, information.)
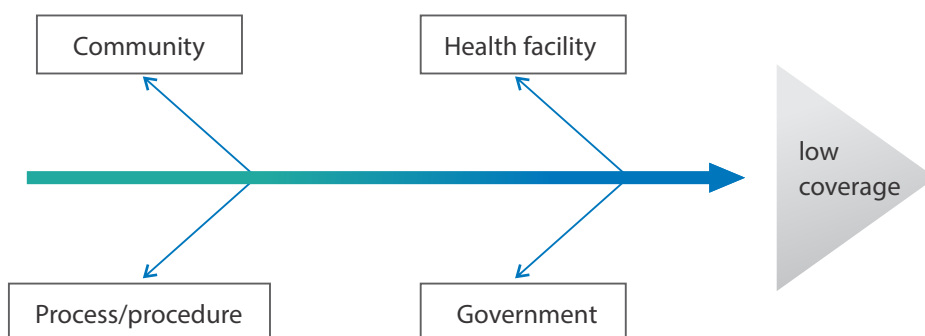
3.   Contributing Factors

Brainstorm possible causes of the problem in each category (or choose one where you can act). Attach each to the appropriate rib. Ideally, each contributing factor would fit neatly into a single category, but some causes may fit into multiple categories.
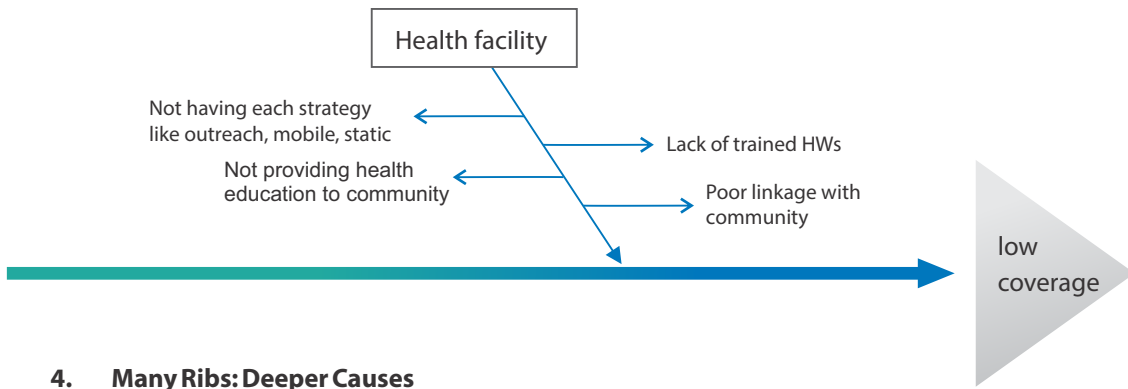
4.   Many Ribs: Deeper Causes

You may end up with multiple branches off of each successively smaller rib. Continue to push deeper for a clear understanding. Ask the question "why" 2-5 times
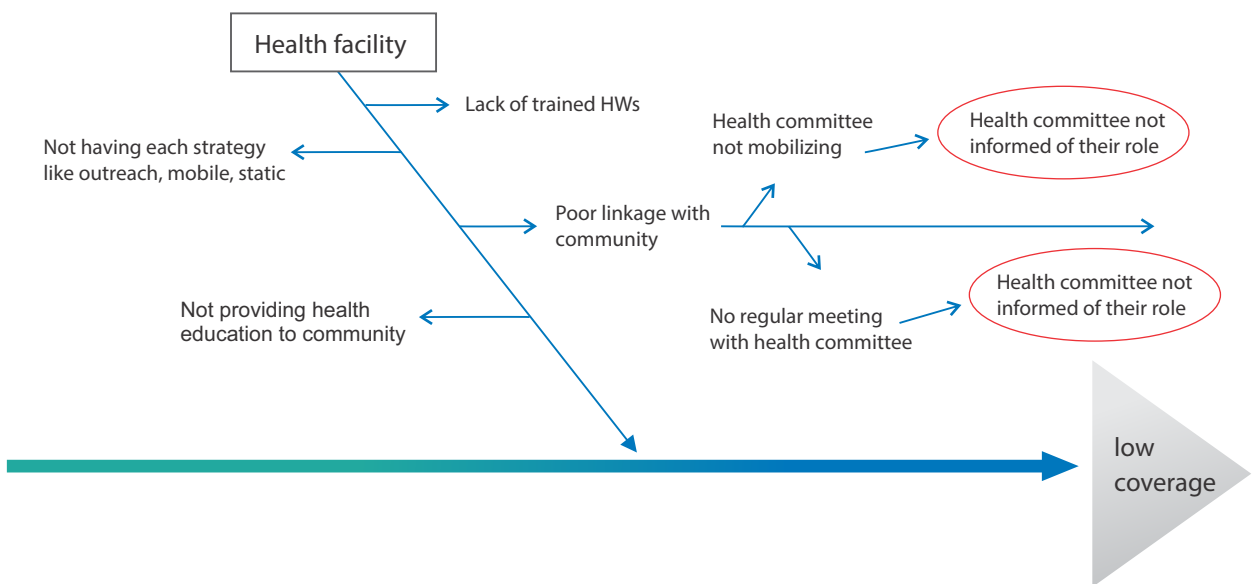
5.   Identify the main reasons/root causes

Test for the root causes by looking for causes that appear more than once. Addressing the root cause of a problem can affect many contributing factors and addressing it can have far-reaching effects. Other options for deciding which main reason/root cause to address include:

- The likely impact of addressing that root cause (the greater the likely impact, the more important it is to address)

- How difficult it will be to address the root cause

- The resources available to address the root cause

- Whether there is a logical order in which to address the root causes

The process of finding the right root cause to address might involve trial and error. If the team decides to address an identified root cause and the problem continues to occur, it probably is not the root cause. Take another look at the identified root causes and keep asking "Why?"

