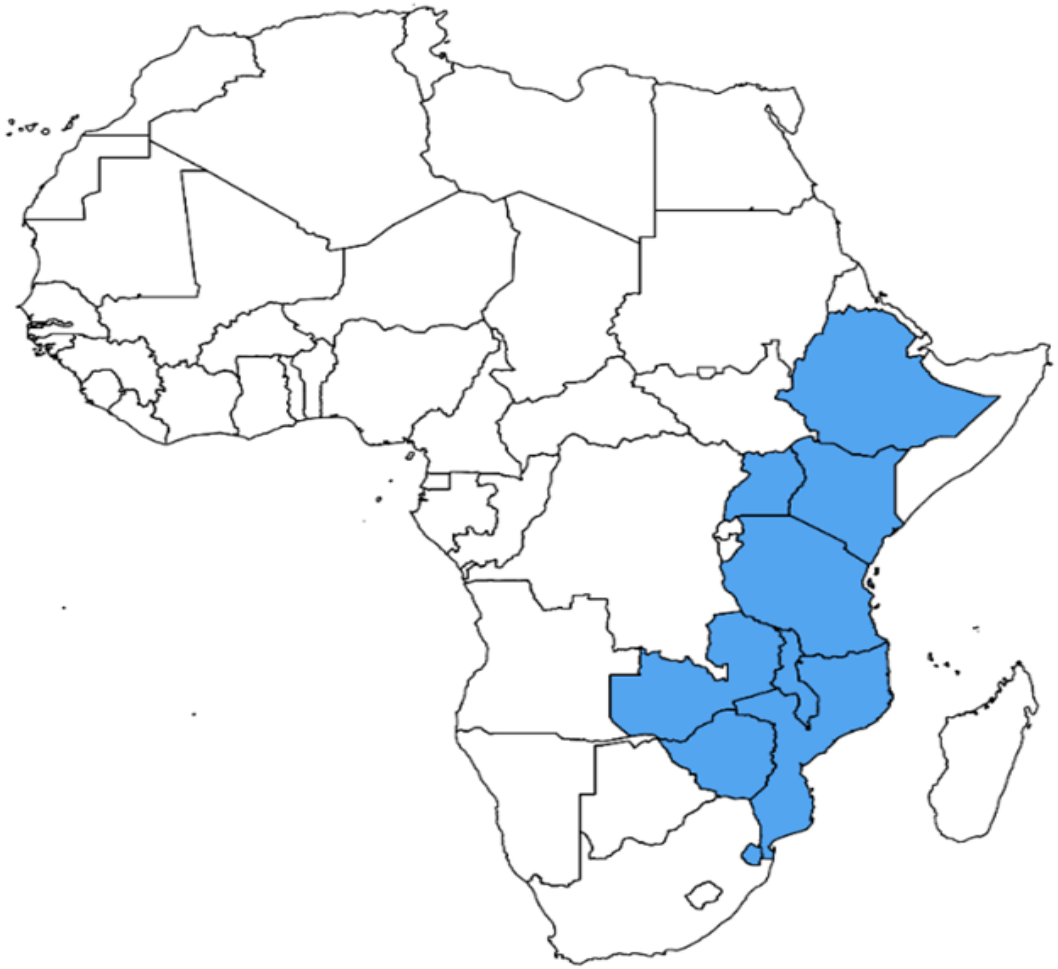
COE “Workshop series for strengthening capacity to manage child and adolescent TB”

Session 4: South-to-South Sharing

Date: October 6, 2022

Moderator: John Paul Dongo



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Session 4 Agenda (Cohort 1)

1) **Quick round of introductions** (All)
2) **Session 3 recap** (John Paul Dongo)
3) **Session 4 outline** (Brittany Moore)
4) **Presentation on successful capacity-building strategies used in other countries and public health programs** (FETP and AFENET)
5) **Discussion** (All)
5) **Closing remarks** (Riitta Dlodlo)

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Remind ourselves - who is present for session 4!

- Quick round of introductions (*Name, Organisation/Country and position title*)
- The Union
- CDC
- Member countries
  - Tanzania
  - Mozambique
- AFENET
- FETP

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COE Union Team

John Paul Dongo

Ritah Mande

Riitta Dlodlo

Selma Dar Berger

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COE CDC Team

Brittany Moore

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Tanzania

- Allan Tarimo
- Mandala Adam
- Issa Sabi
- Bhavin Jani
- Peter Neema

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Mozambique

- Criménia Mbate Mutemba
- Benedita José
- Yolanda Cachomba
- W. Chris Buck

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FETP and AFENET

- Peter Thomas, Field Epidemiology Training Program, CDC Atlanta

- Kevin Mugenyi, Senior Epidemiologist, AFENET Uganda

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Session 3 recap, session 4 outline, and workshop series running schedule

John Paul Dongo, Country Director, The Union Uganda office

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3. Adapting/developing a national capacity building strategy for child and adolescent TB

Objectives	Post-session work completed by country team
1. Describe adult learning theory and effective training techniques for adult-learners 2. Use learner-centered ADDIE model (Assess, Design, Develop, Implement and Evaluate) to adapt and/or develop a national capacity building strategy for child and adolescent TB	**Assess**: • Conduct root cause analysis to determine root causes of challenges for successfully implementing child and adolescent TB activities in country • Identify causes that are within the country's control to change/improve, and that can be improved through capacity building **Design**: • Brainstorm solutions/interventions for root causes that are identified as within the country's control to change/improve and can be improved through capacity building (root causes related to poor workforce skills, knowledge, and attitudes) • Use impact resource matrix to start prioritizing solutions/interventions based on impact and resources needed

4. South-to-south experience sharing: Country experiences of implementing public health capacity-building strategies!

Objectives

1. Become familiar with successful capacity-building strategies used in other countries and public health programs

Post-session work completed by country team

- Begin shaping a document that links capacity building solutions and strategies with identified problems/barriers/performance issues
- Identify and integrate best practices/lessons learned from south-to-south learning into the country's national child and adolescent TB capacity building strategy
- Develop broad costing estimates for each intervention, including annual budgets for ongoing activities, if applicable.

Deliverable: Country team develops a presentation summarizing proposed components of national capacity building strategy for child and adolescent TB.

Session calendar

No	Session	Dates	Duration
1	Let's get started: What is the COE "Workshop series for strengthening capacity to manage child and adolescent TB" - Introduction.	March 30, 2022	1 hour 30 minutes
2	Sharing findings from countries' review of their national training strategy, training materials, and staff training needs for child and adolescent TB	May 19, 2022	1 hour 30 minutes
3	Adapting and/or developing a national capacity building strategy for child and adolescent TB, incorporating best practices for adult learning	June 14, 2022	1 hour 30 minutes
4	South-to-south experience sharing: Real-life country experiences of implementing public health capacity-building strategies!	October 06, 2022	1 hour 30 minutes
5	Sharing countries' national child and adolescent TB capacity-building strategies	TBD	1 hour 30 minutes

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Presentations on implementing public health capacity-building strategies

FETP and AFENET

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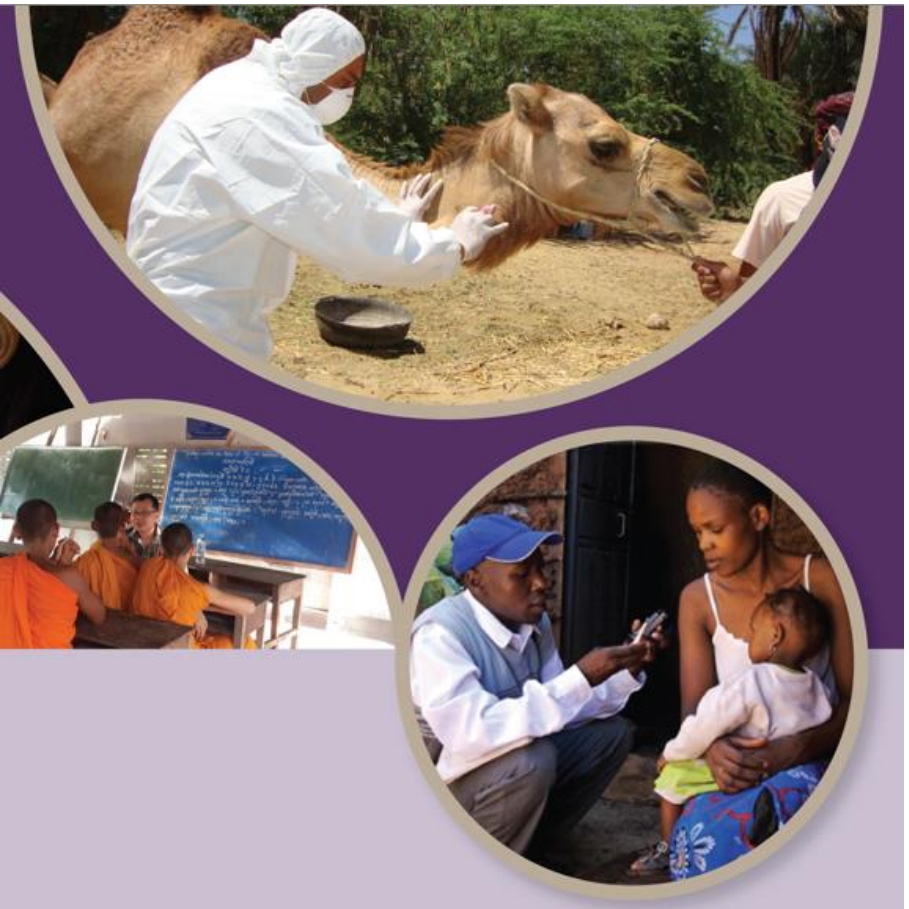
Overview of Field Epidemiology Training Programs



6 October 2022

Peter Thomas PhD, MPH

Division of Global Health Protection
Center for Global Health
CDC, Atlanta, USA

“Field Epidemiology Training Programs – in the tradition of CDC’s Epidemic Intelligence Service – may be the single most important thing CDC does in global health.”

