**Uganda 2017-2018**

The Gavi Full Country Evaluations (FCE) are mixed-methods, prospective evaluations in Mozambique, Uganda, and Zambia, funded by Gavi, the Vaccine Alliance. The second phase of the FCE (FCE2), implemented from 2017-2019, aims to identify drivers of vaccine coverage and equity with an emphasis on Gavi’s contribution. Evaluation results are intended to support the ongoing learning and improvement of Gavi and national immunization programs. The implementation of FCE2 is guided by a number of principles to ensure the usefulness, relevance, and quality of FCE2’s findings and of the sustainability and transferability of the platform beyond FCE2. In Uganda, the FCE is implemented by the Infectious Diseases Research Collaboration and PATH.

This brief summarizes the findings from the first report of Gavi FCE Phase 2. Full reports are available at [https://www.gavi.org/results/evaluations/full-country-evaluations/](https://www.gavi.org/results/evaluations/full-country-evaluations/).

### METHODS

The Gavi FCE triangulates multiple sources of data to answer predetermined evaluation questions. To generate the evidence and findings presented here, we used:

- Process tracking
- Meeting observation
- Document review
- Key informant interviews
- Analysis of DHIS2 and secondary data
- District case studies
- Policy analysis

### Key immunization activities evaluated

- Routine delivery of vaccines, with a focus on coverage and equity
- Slow scale-up of HPV vaccine second dose
- The structure of the immunization partnership nationwide
- Gap in HSS funding at subnational levels
- Uganda National Expanded Programme on Immunisation’s (UNEPI) efforts to address the grant management requirements for HSS2

### SUMMARY OF RECOMMENDATIONS

- **Act now:** In light of sustainability of the immunization program, UNEPI should establish a strong coordination system to leverage on existing partners in the districts to push the immunization agenda in terms of conducting integrated outreaches, support supervision, and other related activities.

- **Act now:** UNEPI should encourage District Health Officers (DHOs) to prioritize immunization coverage as a key health indicator in their districts and increase their vigilance in monitoring immunization performance, as this can directly influence health workers to improve immunization data quality and service delivery.

- **Act now:** Even as the country plans to introduce more vaccines, UNEPI should pay more attention to routine immunization.

- **Act now:** UNEPI should conduct intensified social mobilization for HPV vaccine to raise awareness of HPV among the population. Social mobilization should specifically target adolescent girls and boys, all primary school teachers (not only those of primary four), religious leaders, and parents.

- **Act now:** UNEPI should strengthen the communication between schools and health workers regarding HPV vaccination to facilitate smooth planning and implementation of HPV vaccination in schools.
National trends and possible explanations

In 2017 there was a general decline in coverage of DPT, OPV, BCG, and measles vaccines, according to DHIS2 data. Factors that may explain the observed decline in coverage include:

1. Data quality improvement (see below).
2. The gap in Gavi cash support (see page 3).
3. Findings from a district case study approach, including inadequacy of primary health care funding, data quality (poor documentation and unclear denominators), and the presence of religious sects opposed to immunization (see pages 4-5).
4. Strong focus by the EPI team on recurrent applications for Gavi support, rollout of new vaccines, and implementation of campaigns, thus sidelining routine immunization activities (see page 6).

DATA QUALITY IMPROVEMENT

Some key informants at national level attribute the observed decline in coverage to data-cleaning exercises under the Data Improvement Teams (DIT) strategy. Health workers are now reporting more accurate data, thus bringing down the coverage figures.

The DIT strategy is a multi-stakeholder initiative under the Ministry of Health, UNEPI, and partners (WHO, CDC, Gavi, UNICEF) to improve management, collection, analysis, and use of immunization data at district and health facility levels. Preliminary results of performance indicators for the first two rounds of the DIT implementation (as of October 2017) show improvements in the percentage of health facilities and districts with documented evidence that routine immunization data are used for action. Based on these preliminary results and the key informant interviews conducted by the FCE team, data quality improvement may partially explain the observed decrease in national coverage in 2017.

“Previously, we had coverages of up to 150%, which is poor math! But because of DIT (Data Improvement Teams), people have started disciplining themselves. And instead of forging data, they are now reporting the truth. Since we are now getting fairly correct results, coverage is also coming down.”

—KII

RECOMMENDATIONS

• UNEPI should make efforts to strengthen and institutionalize data quality checks and improvements.
The gap in Gavi cash support to districts may have contributed to the observed decline in the number of outreaches conducted and consequently the observed decline in DPT3 coverage in 2017.