Note 1:   Removing a contributing factor might improve the situation, but it will not necessarily keep the problem from occurring. This is one way to distinguish a contributing factor from a main reason/root cause.

Note 2:   Try solutions within your control to make the situation better. Also share your fishbone with higher-ups. Ask them for help addressing root causes your team cannot address.

2a. Session planning: refer to Immunization In Practice Annex 4.1 (4)25:

For the upcoming year, process and tables required to plan # of sessions, delivery strategies and key resources to reach target eligible population, with focus on high risk populations

A Health Facility based tool

Examples of tables given below, but refer to Immunization in practice for process

Date filled in: _____

Region: _____ District: _____

Health center: overall session plan				
Community name (Note this includes all communities, some of which may be scheduled for fixed sessions (at the health centre) and some for outreach)	Distance from HF in km or time taken to reach (minutes)	Type of session (fixed or outreach)	Total population	Session frequency

Estimating session frequency	Total population community	Session frequency (30 infants per vaccinator per session)	
		1 vaccinator per session	2 vaccinators per session
4-5 contact schedule			

Name of the village/ services/ delivery sites	Target Population per year								Distance or time to vaccination post (km or minutes)	# injections per year	Session type	Sessions			Other key MNCH activities for Integration (eg. Vit A or mebendazole)	High risk populations
	Live Births	Surviving Infants	Pregnant Women	women of child bearing age (15-45)	TTCV target population	12-23 months	12-59 months	HPV target			Fixed (F), Outreach (O) & Mobile (M)	Day of session	# per month	# per year		
A	B	C	D	E		F		G	J		K	N	O	P	Q	R
Total																

3a. Engaging communities

Planning monthly / annual activities for each stakeholder identified in 1d. Stakeholder assessment to strengthen links with communities

A health facility based tool

Date filled in: _____ Name of Zone / Province: _____ District: _____ Health Facility: _____

No.	List of activities from tool 1d (stakeholders)	Where (Location)	Officer Responsible	When (Dates)											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec

4a. Supportive supervision checklist

Generic comprehensive example of a supportive supervision checklist for use by district staff

This a district based tool

Date filled out: _____

Name and type of health facility: _____

Name(s) and position of health provider(s): _____

Name of supervisor: _____

Date of supervision: _____

Part 1: Assessment format

Key Practices	Excellent	Acceptable	Needs Work

Note: Tick (V) one column for each practice. Practices should include national technical standards regarding such practices as checking and recording refrigerator temperatures twice daily, following the contraindication policy, and following the multi-dose vial policy; as well as practices that reflect positive attitudes, such a communicating key information clearly to caregiver, treating families kindly and sensitively, and respecting and working cooperatively with supervisors.

Part 2: Give feedback to the health provider(s) on what they are doing well and on what they need to improve. Then discuss the weaker areas and reach an agreement with the provider(s) on one to three areas that they agree to improve. If possible, the facility director should participate.

Part 3: Together with the provider(s), discuss how improvements can be made in the one to three weaker areas. Consider what you can do to help, what the provider(s) should do, and what others (facility director, staff at district or provincial level; community leaders or members) need to do to address the weaker practices. Write down the plan in the form below. Keep this copy and give another copy to the provider(s). Finally, propose approximately when you might return to assess practices again.

Note: The assessment part of supportive supervision is done through a combination of observation, questions to providers, and review of records. Never criticise or correct a provider in front of the public. If one or two providers need to improve a certain area, discuss, or even demonstrate, how to do it better in front of the entire staff. It is best to present the issue as a problem for all to solve together; e.g., some providers give incomplete information to mothers and fail to invite their questions. How can all providers improve on this?

The supervisor should keep the assessment and agreement forms so he or she can compare results over time. S/he should always bring the assessment and agreement forms from the last supervision to the next one.