Dr. Thomas Frieden, Former CDC Director

What is a Field Epidemiology Training Program (FETP)?

- Mentored, on-the-job, competency-based **training and service** program
- Recruit health professionals to gain important skills while providing key services to their health system
- Curriculum centers on field projects with supporting **didactics at all levels**

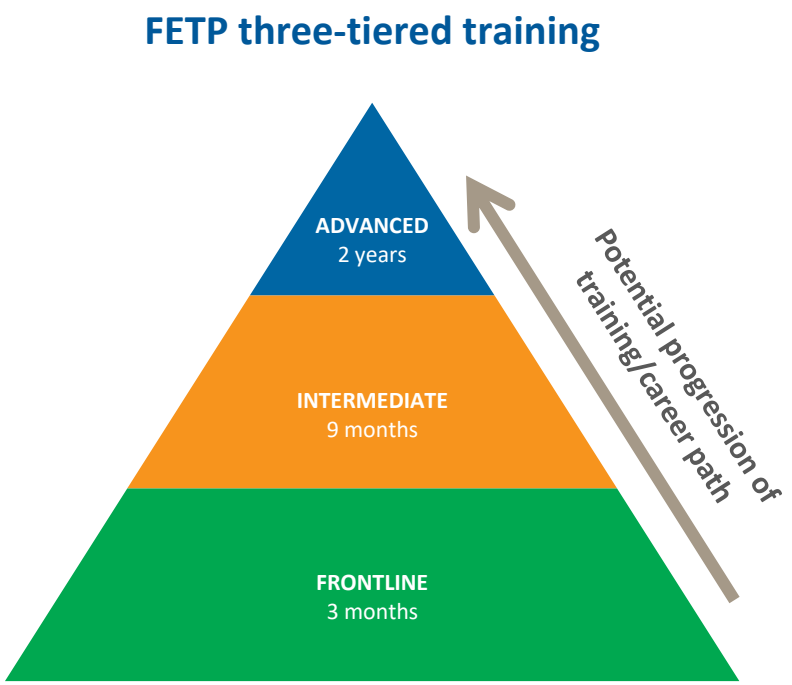
Sample collection conducted by members of the Malaysia Epidemic Intelligence Program. (Photo from TEPHINET)

FETP variations

- Variations in FETP levels
  - FETP-Frontline
  - FETP-Intermediate
  - FETP-Advanced
  - FELTP: Includes laboratory training
  - FETP-V: Includes training for veterinarians
- Variations in FETP structure
  - Some programs award a degree
  - Proportion of coursework vs. field work
  - Location of field placements
  - Country vs. regional program
  - Funding sources
  - Background, source, and number of trainees
  - Post-graduation job opportunity / requirement

CDC's FETP has a three-tiered training approach

	FRONTLINE	INTERMEDIATE	ADVANCED
Target Audience	District, Regional, National	Regional, National	National
Duration	3 Months	9 Months	2 Years
Cohort Size	20 - 30	15 - 20	8 - 15
Part-time or Full-time	Part-time	Part-time	Full-time
Awarded on Completion	Certificate	Certificate	Certificate, MPH, or other Master's
Classroom Time / Field Time	2 Weeks+ / 10 - 12 Weeks	8 Weeks / 33 Weeks	10 - 26 Weeks / at least 68 Weeks



Tier 1: FETP Frontline

- Goal
  - Build epidemiologic capacity
  - Strengthen public health surveillance
  - Promote use of data for decision-making at local level
- Target audience
  - Governmental public health workers responsible for surveillance data collection, compilation, analysis, reporting and response at local level of health system
  - Staff at the intermediate and central level responsible for analysis of surveillance data
- Proposed program length: ~3 months
  - Classroom sessions: 2 weeks (divided)
  - Field work: 8–10 weeks

Tier 2: FETP Intermediate

- Goal: Build epidemiologic capacity (surveillance, outbreak investigation and response, data for decision-making) at the intermediate level
- Target audience: Public health workers responsible for surveillance data analysis, outbreak investigation and response, reporting at the intermediate (and national) level of the health system
- Proposed program length: ~9 months
  - Classroom sessions: 5–9 weeks (divided)
  - On the job (with assignments): 31–35 weeks

Tier 3: FETP Advanced

- Goal
  - Train public health personnel in applied (field) epidemiology by providing epidemiologic services to national and sub-national health authorities
  - Strengthen country's capacity to
    - Respond to public health emergencies
    - Build and evaluate surveillance systems
    - Lead research activities on priority public health problems
    - Improve communications and networking within the country and throughout the region
- Target audience: Public health workers at the national level of the health system
- Proposed program length: 2 years
  - Classroom sessions: 20–25% of 2 years
  - On the job (with assignments): 75–80% of 2 years

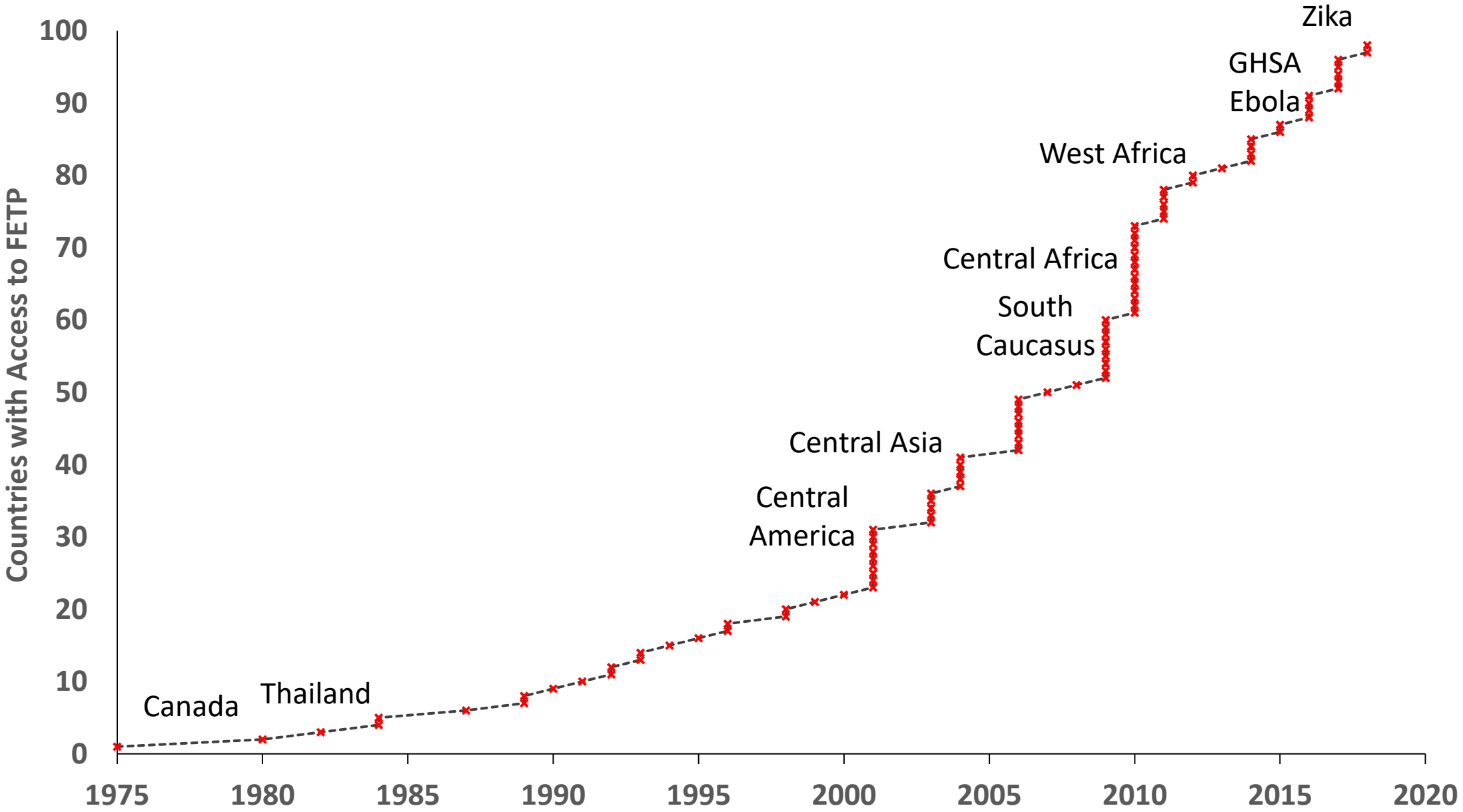
The Global Field Epidemiology Roadmap vision is shared by CDC's FETP

2030 FETP Vision

Every country in the world will have the applied epidemiology capacities needed to protect and promote the health of its own population, and to collaborate with others to promote global health **[and health security]**.