HSS1 funding disbursements to districts ceased in February 2016 and HSS2 implementation had not started as of April 2018. Analysis of DHIS2 data shows a general drop in the number of outreaches conducted following the cessation of HSS1 funding.

The observed reduction in the number of outreaches conducted despite availability of HSS1 funding to districts could be due to the following reasons:

1. Disbursement of funds was planned to be on a quarterly basis. However, due to several challenges (such as delayed accountabilities from several districts, change of account numbers by districts), actual disbursements did not follow this sequence and therefore it was difficult to sustain the number of outreaches conducted.

2. Even when funds were accessed, in several districts the persons who received the money were different from the ones who implemented the activities. As such, health workers had limited morale to conduct outreaches.

Districts adapted to the gap in HSS1 funding differently. The most common ways of adaptation were to use PHC funds and to rely on existing partnerships. Other factors facilitating adaptation to the gap in fund included strong leadership and management of facility in-charges and DHOs, having a dedicated health workforce, finding alternative sources of funding (from the district or community), riding on the high community demand for outreaches, conducting outreaches at specific locations, and giving false hope to health workers regarding future availability of HSS funds.

RECOMMENDATIONS

ACT NOW

- As the country plans for implementation for HSS2, the Ministry of Health should:
  - Ensure more consistent disbursement of HSS funds to districts to sustain HSS-supported activities and consequently realize impact.
  - Devise a system of tracking the flow of funds to the end user to better realize implementation of HSS-supported activities.
  - Drawing from the lessons learned in HSS1 disbursement, the Ministry of Health should develop a grant closeout strategy that includes a communications plan that reaches the end user of funds.
**District-level best practices**

1. **Leveraging partner-planned activities to push the immunization agenda both at district and facility levels.**

2. **Prioritization of immunization performance by the DHOs.**

3. **DHO’s gratitude and recognition of health workers for good immunization performance.**

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**District Case Study Approach**

To understand the varying trends in coverage and equity, the FCE applied a district case study approach to compare districts with varying immunization performance. The FCE team visited Pader, Manafwa, Kibaale, and Mpigi districts in February 2018 to explore the major drivers of coverage and equity.

In Pader and Manafwa districts, where DPT3 coverage declined in 2017, contributing factors included:

- Inadequate primary health care funds to conduct routine immunization, especially outreachs.
- Poor recording of immunization service delivery, both at outreach and static activities, thus affecting data quality.
- Unclear denominators for target immunization populations.
- Presence of religious sects that are resistant to immunization.

In Kibaale and Mpigi districts, where DPT3 coverage increased in 2017, contributing factors included:

- Leveraging on existing partner support in districts to also conduct immunization-related activities.
- Strong management and leadership, especially by the DHO, which led to a motivated workforce and close monitoring of immunization coverage indicators.
IMMUNIZATION PARTNERSHIP

Given the increasing number of immunization partners, lack of coordination, and the unclear roles and unknown areas of operation, the FCE sought to understand the structure of the immunization partnership nationwide. The FCE team surveyed each district in February 2018 to learn which partners were actively supporting immunization, at what levels, and through which types of activities.

Key Findings

- Ninety-three partners were mentioned to be supporting immunization in Uganda.
- Those with the largest geographic presence are Gavi core partners (UNICEF, WHO).
- Only a subset of these 93 partners (WHO, UNICEF, CHAI, CDC, CRS) were funded with PEF-TCA in Uganda in 2017.
- The most commonly supported activities by partners are social mobilization, routine service delivery, outreaches, and integrated service delivery.

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**Figure 4. Comparison of the DPT3 coverage by district in 2017 and the number of partners per district**

DPT3 coverage by district in 2017.

Number of local partners per district in Uganda

**RECOMMENDATIONS**

**ACT NOW**

- In light of sustainability of the immunization program, UNEPI should establish a strong coordination system to leverage on existing partners in the districts to push the immunization agenda in terms of conducting integrated outreaches, support supervision, and other related activities.
- UNEPI should encourage DHOs to prioritize immunization coverage as a key health indicator in their districts and increase their vigilance in monitoring immunization performance, as this can directly influence health workers’ immunization data quality and service delivery.
Strong focus by the EPI team on recurrent applications for Gavi support for new vaccines and cash support, rollout of new vaccines, and implementation of campaigns has sidelined the focus on coverage and equity of routine immunization activities.