General Information

1   Name of health facility: _____ Who owns the HF: _____

     District _____ State _____

2   Date of visit: _____ Date of previous supervision: _____

3   Name and position of the contacted person/supervisee: _____

4   Total catchment area population: _____

5   Target population for the year. Total birth/PW _____
     Surviving infants NPW _____

6   EPI static sites: _____ Outreach sites: Mobile: _____

7   Are there hard-to-reach communities: Yes _____ No _____

8   If yes, number of hard-to-reach communities: Total population: _____

9   Are the EPI activities managed by EPI trained personnel? Yes _____ No _____

10   If yes, when? _____

11   Is the EPI policy document available? Yes _____ No _____

12   Are country micro plans and budget prepared annually? Yes _____ No _____

II. EPI Plan:			
No	Description	Yes	No
1	**Is there an updated EPI Work Plan (monthly/quarterly) including outreach and mobile?**		
2	**Is there annual and quarterly vaccine, Ad syringe, mixing syringe and safety box forecast for the HF?**		
3	**Were outreach and static services reestablished according to RED approach?**		
4	**Is there a social mobilization plan incorporated in the EPI plan?**		
III. EPI Service Delivery			
1	**Have all of the planned immunization sessions taken place?**		
2	**Has the HF monitored its immunization coverage monthly?**		
3	**If yes, compare the coverage against the total catchment area surviving infants?**		
4	**BCG coverage _____ (____%)**		
	Pentavalent3 Coverage _____ (___%)		
	OPV3 Coverage _____ (____%)		
	PCV3 Coverage _____ (_____%)		
	Rota2 _____ (____%)		
	Measles Coverage _____ (____%)		
	PW TT2+ Coverage _____ (____%)		

	III. EPI Service Delivery		
5	**NPW TT2+ Coverage _____ (_____%)** **Is Vitamin A given as part of your routine EPI program?**		
6	**Is open multi-dose vial policy in use?**		
7	**Is there defaulter tracing mechanism? If yes, specify --**		
	IV. EPI Monitoring Tools		
1	**Has the vaccination monitoring chart been updated to the current month and used correctly?**		
2	**Is drop-out rate monitored monthly?**		
3	**What is the current drop-out rate for the vaccines listed below?**		
4	**i) PENTAVALENT1-PENTAVALENT3 _____%**		
5	**ii) PENTAVALENT1-Measles_____%**		
6	**iii) PW TT1-TT2 _____%**		
7	**iv) NPW TT1-TT2 _____%**		
8	**Did a supervisor visit this health facility in the last quarter?**		
9	**Was there any written feedback from the supervisor?**		
10	**Any regular EPI performance assessment meetings conducted by Boma health committee?**		
11	**Was there any program where CHW/Boma health committee are involved in EPI assessment?**		
12	**If yes who and how frequently?**		
13	**Have you ever explored the degree of users' satisfaction for EPI?**		
	V. Vaccine and Cold Chain management		
1	**Is there enough vaccine at least for one month at HF level?**		
2	**Does the cold chain person know the actions to be taken during power interruption?**		
3	**Are there enough wicks and glasses?**		
	VI. Safety of Injection		
1	**Is there a sufficient amount of AD syringes for one month?**		
2	**Are safety boxes used for needles and syringes?**		
3	**Is incinerator available and properly used?**		
4	**Do you use one mixing syringe for each vial?**		
5	**At the end of the EPI sessions what do you do with filled safety boxes? (Specify: _____)**		

	VI. Safety of Injection		
6	**What do you do if you face Adverse Events Following Immunization (AEFI)? (Specify:** _____ _____**)**		

	VII. Community mobilization/ community involvement		
1	**How is mobilization carried out for immunization in the community?**		
2	**Who mobilizes the target population at the community level?**		
3	**Is there community involvement in outreach site selection?**		
4	**Is there community involvement in scheduling outreach sessions?**		
5	**Is there community involvement in mobilizing mothers?**		
6	**How frequent dose the community health committees meet?**		

	VIII. Support from Higher Level		
1	**Does this health facility receive feedback on monthly EPI reports?**		
2	**Does this health facility receive EPI policies and guidelines?**		
3	**Does the district conduct review meetings?** **If "yes," how often?**		
4	**Does this health facility receive financial support to conduct EPI services?**		
5	**Does this health facility receive a regular supply of kerosene or gas?**		
6	**Does this health facility receive a regular supply of reporting formats?**		

	IX. Observations by supervisors		
1	**Is the expiry date and batch no of vaccines recorded?**		
2	**Do you have refrigerators out of order?** **How many? _____, Type:_____, Reasons for non-functioning**		
3	**Is the refrigerator placed close to the wall, heat object, sunlight?**		
4	**What is the current temperature reading of the refrigerator?**		
5	**Does someone record the refrigerator temperature twice daily, including weekends?**		
6	**Has refrigerator temperature of >+8o c and/or <2 o c been recorded in the last month? What was the range?**		
7	**Are there unnecessary materials placed on the top of the refrigerator?**		
8	**Are there sufficient ice packs in the freezing compartment?**		
9	**Is there frost beyond the acceptable amount above 5 mm?**		
10	**What is the method of defrosting?**		
11	**Are the vaccines stored in the proper compartment?**		
12	**Is there vaccine that has exceeded expiry date in the refrigerator?**		