www.tephinet.org/the-global-field-epidemiology-roadmap

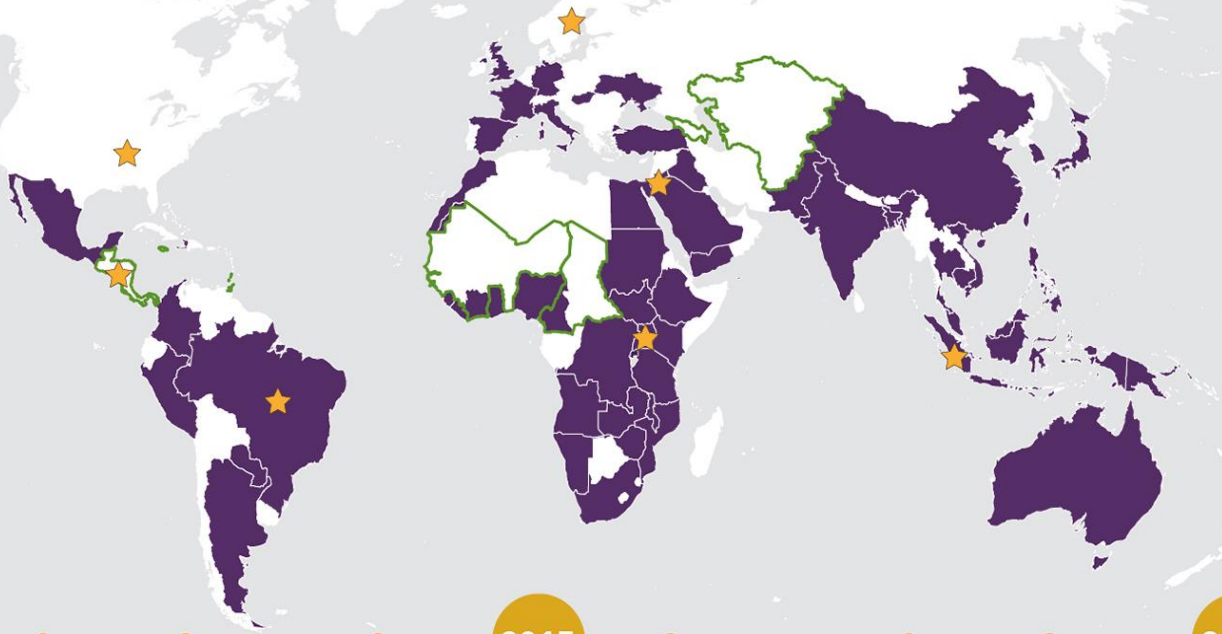
Growing CDC-engaged FETPs, 1975–2018



FETP at 40

Expanding the footprint of disease detectives worldwide

Over the past 40 years, CDC helped establish Field Epidemiology Training Programs (FETPs) throughout the world, starting with Thailand in 1980. The map and timeline show when FETPs began in countries and in regions, as well as the dates when FETP networks were established. Additionally, Canada's FETP launched independently in 1975 and CDC's Epidemic Intelligence Service (EIS) launched in 1951.



LEGEND

- FETP launched with CDC support
- Regional FETP launched with CDC support
- FETP network
- FETP launched independently

1980
- Thailand

1982
- Indonesia

1984
- Mexico
- Taiwan

1985

1987
- Philippines

1989
- Peru
- Saudia Arabia

1990

1991
- Australia

1992
- Colombia
- Italy

1993
- Egypt
- Zimbabwe

1994
- Spain
- Uganda

1995
- EPIET
- Ghana
- Hungary

1996
- Germany
- Vietnam

1997
- TEPHINET

1998
- Jordan

1999
- Japan
- South Korea

2000
- Brazil
- Central America

2001
- China
- India

2002
- France
- Malaysia

2003
- Central Asia

2005
- AFENET

2006
- Afghanistan
- Pakistan
- South Africa

2008
- Nigeria
- Tanzania

2009
- South Caucasus
- EMPHNET
- Ethiopia
- Laos
- Mongolia
- SAFETYNET

2010
- Central Africa
- West Africa
- Argentina
- Iraq
- Morocco
- Mozambique
- Rwanda
- Singapore

2011
- REDSUR
- Angola
- Cambodia
- Indian Ocean
- Paraguay
- United Kingdom
- Yemen