The table at right shows many of the activities the EPI team was focused on.

### Timeline for new vaccine introductions and applications for Gavi cash support

<table>
<thead>
<tr>
<th>EPI ACTIVITY</th>
<th>ACTUAL / EXPECTED TIMING</th>
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<tbody>
<tr>
<td>PCV introduction</td>
<td>April 2013</td>
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<tr>
<td>HPV vaccine introduction</td>
<td>November 2015</td>
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<tr>
<td>HSS2 and CCEOP grant application</td>
<td>November 2015-May 2016</td>
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<tr>
<td>IPV introduction</td>
<td>April 2016</td>
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<td>Meningitis A campaign</td>
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<tr>
<td>Rotavirus introduction</td>
<td>June 2018</td>
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<tr>
<td>Switch from PCV10 to PCV13</td>
<td>2018</td>
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<tr>
<td>Switch from adult tetanus toxoid to tetanus-diptheria vaccine</td>
<td>2018</td>
</tr>
<tr>
<td>Measles/Rubella introduction</td>
<td>2019</td>
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**UNEPI’s focus on applications and new vaccines**

**RECOMMENDATIONS**

**ACT NOW**

- Even as the country plans to introduce more vaccines, UNEPI should pay more attention to routine immunization.

**Effects of Gavi processes on implementation of Gavi support at country level**

The Uganda program capacity assessment recommendations informed the grant management requirements (GMRs), which had to be addressed before disbursement of the first tranche of HSS2 funds. Despite the country’s efforts to implement the GMRs, Gavi changed course and made a decision to channel HSS2 funds through UNICEF. This decision has already resulted in unintended consequences, such as a delay in implementation of the HSS2 grant.

The FCE will continue to prospectively track the unintended consequences resulting from this decision, taking into consideration the above-observed and envisioned consequences, among others.

Based on insights from key informants and learnings from countries with similar experiences in funding modality, future consequences from this decision may include:

1. Limited country ownership of the HSS2 implementation.
2. Lack of clarity in roles and responsibilities.
3. High management fees incurred.
4. Implementation delays due to an additional layer of bureaucracy.
5. Challenges with coordination of funds flow and activity implementation at district level.
Demand-side reasons for low coverage of HPV second dose

In February 2018, key informant interviews were conducted in four districts: two low-performing districts (Wakiso and Rubirizi) and two high-performing districts (Arua and Buliisa). Respondents were District Health Officers, District Education Officers, teachers of primary four, caregivers of girls aged 9–13 years, and health workers. The demand-side reasons for low coverage for HPV2 that emerged were:

- Low awareness of HPV vaccine among parents, teachers, and health workers.
- Inadequate follow-up system for tracking vaccinated girls.
- Presence of a communication gap between health workers and teachers.
- Confusion on the target age group among health workers.
- Other school-based constraints (boys bullying girls and limited time for vaccination due to busy school programs).

**RECOMMENDATIONS**

**ACT NOW**

- UNEPI should conduct intensified social mobilization for HPV vaccine to raise awareness of HPV among the population. Social mobilization should specifically target girls, boys, all teachers in primary school, religious leaders, and parents.
- UNEPI should strengthen the communication between schools and health workers regarding HPV vaccination to facilitate smooth planning and implementation of HPV vaccination in schools. Planning would include scheduling of school visits and making sure the girls are informed and available. This would also facilitate follow-up of the girls who received the first dose.
- UNEPI should involve the Ministry of Education in planning for implementation of HPV vaccination at both national and district levels.
Conclusion

There has been a decrease in immunization coverage for most antigens in Uganda in 2017. The decrease in coverage coincided with the end of HSS1 disbursements to districts and rollout of the data improvement strategy in several districts around the country.

Evidence from this evaluation shows that the funding gap left by the end of the HSS1 grant at the subnational level was never filled by government, thus resulting in suboptimal immunization service delivery. But important too is that there have been concerted efforts by UNEPI and partners to improve the quality of health management information systems, specifically immunization data, thereby reducing cases of overreporting. The current coverage figures from DHIS are trending closer to coverage reported by different household surveys and to WHO and UNICEF estimates of national immunization coverage. However, some districts have posted improvement in coverage over the same period. These districts were found to have strong support by partners who bridged the gap in funding, as well as strong management and leadership. The EPI needs to operationalize the 2017 immunization sustainability plan so as to overcome the funding challenges.

ACKNOWLEDGEMENTS

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