	IX. Observations by supervisors		
13	**Are there vaccine vials without labels in the refrigerator?**		
14	**Is there frozen PENTAVALENT or TT vaccines confirmed by shake test?**		
15	**Are there vials with VVM that has reached the discard point?**		
16	**Are needles separated from the syringe after use?**		
17	**Are needles recapped?**		
18	**Is a single mixing syringe used for one vial?**		
19	**Have the vaccination schedules for children and women and contraindication for vaccination been explained?**		
20	**Is the immunization status of children and mothers checked?**		
21	**Are mothers told when to come for the next vaccination?**		
22	**Are there BCG and measles vaccines reconstituted before 6 hours?**		
23	**Is the number of vials of measles/BCG vaccine available equal to the no. of vials of diluents?**		
24	**Is open multi-dose vial policy in use?**		
25	**Are the opened vials properly labeled and kept in the refrigerator?**		
26	**Is there a specific place in the refrigerator for opened vials?**		
27	**Is this health facility using appropriate tally sheets and reporting formats?**		
28	**Are the used tally sheets and reporting formats appropriately filed?**		
29	**Is reporting complete?**		
30	**Is reporting timely?**		
31	**Verify the validity of doses by comparing immunization reports from registration books for:** **1) PENTAVALENT1 to PENTAVALENT2** **2) TT1 to TT2**		
32	**Verify the validity of doses by checking the age of the child when he/she received the vaccine** **1) Number of PENTAVALENT1 doses received before the age of 6 weeks in the previous one month. Number:_____** **2) Number of MEASLES doses received before the age of 9 months in the previous one month. Number:_____** **3) No. of children vaccinated after age one year and misclassified and reported as under one in the previous one month. Number:_____**		
33	**Are birth dates for all children documented?**		
34	**Are all dates for vaccine receipt documented?**		
35	**Is there a health worker assigned to community outreach?**		
36	**Is there an EPI registration book for the community?**		
37	**Is vaccine wastage monitored?**		
38	**If yes, compare wastage rate of :** **1. BCG_____% , 2. Measles_____%, 3. PENTAVALENT____%, 4. OPV_____%, 5. TT_____%**		

X. Client exit Interview

Questions:

1.   Were parents/caretakers told about the vaccine and AEFIs?

2.   Do the clients know when to come back for the next vaccination?

	Question 1		Question 2	
1st Interview	**Yes**	**No**	**Yes**	**No**
2nd	**Yes**	**No**	**Yes**	**No**
3rd	**Yes**	**No**	**Yes**	**No**
4th	**Yes**	**No**	**Yes**	**No**
5th	**Yes**	**No**	**Yes**	**No**

4b. Health facility supportive supervision & self-assessment record

A brief assessment for HF review either by district staff or self assessment by HF staff

For use at health Facility level either by district (as part of supportive supervision) or health facility staff (as self assessment)

Name of LGA: Xx		Ward:Yy		Name/Type of Health Facility (HF): Zz Dispensary			
	SN	Year: 20XX Day/Month of Review Name of Reviewer Self -Assessment (SA) or Supportive Supervision (SS)		5/1 AB SA	10/2 AB SA	4/3 MJ SS	18/4 AB SA
Plan-ning	1	Map (catchment area boundaries, settlements, HF, OR sites)?		No	No	Yes	Yes
	2	Catchment area list of settlements with pop < 1 year and total population		No	No	No	Yes
	3	Waiting area (places to sit)?		No	Yes	Yes	Yes
	4	Local language RI poster in waiting area?		No	Yes	Yes	Yes
	5	Static/OR session schedule on wall in waiting area?		No	Yes	No	Yes
	6	All static/OR sessions held last month?		Yes	No	No	No
Data	7	Copy of RI monthly report sent for previous month?		Yes	Yes	No	Yes
	8	RI registers with all appropriate columns available?		No	No	Yes	No
	9	Columns in the register filled correctly?		No	No	No	No
	10	Data in register = data in monthly report (last month)?		No	Yes	No	Yes
	11	Tally sheets used during the last month?		No	No	Yes	Yes
	12	Cumulative coverage/drop out monitoring chart up-to-date?		Yes	Yes	No	Yes
	13	Assessment-record form on file?		No	Yes	Yes	Yes
	14	Self-assessments recorded by HF staff in the previous month?		No	Yes	No	Yes
Vac-cines	15	Standard vaccine transaction & supply ledger available?		No	Yes	No	Yes
	16	Vaccine transaction & supply ledger in use, correct, up-to-date?		No	Yes	No	Yes
	17	At least two GEOSTYLE type vaccine carriers?		Yes	Yes	Yes	Yes
	18	Enough reconstitution (5ml, 18g) syringes/needles in stock?		No	No	Yes	Yes
	19	Enough BCG sterile syringes/needles in stock?		Yes	Yes	No	Yes
	20	Enough sterile syringes/needles (0.5ml, 23g/25mm) in stock?		No	No	Yes	No
	21	Enough child health cards?		No	No	Yes	No
	22	At least one unused safety box in stock?		No	No	Yes	Yes
	23	Supplies stored neatly?		No	No	No	No
Injec-tion	24	Used syringes/needles burned/buried (all syringes/needles burned)?		No	No	Yes	Yes
	25	Area around HF free from used syringes and needles?		No	No	Yes	Yes
Total		Number		5	11	13	19
		%		20%	44%	52%	76%

4c.   Supportive supervision activity schedule

A planning tool for scheduling HF visits by month for district staff

This is a district level tool

Date filled in: _____

Name of Zone / Province: _____   District: _____

No.	Where (Health Facility to be visited)	Person Responsible	When (Dates)											
			Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec

Note: list of activities while duing supporting supervision
1. Communication and Social Mobilization: Reproductive and Child Health promotional materials e.g poster, immunization charts, Flip charts
2. RCH workplan: RCH session plan, achievement, cancellation and find reasons of dropout
3. Cold Chain and vaccines and logistics management: temperature chart, vaccines organization, VVM with expiry date, Shake test, vaccines and logistics inventory for shock out
4. Planning and management of resources: RED planning update, adequate number of Health Surveillance Assistants for RCH services, annual RCH workplan, communication plan
5. Data for action: Review <1 year register, tally sheets, monthly reporting format, drop-out chart and identify problems , causes of problems and on the job training
6. Community Survey: conduct househose survey in each visit and check 7 children (12-23 m) and 7 mothers who has a baby of < 1 year and assess their FIC and TT vaccination status
7. Debriefing session: Held meeting with the HF incharge and HSAs and share findings and suggest interventions and submit report to DHO and copy to DEHO/EPI Coordinator

5.a   Monitoring chart

A chart used at health facility level for tracking monthly cumulative immunization performnace by month

M = Monthly target infants of age of 0-11 months

Left axis labels (top to bottom):

- M x 12 =
- M x 11 =
- M x 10 =
- M x 9 =
- M x 8 =
- M x 7 =
- M x 6 =
- M x 5 =
- M x 4 =
- M x 3 =
- M x 2 =
- M x 1 =
- 0

Right axis percentage bands: 100%, 90%, 80%, 50%, 25%, 0%

FILL IN AT THE END OF EACH MONTH	January		February		March		April		May		June		July		August		September		October		November		December	
	monthly	Cumul	monthly	Cumul	monthly	Cumul	monthly	Cumul	monthly	Cumul	monthly	Cumul	monthly	Cumul	monthly	Cumul	monthly	Cumul	monthly	Cumul	monthly	Cumul	monthly	Cumul
Infants vaccinated DTP1																								
Infants vaccinated DTP3																								
Drop out (#) = DTP1 - DTP3																								
Drop out (%) = (DO/DTP1) * 100																								
Infants vaccinated Measles																								
Drop out (#) = DTP1 - Measles																								
Drop out (%) = (DO/DTP1) * 100																								

6.a Logistics and supply chains

Logistics and supplies

Date filled in: _____ Name of Zone / Province: _____ District: _____ Health Facility: _____

Vaccines & Supplies	Target Pop. (Tool 3)	Doses	Coverage Expected	Sessions per week	Weeks per year	Mean session size	Vial size	Status of MDVP	Anticipated wastage rate	Doses needed		Buffer/ safety stock
	No.	No.	%	No.	No.	No.	No.	No.		Annual	Monthly	
	A	B	C	D	E	F	G	H	I	J	K	L
BCG (Live Birth)	120	1	90%	1	48	2.25	20	No	89%	960	80	
Hep B birth dose		1		3			10					
Pentavalent (Surviving Infants)		3		5			1					
Oral Polio Vaccine (OPV) (LB)		4		5			10					
IPV		1		5			1					
MCV/MR		2		2			10					
YF		1		2			10					
Pneumococal (SI)		3		5			1					
Rota virus vaccine (SI)		2		5			2					
Tetanus Toxoid (TT/Td) (Pregnant)		2		3			10					
HPV		2		2			10					
Men A		1		2			10					
Vit A 100.000 IU* (< 1 year)		2		2								
Vit A 200.000 IU** (2-5 years)		6		0.5								
Mebendazole-500mg (12-59 months)		1		0.5								
Other supply (LLINs, etc)												

Mean session size (F) = Target pop. (A) * Doses per target (B) * Expected Coverage (C) / (Sessions per week (D) * # weeks per year (E))

Wastage rate (I) = (Doses of vials opened per session - Doses administered per session) / Doses of vials opened per session

Monthly consumption = # vials opened per month * # doses per vial

Monthly requirement = Yearly requirement / 12

Population-based formula is used to make it simple! The proposed method here is an attempt to simplify.

All input data are from micro-planning (i.e. target population, expected coverage, frequency of sessions and # weeks per year.

In addition need to enter information on the vaccine used (vial size and status regarding MDVP, i.e. number of weeks an opened vial can be reused.

Frequency of supply is monthly at HF level

6.b Injection supplies

Injection Material Forcast

Date filled in: _____ Name of Zone / Province: _____ District: _____ Health Facility: _____

Injection materials	Annual vaccine and supplies need			Calculation	Syringes needed	
	Doses	Vials	Buffer stock (25%)		Annual	Monthly
	A	B	C	D	E	F
0.05mls AD Syinges for BCG (Tool 6A (J) =annually)				1 per dose		
1ml Syringes BCG for Dilution (Too 6A (J)/20= annually)				1 per vial		
0.5mls AD syringes for Pentavalent (Tool 6A (J) =Annually)				1 per dose		
0.5mls AD syringes for Pneumococcal (Tool 6A (J)= Annually)				1 per dose		
0.5mls AD Syringes for Measles (Tool 6A (J)= Annually)				1 per dose		
5mls Syringes for Measles Dilution (Tool 6A (J)/10 = Annually)				1 per vial		
0.5mls AD syringes for TT Pregnant (Tool 6A (J) = Annually)				1 per dose		
Total syringes						
Safety boxes 5 litres (# Safety boxes = Total (O.5 + 0.05 + 1 + 5) ml/100)				1 per 100 syringes		