2012
- Turkey

2013
- Bangladesh
- DRC
- Papua New Guinea

2014
- Namibia
- Zambia

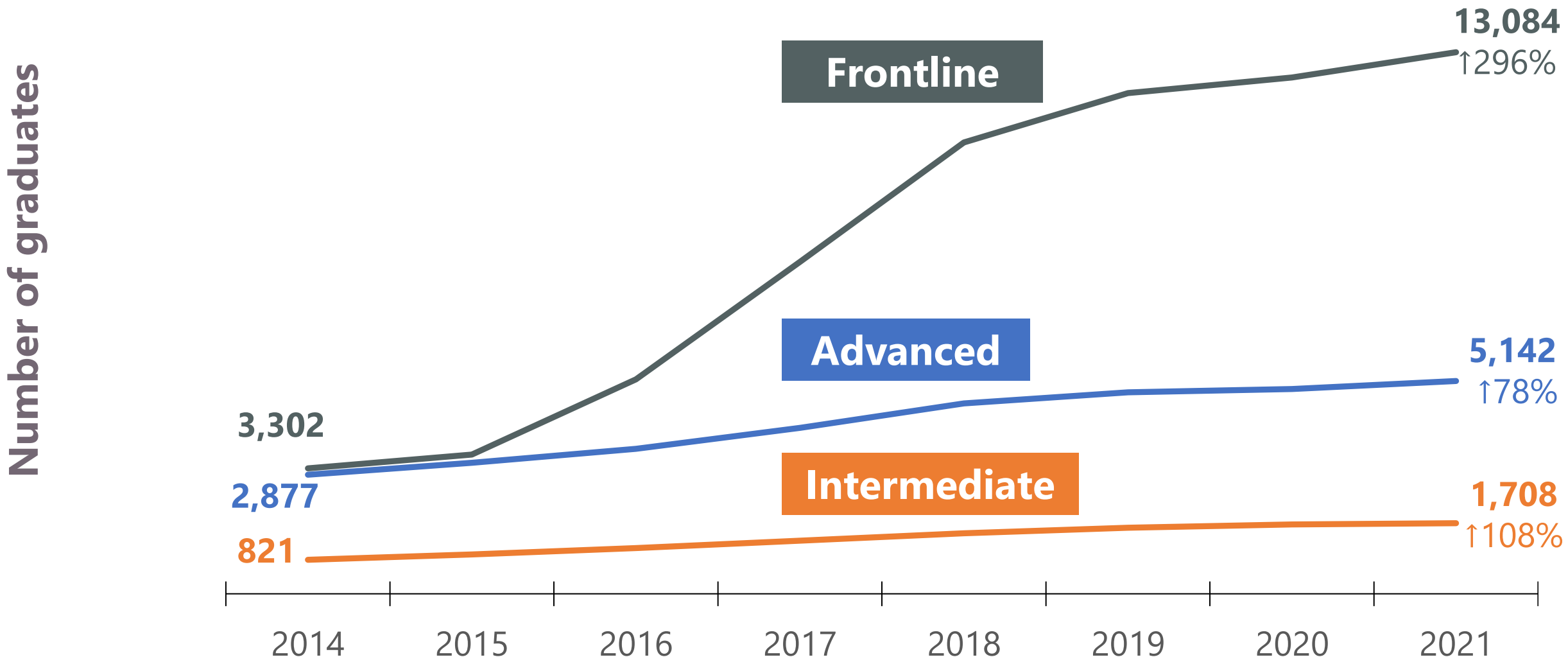
2015
- Liberia

2016
- REDCEC
- The Gambia
- Sierra Leone

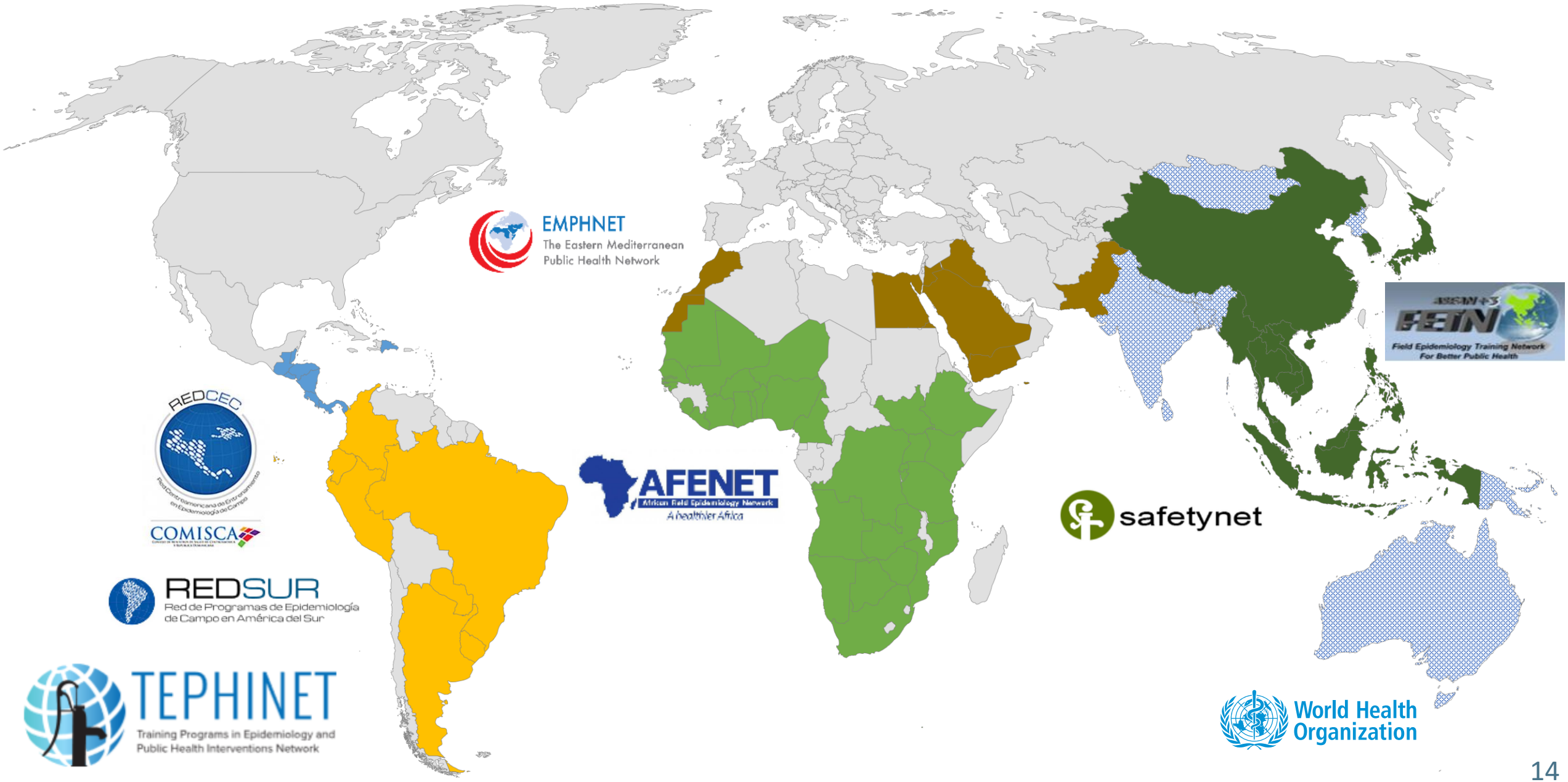
2017
- Caribbean
- Ecuador
- Uruguay

2018
- Myanmar
- Ukraine

FETP programs, particularly Frontline, continue to grow



Key FETP Partners around the Globe



FETP key to Nigeria's Ebola response

- July 2014: Traveler infected with Ebola arrive in Lagos, Africa's largest city

- FETP involvement:
  - Helped identify and isolate cases
  - Identified 894 contacts
  - Completed nearly 19,000 contact tracing visits
  - Implemented social mobilization strategy, reaching 26,000 households
  - Established Ebola Treatment Unit in 2 weeks

Training on effective use of PPE

- Outbreak ended in October (19 cases total)

FETP-Frontline Impact — Benin

On-time reporting: 37%

Percentage of facilities reporting on time, by district – Benin

		Frontline Workshop 1	Frontline Field Work 1						Frontline Workshop 2	Frontline Field Work 2		
Districts	W 25	W 26	W 27	W 28	W 29	W 30	W 31	W 32	W 33	W 34	W 35	W 36
1 NIKKI	94%											
2 SO-AVA	56%											
3 PEV d'Abomey-Calavi	25%											
4 Save	0%											
5 Zagnanado	25%											
6 Malanville	100%											
7 Allada	25%											
8 Cotonou 7	0%											
9 Aguégués	0%											
10 Pobe	67%											
11 Abomey-Calavi	25%											
12 Ze	50%											
13 Sèmè-Podji	30%											
14 Ifangni	9%											
15 Adja-Ouèrè	100%											
16 Adjarra	14%											
17 Tchaourou	31%											
18 Perere	0%											
19 Kalale	27%											
20 Cotonou V (Zone)	0%											
21 Segbana	100%											
22 Cotonou I & IV (Zone)												
Average by Week	**37%**											

FETP-Frontline Impact — Benin

On-time reporting: 37% to 79%

Percentage of facilities reporting on time, by district – Benin

		Frontline Workshop 1	Frontline Field Work 1						Frontline Workshop 2	Frontline Field Work 2		
Districts	W 25	W 26	W 27	W 28	W 29	W 30	W 31	W 32	W 33	W 34	W 35	W 36
1 NIKKI	94%	94%	88%	56%	31%	31%	38%	38%				
2 SO-AVA	56%	56%	56%	78%	100%	100%	100%	100%				
3 PEV d'Abomey-Calavi	25%	25%	38%	50%	63%	75%	75%	88%				
4 Save	0%	0%	42%	83%	83%	92%	100%	100%				
5 Zagnanado	25%	0%	0%	50%	100%	100%	100%	100%				
6 Malanville	100%	100%	100%	100%	100%	100%	100%	100%				
7 Allada	25%	25%	50%	75%	100%	100%	25%	50%				
8 Cotonou 7	0%	0%	0%	0%	0%	0%	50%	50%				
9 Aguégués	0%	0%	0%	0%	100%	100%	100%	100%				
10 Pobe	67%	83%	100%	83%	83%	83%	100%	100%				
11 Abomey-Calavi	25%	25%	38%	50%	63%	75%	75%	88%				
12 Ze	50%	75%	100%	100%	100%	100%	100%	100%				
13 Sèmè-Podji	30%	20%	30%	40%	60%	80%	90%	90%				
14 Ifangni	9%	27%	9%	9%	9%	36%	9%	9%				
15 Adja-Ouèrè	100%	100%	100%	100%	100%	100%	100%	100%				
16 Adjarra	14%	29%	43%	43%	57%	57%	71%	57%				
17 Tchaourou	31%	54%	46%	46%	46%	62%	100%	100%				
18 Perere	0%	0%	27%	36%	36%	36%	45%	36%				
19 Kalale	27%	27%	40%	53%	87%	93%	67%	80%				
20 Cotonou V (Zone)	0%	0%	0%	0%	75%	75%	75%	75%				
21 Segbana	100%	100%	100%	100%	100%	100%	100%	100%				
22 Cotonou I & IV (Zone)	*No Report*											
Average by Week	**37%**	**40%**	**48%**	**55%**	**71%**	**76%**	**77%**	**79%**				

FETP-Frontline Impact — Benin

On-time reporting: 37% to 89% in 3 months

Percentage of facilities reporting on time, by district – Benin

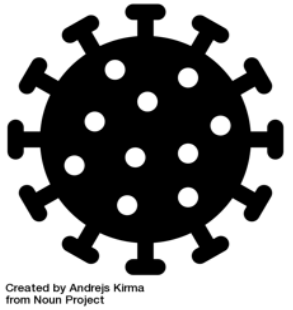
		Frontline Workshop 1	Frontline Field Work 1						Frontline Workshop 2	Frontline Field Work 2		
Districts	W 25	W 26	W 27	W 28	W 29	W 30	W 31	W 32	W 33	W 34	W 35	W 36
1 NIKKI	94%	94%	88%	56%	31%	31%	38%	38%	44%	75%	94%	94%
2 SO-AVA	56%	56%	56%	78%	100%	100%	100%	100%	100%	100%	100%	100%
3 PEV d'Abomey-Calavi	25%	25%	38%	50%	63%	75%	75%	88%	100%	100%	100%	100%
4 Save	0%	0%	42%	83%	83%	92%	100%	100%	100%	100%	100%	100%
5 Zagnanado	25%	0%	0%	50%	100%	100%	100%	100%	100%	100%	100%	100%
6 Malanville	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
7 Allada	25%	25%	50%	75%	100%	100%	25%	50%	25%	75%	100%	75%
8 Cotonou 7	0%	0%	0%	0%	0%	0%	50%	50%	100%	75%	100%	100%
9 Aguégués	0%	0%	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%
10 Pobe	67%	83%	100%	83%	83%	83%	100%	100%	100%	100%	100%	100%
11 Abomey-Calavi	25%	25%	38%	50%	63%	75%	75%	88%	100%	100%	100%	100%
12 Ze	50%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
13 Sèmè-Podji	30%	20%	30%	40%	60%	80%	90%	90%	100%	100%	100%	100%
14 Ifangni	9%	27%	9%	9%	9%	36%	9%	9%	9%	9%	9%	45%
15 Adja-Ouèrè	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
16 Adjarra	14%	29%	43%	43%	57%	57%	71%	57%	71%	57%	57%	57%
17 Tchaourou	31%	54%	46%	46%	46%	62%	100%	100%	100%	100%	100%	100%
18 Perere	0%	0%	27%	36%	36%	36%	45%	36%	36%	45%	18%	36%
19 Kalale	27%	27%	40%	53%	87%	93%	67%	80%	87%	87%	87%	93%
20 Cotonou V (Zone)	0%	0%	0%	0%	75%	75%	75%	75%	75%	75%	75%	75%
21 Segbana	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
22 Cotonou I & IV (Zone)	*No Report*											
Average by Week	**37%**	**40%**	**48%**	**55%**	**71%**	**76%**	**77%**	**79%**	**83%**	**86%**	**88%**	**89%**

How do FETPs support the COVID-19 response?