SK: There is no need to add a wastage factor on top of estimated vaccine doses
That will lead to double counting for wastage, since the estimation of vaccine doses has already included a wastage rate

OP.   Due list

Due list: list eligible children under 5 and women before the session (due and defaulters)

Purpose: ensure that the community is informed before the session and eligible children and women will be present for the vaccination session

Lists for follow-up children and mothers before immunization session

Child Follow-up list

Health Center Name: _____   Date: _____

Village Name: _____

	Child's name	Mother's name	Age in Months	Remarks
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
etc				

Woman's TT doses Follow-up

Health Center Name: _____ Date: _____

Village Name: _____

	Woman's name	TT Vaccination Status	Remarks
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
etc			

OP. MyVillage, MyHome (example from Malawi)

District: ....
Village: ....

Date started: ....

Date finished: ....

Total population: ....
Under one population: ....

My village my home

S. No.	Name of infant	DOB	Sex	BCG Date given	OPV0 Date given	OPV1 Date given	OPV2 Date given	OPV3 Date given	IPV Date given	Penta1 Date given	Penta2 Date given	Penta3 Date given	PCV1 Date given	PCV2 Date given	PCV3 Date given	Rota1 Date given	Rota2 Date given	Measles1 Date given	FULLY VACCINATED Yes	No
										IMMUNIZATION DOSES ADMINISTERED										
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
etc																				

Immunization Schedule
At birth: BCG and OPV 0
At 6 weeks: Penta1, PCV1, OPV1 and Rota1
At 10 weeks: Penta2, PCV2, OPV2 and Rota2
At 14 weeks: Penta3, PCV3, OPV3 and IPV
At 9 months: Measles

INSTRUCTIONS FOR TRACKING OF IMMUNIZATION STATUS OF CHILDREN IN A VILLAGE (MVMH TOOL)

This tool is used for tracking immunization status for children in a community. This is a responsibility of every village headman to ensure that every child in his/her village is protected against vaccine preventable diseases.

a. How to track immunization status of children in a village

1   Register all under one children in the village.
2   During registration, collect information on all antigens received using a notebook.
3   Transfer the information from the notebook onto this chart.
4   Monthly follow up the children and update the antigens received in the previous month using a notebook.
5   Transfer the information from the notebook onto this chart.
6   When a child is born in the village, register the child and collect all immunization information

b. How to write on this chart

1   Write the first child at the bottom of this chart and the subsequent ones on top.
2   Write the name of the child by writing both the child's name and father's name (family name).
3   Write the date of birth of every child by indicating the day, month and year when the child was born.
4   Indicate the sex of the child. Write M for male and F for female.
5   Indicate the immunizations given to the child by writing the date when the antigen was received in the cell provided under each antigen. The date should have day, month and year.
6   If the child is one year old, check if he/she has received all the vaccines and tick yes or no under fully immunized.

c. How to use this chart

1   This chart should be kept safe by the headman or any person appointed by the headman.
2   This chart should be used by both the volunteers and HSAs to monitor immunization coverage in their village.
3   This chart should be made public when opportunity arises, so that communities can see the immunization status of their children.

OP.   Defaulter tracing

Refer to IIP tickler box in IIP and defaulter tracing

List of children under 2 and women that <u>missed</u> the session (compiled after the session)

Purpose: ensure that children and women that missed the vaccination session are followed up.

TRACING UNVACINATED CHILDREN

Lists for follow-up children and mothers <u>after</u> immunization session

Child Follow-up list

Health Center Name: _____ Date: _____

Village Name: _____

	Child's name	Mother's name	Age in Months	Other information
1				
2				
3				
4				
5				
6				
7				
8				
etc				

Woman's TT doses Follow-up list

Health Center Name: _____ Date: _____

Village Name: _____

	Woman's name	TT Vaccination Status	Other information
1			
2			
3			
4			
5			
6			
7			
8			
etc			

OP. Card check

Visits to priority villages to measure immunization status of children & women - house to house

The purpose of this step is to understand the reasons why children are not vaccinated and the immunization gap in the community and compare the finding with the register. If discrepancies between the findings and the register are present, the register will be completed and improved.

Village / Area name: _____ Distance from Fixed Site: _____km

Health facility name: _____ Date : _____ Name of Team leader: _____

Questions about immunization of children under two years of age (0 – 23 months) and mothers (women in child bearing age (15 - 49 years))

Response	Tally			Total
A. Tally the number of households visited				
B. Immunization status by card:	Tally children	Tally mothers	Total children	Total mothers
Not immunized (never immunized)				
Partially immunized				
Adequately or fully immunized (for their age)				
No Card available Lost card				
No Card available Never vaccinated				

C. Child name	Reasons given for being partially or never immunized

D. Mother's name	Reasons given for being partially immunized with TT/Td

E. Suggestions for improvement

OP. Monitoring session schedules

Monitoring session schedules (fixed, outreach, mobile (specify 'overnight' if required) transportation means and community contact

Purpose: to plan for vaccination sessions in each village/settlement/neighborhood in the catchment area of the health facility