Conducting Epidemiologic Activities

Contact Tracing

Sample Collection



Situation Reports

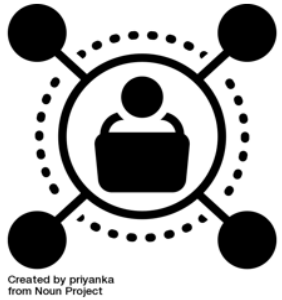
Case Investigations

Leading Risk Communication Efforts

Communication Materials

Combat Misinformation

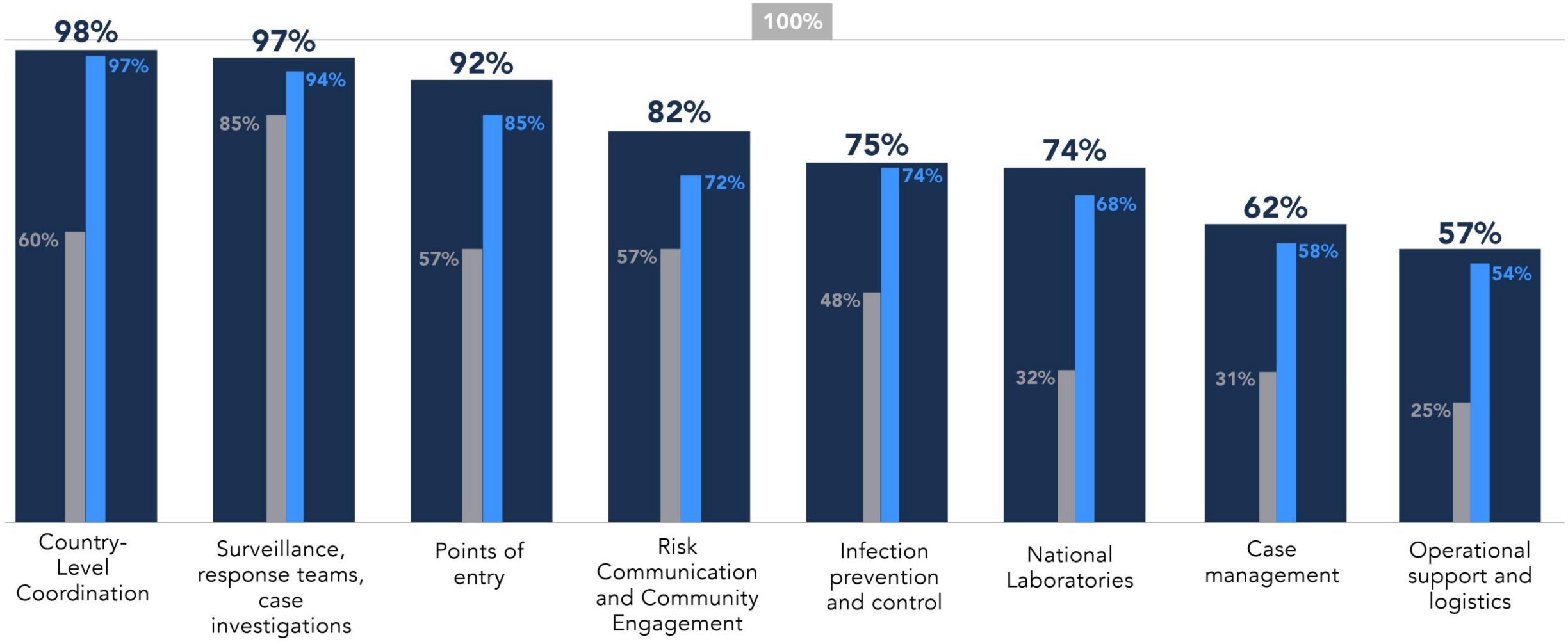
Public Awareness Campaigns



Call Centers

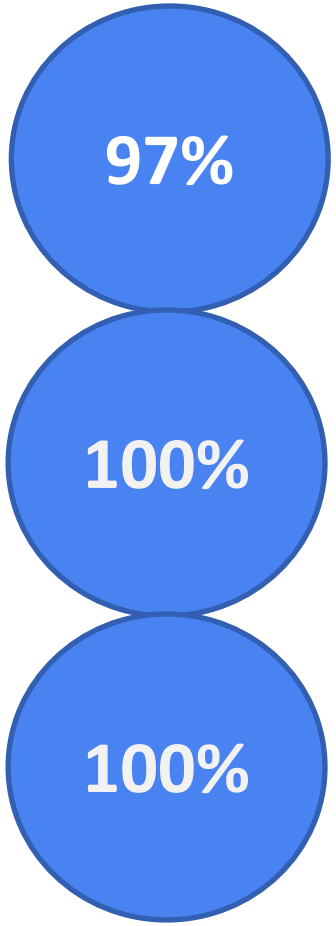
*Hu AE, et al. Field Epidemiology Training Programs contribute to COVID-19 preparedness and response globally. BMC PubH. In Press.

How do FETPs support the COVID-19 response?



*Hu AE, et al. Field Epidemiology Training Programs contribute to COVID-19 preparedness and response globally. BMC PubH. In Press.

FETP trainee, graduate, and staff engagement



of 32 programs report trainee engagement*

of 32 programs report graduate engagement

of 32 programs report staff engagement

* one program not currently training, has not trainees to report

Impact and Effectiveness: Recent publications

- **Impact of Kenya's Frontline Field Epidemiology Training Program on Outbreak Detection and Surveillance Reporting: a Geographical Assessment, 2014-2017.** *Health Secur. 2021 May-Jun*
- **Field Epidemiology Training Programs contribute to COVID-19 preparedness and response globally.** *BMC Public Health 2022 Jan*
- **Strengthening the global one health workforce: Veterinarians in CDC-supported field epidemiology training programs.** *One Health 2022 Mar*
- **A Comparative cross-sectional evaluation of the Field Epidemiology Training Program – Frontline in Ethiopia.** *BMC Public Health 2022 May*
- **Evaluation of the first two Frontline cohorts of the Field Epidemiology Training Program in Guinea, West Africa.** *Hum Resour Health 2022 May*

FETP Challenges

- Program institutionalization within MOH or national public health institute
  - Organizational integration
  - Technical and administrative oversight
  - Stable financing

- Challenges for career path for FETP graduates

- Hard to network and innovate
  - Scientific conferences
  - Networking platforms
  - Accreditation
  - E-learning platforms

Thank you

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The African Field Epidemiology Network (AFENET) – Experience sharing on capacity-building

Dr. Kevin Mugenyi

6th October 2022

AFENET
African Field Epidemiology Network
A healthier Africa

What is AFENET?

- **A** non-profit organization and networking alliance dedicated to helping Ministries of Health in Africa build strong, effective and sustainable programs and capacity to improve public health systems
- **N**etwork of Field Epidemiology and Laboratory Training Programs (FELTPs) in Africa

Vision

A healthier Africa

Mission

Committed to ensuring effective prevention and control of epidemics and other priority public health problems in Africa

Objective

- To strengthen field epidemiology and public health laboratory capacity and, effectively contribute to addressing epidemics and other major public health problems in Africa