Name of villages/ settlements/ neighborhoods in health facility catchment area	Activity to address high risk community ('Hard to Reach'[1] specify type)	type of session (fixed, outreach, or mobile)	Frequency of sessions (weekly, monthly, etc...)	Name of community contact and mobile phone #	Date scheduled and done	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
					Date scheduled:												
					Date done:												
					Date scheduled:												
					Date done:												
					Date scheduled:												
					Date done:												
					Date scheduled:												
					Date done:												
					Date scheduled:												
					Date done:												
					Date scheduled:												
					Date done:												
Monitoring of session implementation and reporting of problems					Sessions planned:												
					Sessions done:												
					% done												
Other activities and other interventions - -					Date scheduled:												
					Date done:												

[1] High Risk Communities are the communities representing largest immunity gaps. The analysis of drivers of inequities identifies possible high risk groups. May include urban dwellers (urban poor), remote populations, migrant workers, refugees, special ethnic groups, religious groups, etc.

OP.   Session Size

Table 4b: How many sessions are needed in the village/settlement or neighborhood?

Purpose: to decide on the frequency of sessions, based on the size of the total population.
The column with the blue bold frequency will give you a manageable number of children for an outreach

Total population	Annual target population (infants <1 year of age)	Total population	Annual target population (infants <1 year of age)	Injections per year *10 injections per infant*	Monthly number of injections	Session type	Frequency of sessions per month	Recommended per month of sessions
3% of total population*)		4% of total population*)		annual target population x 10	annual number of injections / 12	type	**Fixed >80** injections per session; **Outreach >40** injections per session	Review, based on judgment
3%		4%						
100,000	3,000	75,000	3,000	21,000	1,750	fixed	21.9	daily
66,667	2,000	50,000	2,000	20,000	1,667	fixed	20.8	3 times a week or daily
13,333	400	10,000	400	4,000	333	fixed	4.2	weekly or daily
20,000	600	**15,000**	600	6,000	500	**outreach**	12.5	**3 times a week**
16,667	500	**12,500**	500	5,000	417	**outreach**	10.4	**2 times a week**
11,667	350	**8,750**	350	3,500	292	**outreach**	7.3	**2 times a week**
10,000	300	**7,500**	300	3,000	250	**outreach**	6.3	**weekly**
6,667	200	**5,000**	200	2,000	167	**outreach**	4.2	**weekly**
5,000	150	**3,750**	150	1,500	125	**outreach**	3.1	**two-weekly**
3,333	100	**2,500**	100	1,000	83	**outreach**	2.1	**two-weekly**
1,667	50	**1,250**	50	500	42	**outreach**	1.0	**monthly**
1,000	30	**750**	30	300	25	**outreach**	0.6	**monthly**
833	25	**625**	25	250	21	**outreach**	0.5	**every 2 months**
500	15	**375**	15	150	13	**outreach**	0.3	**every 2 months**
333	10	**250**	10	100	8	**outreach**	0.2	**every 3 months**
167	5	**125**	5	50	4	**outreach**	0.1	**every 3 months**

OP.   Summary activity plan

District: _____ Sub-District: _____ Health facility: _____

s/n	Activities	Details	Start date	Finish date	Total cost	Responsible person	Remarks
A	Planning and management of resources						
A1							
A2							
A3							
B	Reaching the target population						
B1							
B2							
B3							
C	Linking thew service with the community						
C1							
C2							
C3							
D	Supportive supervision						
D1							
D2							
D3							
E	Monitoring and use of data for action						
E1							
E2							
E3							
	Grand total						

Table 6b: Budget for outreach and other related activities to ensure reliable immunization (and integrated) services

Purpose: to identify budget needed to conduct the outreaches and other activities needed to reach the unreached.