AFENET
African Field Epidemiology Network
A healthier Africa

AFENET's Strategic Priorities

01 Field Epidemiology Capacity Development

02 Public Health Laboratory Capacity Development

03 Public Health Disease Surveillance & Effective Response

04 Public Health Program Management & Research Development

05 Networking & Collaboration For Public Health Advancement

06 Documentation & Publication For Public Health

07 Promoting the 'One Health' Approach

AFENET
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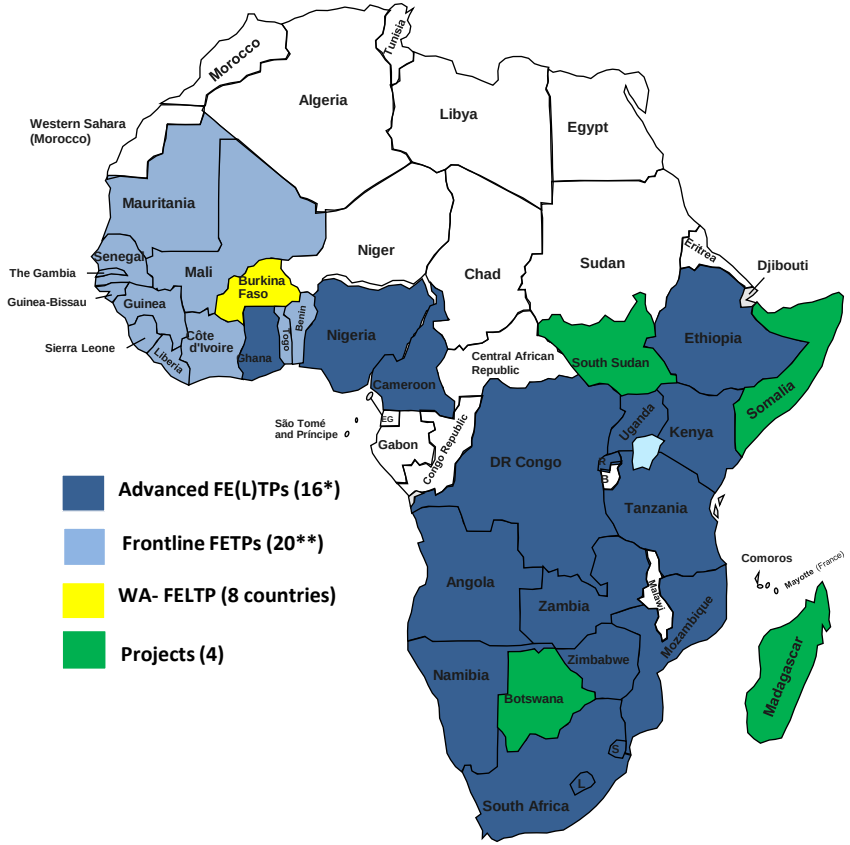
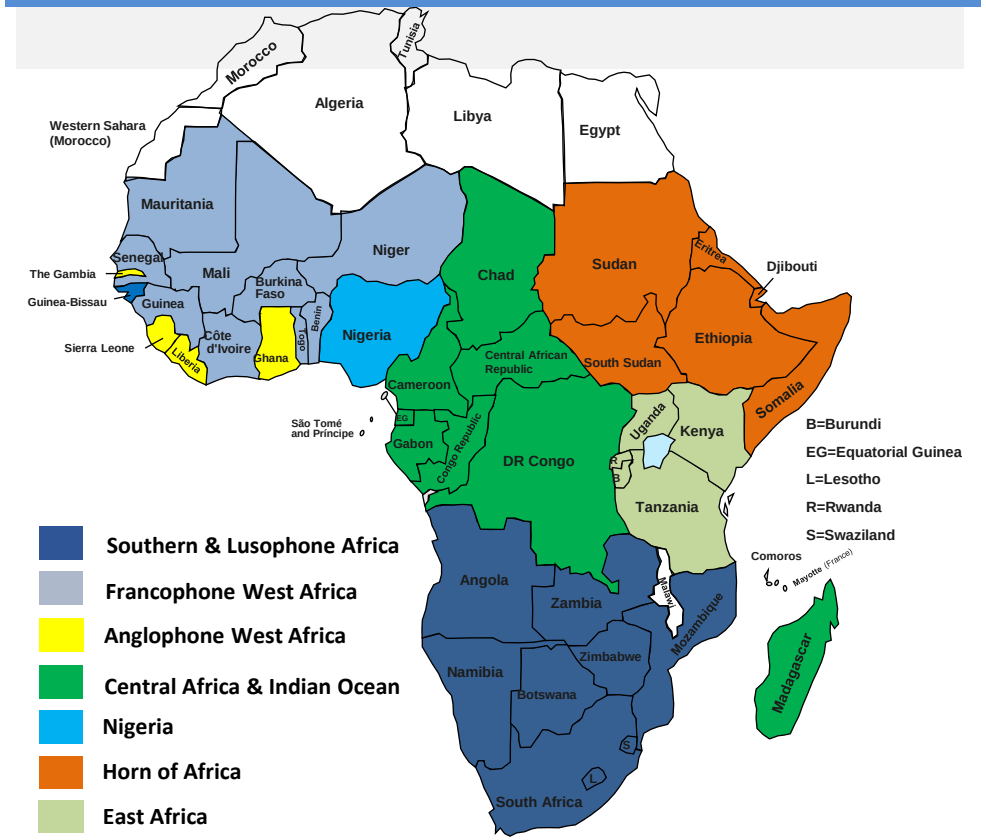
Footprint in Sub-Saharan Africa



AFENET Regionalisation



*8 countries have Frontline FETP
** 6 Countries have Intermediate

www.afenet.net

AFENET
African Field Epidemiology Network
A healthier Africa

Polio Eradication and Immunization Systems Strengthening – Examples of Initiatives Supported

- NSTOP Nigeria
- Polio Outbreak response- Africa
    - 20 countries including – Benin, Cameroon, Chad, Ghana, DRC, Liberia, Mali, Madagascar, Chad, Kenya, Malawi, Tanzania, Uganda, Zambia
- NSTOP South Sudan
- Civil Registration and Vital Statistics (CRVS) – Zambia
- Immunization Data Improvement Teams (DIT) - Uganda
- START – Kenya, Uganda, Ethiopia
- 2YL-Ghana
- Data Quality project Kenya
- International STOP training with CDC, WHO

International STOP & Field work, Nigeria NSTOP

Capacity building - Improvement of EPI Data Quality in Uganda through the Data Improvement Teams (DIT) Strategy

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Presentation outline

- Background
- DIT objectives
- Methodology
  - DIT strategic approach
  - Monitoring & evaluation
- Results from 2 rounds of DIT implementation to date
  - Knowledge and skills
  - Immunization data quality
- Best practices and lessons learned
- Discussion

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Background

- Data Quality Self-Assessment (DQSA) conducted August 2013
- Data Improvement Team (DIT) strategy was developed to implement recommendations from the DQSA by the Uganda Ministry of Health (Resource Center and UNEPI) with support from partners – WHO, UNICEF, CDC and GAVI
- The DIT strategy was launched in 2014 using a cascading approach and rolled out one region at a time
  - National TOT, Regional trainings, Health Facility mentorship
  - Phase 1 from 2014-2016; Phase 2 from 2016-2020
  - Inception – training materials developed with MOH, WHO, UNICEF, EPI partners. Stakeholder meetings to develop agreed strategy
  - Funding – multi-partner - WHO, UNICEF, CDC and GAVI
  - Standardized training package used across all regions, improvements made from first set of 'pilot' regions

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Key DIT Objectives

- Develop capacity of district and health facility level staff to improve the quality and use of routine immunization data
  - Identify root causes of routine immunization data quality and use challenges
- Build sustainability, ownership and understanding of the importance of immunization data at all levels
- Develop specific, targeted recommendations that are actionable and result in sustainable improvement

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Methodology: **DIT Team Composition**

- Members of Data Improvement Teams are deployed in pairs and include district and sub-district staff
  - **District Biostatistician, District Surveillance Officer, District EPI Focal Person**, and in some districts also **sub-district staff**

- One officer from the Makerere University School of **Public Health (MSPH)** or **Health Informatics (MSHI)** is assigned as a member of the Data Improvement Team in each district

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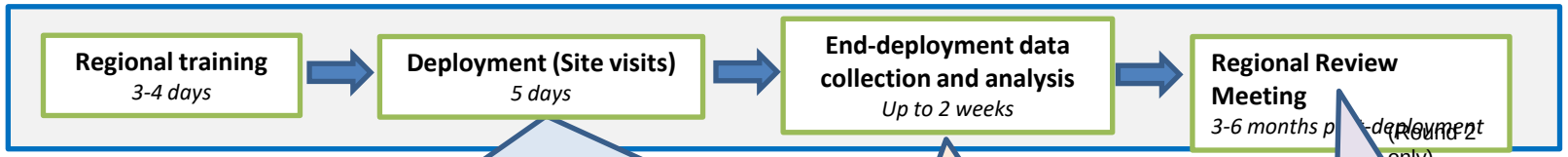
Methodology: DIT Strategic Approach



Key activities

DIT members:

- Conduct data quality activities at district and health facility level
- Identify, document and implement site-specific data quality improvement activities based on assessment findings
- Report shortages of national immunization guidelines and tools

National supervisors *(~ 20% of site visits are accompanied by a national supervisor):*

- Provide feedback to DITs on their interactions with district and health facility staff
- Gain insight on the types of successes and challenges for DITs during deployments

Key activities

MSPH officer:

- Clean and analyze deployment data by district
- Write end-deployment report and share with DHO

DIT members:

- Conduct post-deployment meeting with DHO

Key activities

DIT members:

- Present on data quality improvement efforts after DIT deployment
- Discuss on-going successes and challenges with data quality
- Document agreed action points to address remaining gaps in data quality

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Regional Training – Jinja (I) Region

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Regional Training – Gulu Region

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Regional Training – Facility field practicum, Mubende Region

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Field Deployment – Greater Kampala (II) Region

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Field Deployment (II) – Greater Kampala Region

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Field Deployment – Lobalangit HC II, Karenga district, Karamoja

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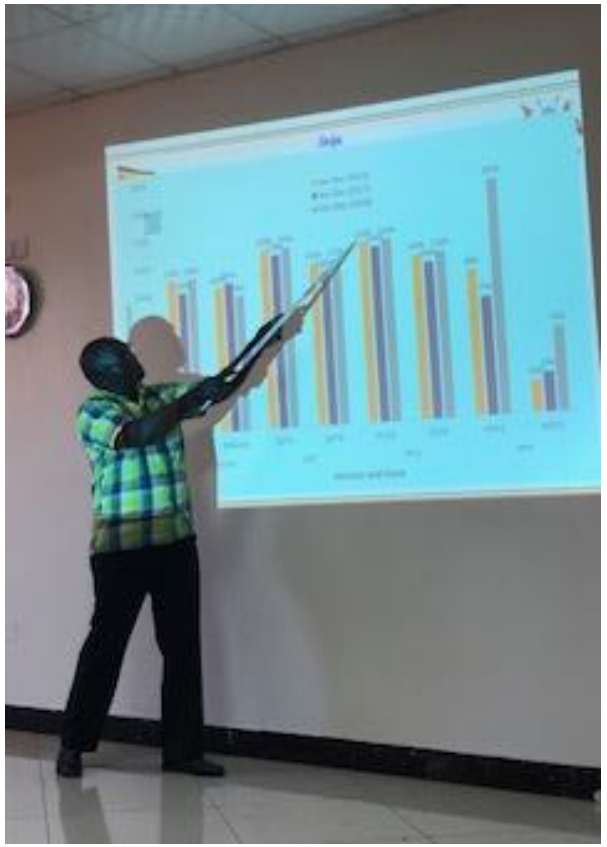
Regional Review Meeting – Jinja Region



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Methodology: **DIT Monitoring and Evaluation**

- Objectives
  - To continuously assess implementation quality and progress toward desired goals and objectives
  - Identify and document best practices, challenges and improvement strategies for DIT implementation

- Tools used to identify gaps in routine immunization data management practice and data quality:
  - *District Level Checklist*, *Health Facility Checklist* and *Data Quality Improvement* (DQI)

- Smart phones for data entry, LINKS app, reporting templates

- Health facility, district and regional level data analysis is conducted using Tableau to observe changes between Round 1 and 2

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RESULTS FROM ROUND 1 AND 2 OF DIT IMPLEMENTATION

Round 1 and Round 2 implementation status

	Round 1 (2014-2016)	Round 2 (2016 to 2020)
No. of regions	17	17
No. of districts	112 districts + 5 Kampala divisions	123 districts + 5 Kampala divisions
No. of health facilities	3443 *(89% of all immunizing facilities)*	3,882 (97% *of all immunizing facilities*)
No. of DITs trained and deployed	438	750
Average time spend on data collection at HF	1 hour 5 minutes	1 hour 22 minutes
Average time spend on mentorship at HF	1 hour 37 minutes	1 hour 40 minutes

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Standard Immunization Tools – Health facility level

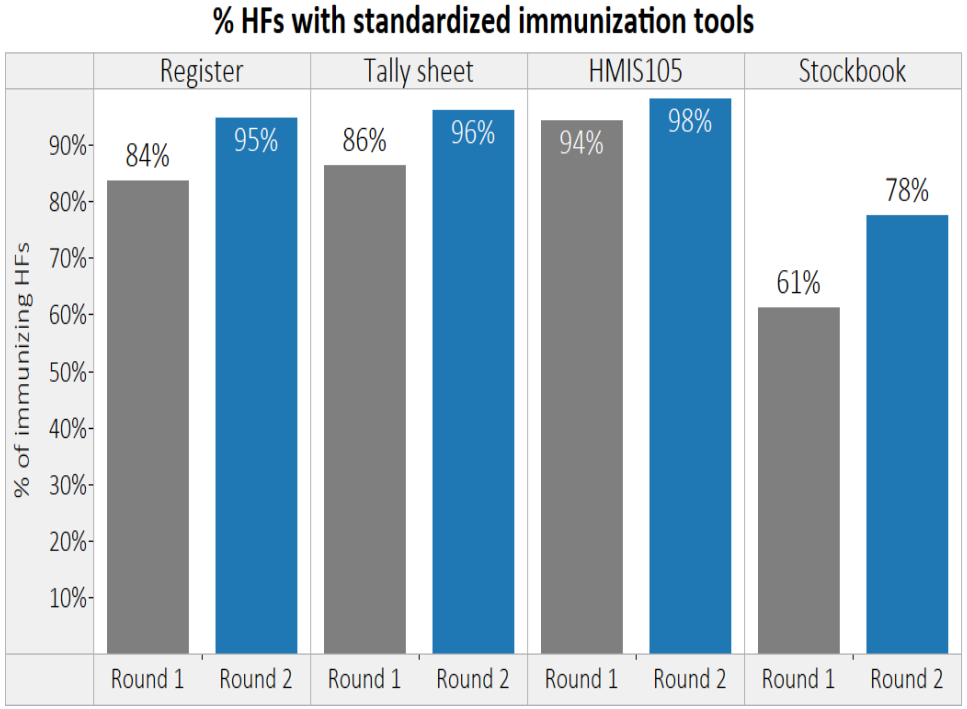
For health facilities that are visited in both Round 1 and Round 2 ***(N= 3221)***

Indicator: Standardized Immunization Tools

Definition:
Standard immunization tools refer to EPI tools that have been designed, developed and issued by the Ministry of Health, as described in the MoH HMIS health facility procedure manual, and include:

- Immunization Child Register (HMIS Form 073)
- Child Tally Sheet (HMIS Form 076)
- Health Unit Monthly Report (HMIS 105)

17 Regions



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Archiving – District level

For districts in regions that are covered in both rounds of DIT implementation (17 regions to date)

Selected Key Indicator	Indicator definition
Archiving: Proportion of districts with paper copies of the HMIS105 forms archived and easily accessible	The district must: 1) Have monthly HMIS 105 forms safely filed e.g. in a box file, and the file must clearly be labeled 2) HMIS 105 forms in the files should be arranged in chronological order, with the most recent month's form placed at the top 3) HMIS 105 forms should stored in a safe place, e.g. a storage shelf or filing cabinet, and must be easy to retrieve when required

Round 1 (2014-2016)	Round 2 (2016 2020)	Potential reasons/factors contributing to the change/observation
87/116 **(75%)**	99/128 **(77%)**	• Inadequate resources to purchase files for storage of forms • Inadequate attitude towards record keeping • Lack of knowledge by newly recruited staff on standard archiving practices • Inadequate external and internal supportive supervision and follow up at all levels • Low motivation to routinely conduct standard data archiving practices

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Example - Archiving finding at field visit – District level (Phase 1)

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R.I. data use for action – District level

For districts in regions that are covered in both rounds of DIT implementation (17 regions to date)

Selected Key Indicator	Indicator definition
Proportion of districts with documented evidence that routine immunization data is used to inform EPI activities	The district must: 1) Have at lease ONE of the following examples of analyzed data: RED Categorization, immunization monitoring chart, catchment area maps completed following micro planning etc. 2) Have at least ONE example of action taken based on analyzed facility data (e.g. monthly meeting minute, other documentation). Probe for explanation of how analyzed data use for action

Round 1 (2014-2016)	Round 2 (2016-2020)	Potential reasons/factors contributing to the change/observation
78/116 **(67%)**	101/128 **(79%)**	• Inadequate knowledge on EPI data analysis and use • Inadequate attitude/apathy towards data analysis and use • Insufficient feedback from supervisors on data submitted to the next reporting level • Inadequate external and internal supportive supervision and follow up at all levels

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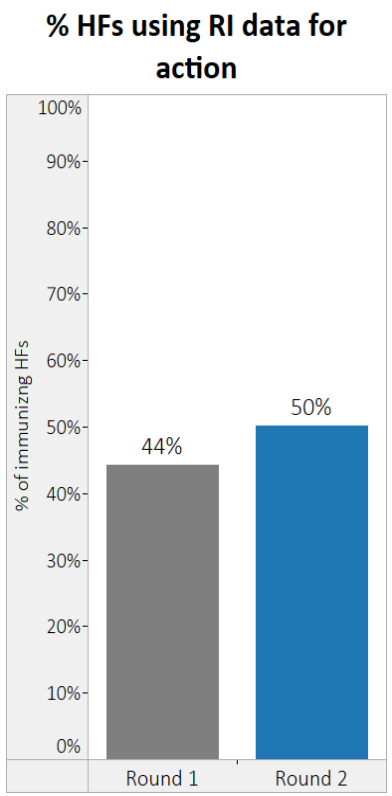
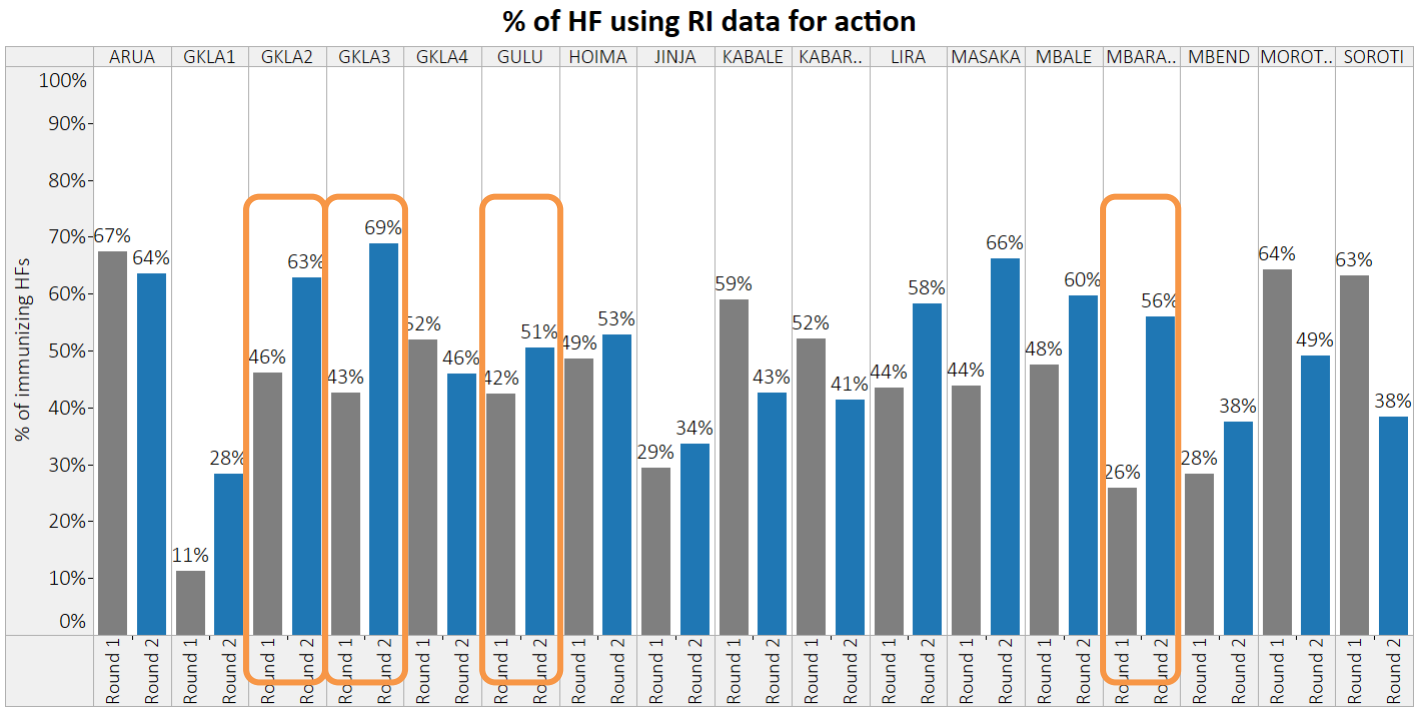
R.I. data use for action – HF level