District: _____ Date: _____

Health Center: _____

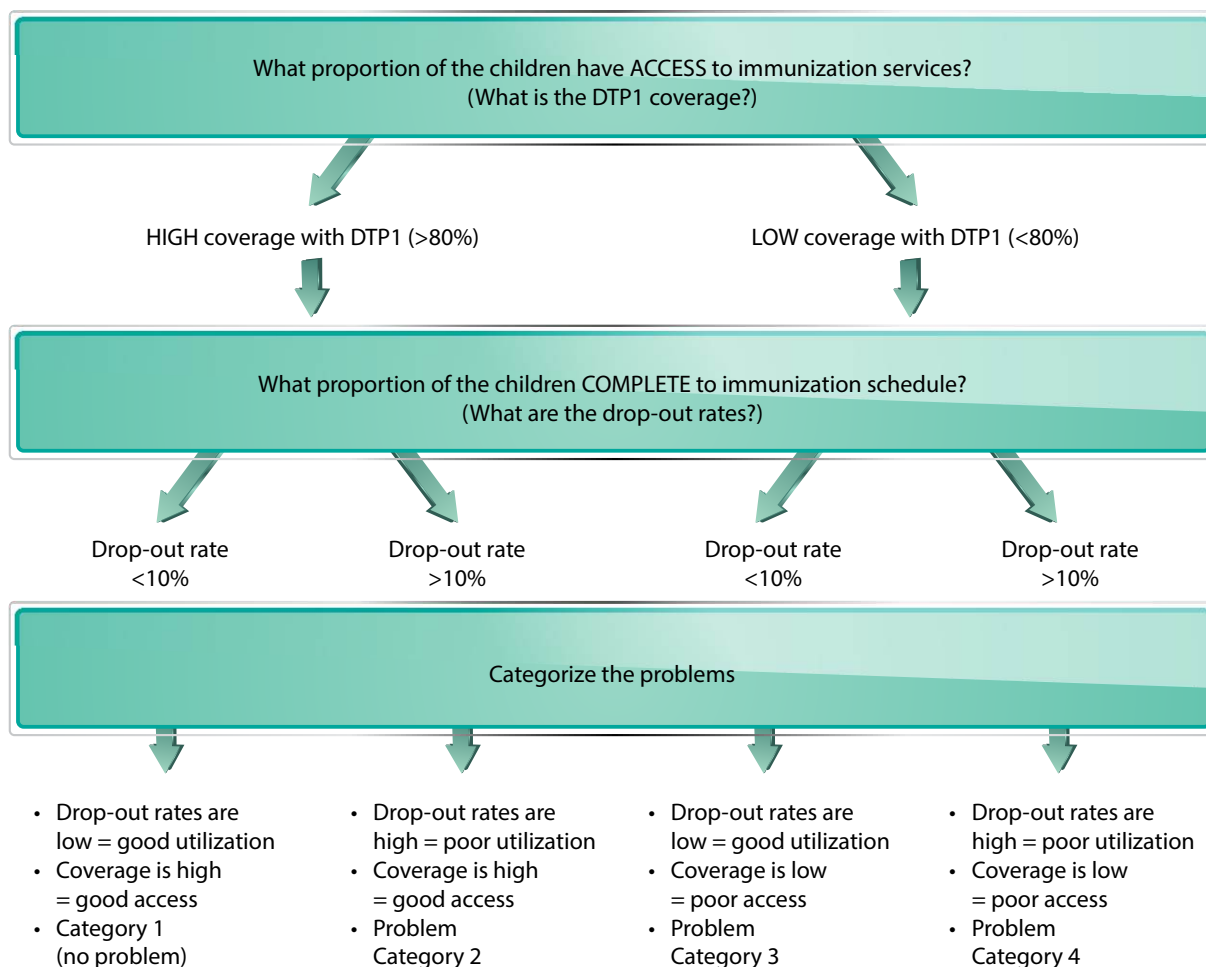| Origin village	Destination	Distance (km)	Time used to travel	Mode of transport (walk, bike, motor, car)	Overnight (Y/N)	Cost of transport (team)	per diem (team)	Total cost outreach	Description cost items *(specify)*	cost other item	Total cost (outreach and other)

OP. Annual RI work plan

Date filled in: _____   Name of Zone / Province: _____   District: _____   Health Facility: _____

Name of service delivery Site	Session Plan (Fixed/Outreach)		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total sessions planned	Total sessions held	% EPI sessions held against planned
	Static	Date scheduled															
		Date held															
		% sessions held as per plan															
	Outreach 1	Date scheduled															
		Date held															
		% sessions held as per plan															
		Transport															
	Outreach 2	Date scheduled															
		Date held															
		% sessions held as per plan															
		Transport															
	Outreach 3	Date scheduled															
		Date held															
		% sessions held as per plan															
		Transport															
	Outreach 4	Date scheduled															
		Date held															
		% sessions held as per plan															
		Transport															
	Outreach 5	Date scheduled															
		Date held															
		% sessions held as per plan															
		Transport															
Grand Total																	

ANNEX 3

ANALYSIS OF ACCESS AND DROP-OUTS

ANNEX 3 : ANALYSIS OF ACCESS AND DROP-OUTS[2]

> **What proportion of the children have ACCESS to immunization services?**
> **(What is the DTP1 coverage?)**

HIGH coverage with DTP1 (>80%)　　　　　　　LOW coverage with DTP1 (<80%)

> **What proportion of the children COMPLETE to immunization schedule?**
> **(What are the drop-out rates?)**

| Drop-out rate <10% | Drop-out rate >10% | Drop-out rate <10% | Drop-out rate >10% |

> **Categorize the problems**

- Drop-out rates are low = good utilization
- Coverage is high = good access
- Category 1 (no problem)

- Drop-out rates are high = poor utilization
- Coverage is high = good access
- Problem Category 2

- Drop-out rates are low = good utilization
- Coverage is low = poor access
- Problem Category 3

- Drop-out rates are high = poor utilization
- Coverage is low = poor access
- Problem Category 4

Category 1: No problem
High DTP1 coverage = **good access**
Low drop-out rates = **good utilization** and a **consistent supply** of **good quality** services

Category 2: Problem
High DTP1 coverage = **good access**
High dropout rates = **poor utilization** and/or **inconsistent supply** of services or services of **low quality**.

Category 3: Problem
Low DTP1 coverage = **poor access**
Low drop-out rates = **good utilization** and a **consistent supply** of **good quality** services, at least in those areas with access

Category 4: Problem
Low DTP1 coverage = **poor access**
High drop-out rates = **poor utilization** and/or an **inconsistent supply** of services or services of **low quality** at least in those areas with access

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