17 Regions Overall

For health facilities that are visited in both Round 1 and Round 2 (N= 3221)



By Region



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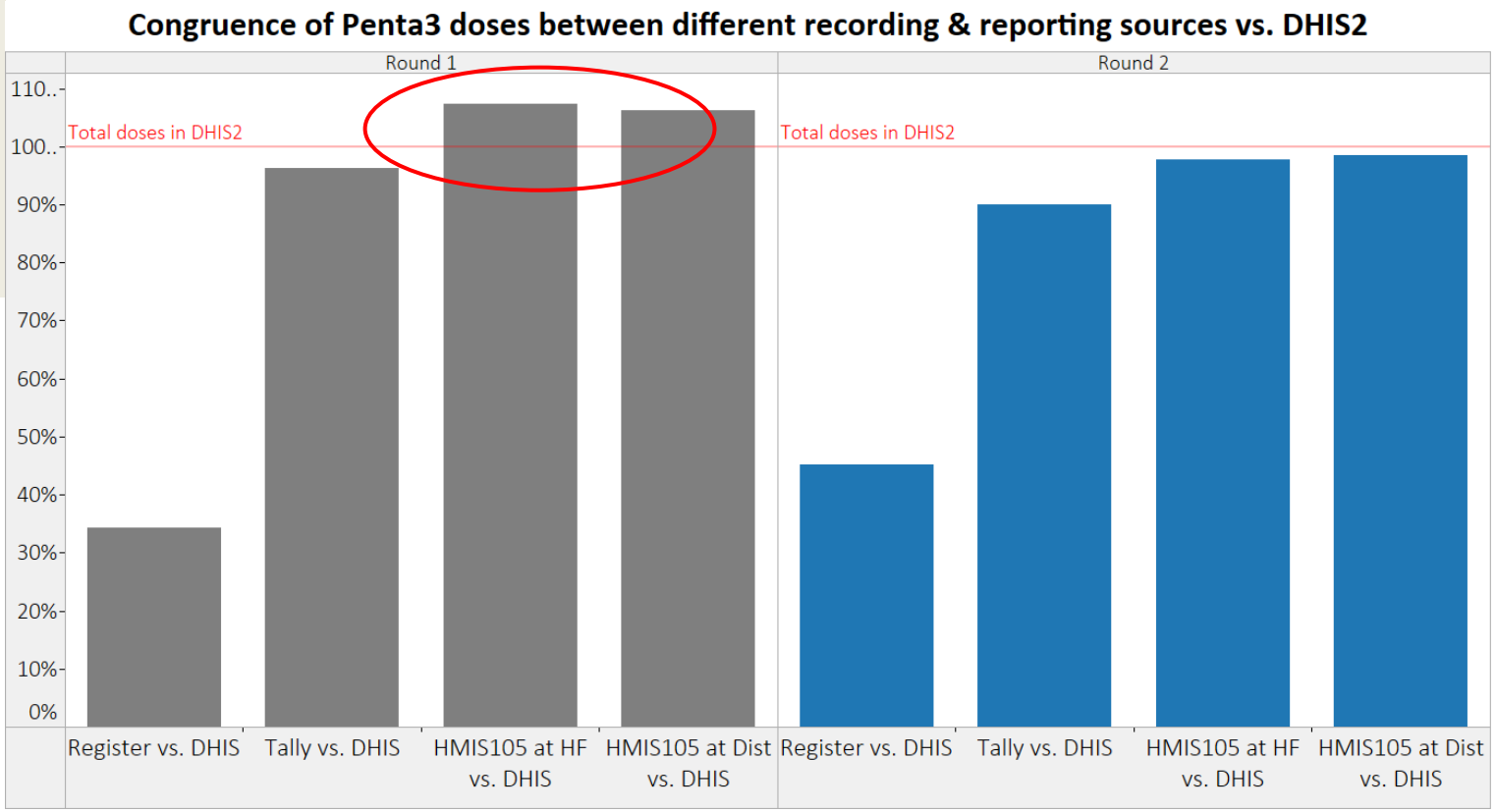
Immunization Data Congruence – All 17 Regions, DPT3

17 Regions Overall *(for one assessment month)*



Data agreement for Penta 3 doses in round 2 improved, especially between DHIS and the HMIS105 forms. However, the use of child register is still low.

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Field deployment - Assessing records for data congruence, Otuke District

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BEST PRACTICES AND LESSONS LEARNED

Best practices: District

- Improved data archiving at the district level

Abim District

Best practices: Health Facility Level

Before Visit

During Visit

After Visit

Before Visit

During Visit

During Visit

After Visit

Photo from health facility in Jinja region, Nov 2017

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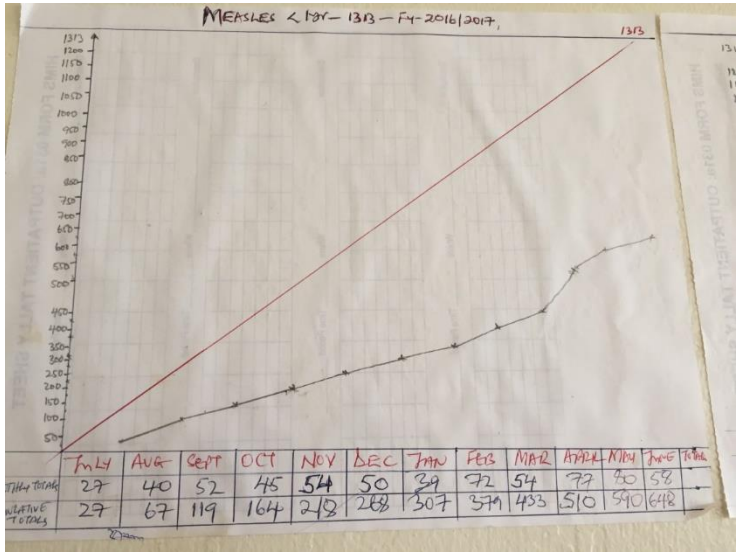
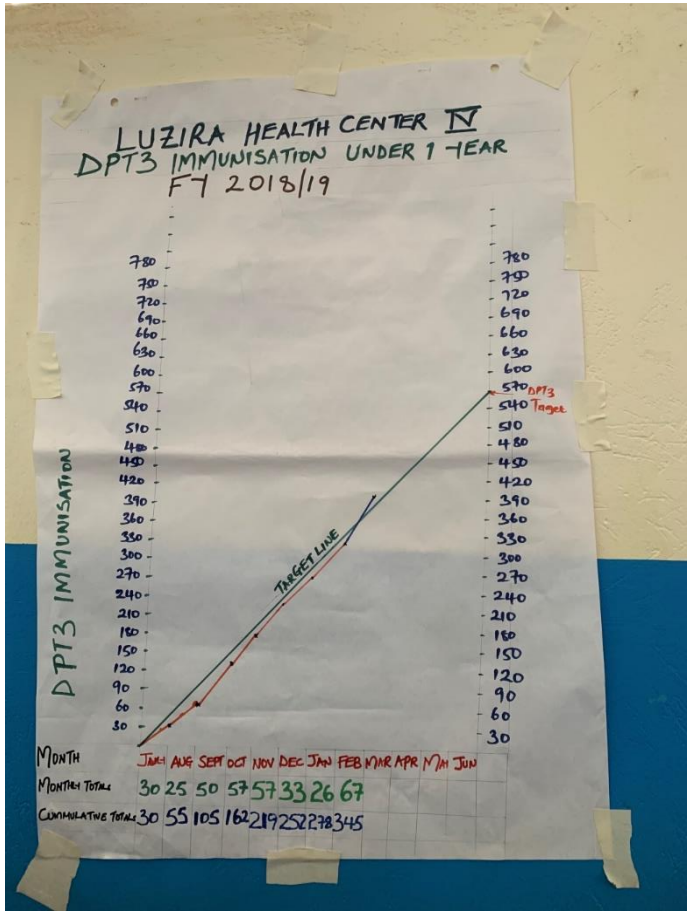
Best practices: Health Facility Level





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Best practices: Health Facility Level analysis

2016/2017

2017/2018

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Challenges

- Competing national priorities
- Human resource gaps in health facilities - workload
- Funding constraints
- Needed to increase number of days of trainings due to increasing training content
- High costs of field deployment, national supervision
- Sustainability – long term

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Lessons learned (1)

- During Round 2 DIT training, overall 70% district level staff were newly trained
- Key DIT roles:
  - 64% EPI Focal Persons are newly trained
  - 51% Biostatisticians are newly trained
  - 45% Surveillance Focal Persons are newly trained
- Infrequent supportive supervision on data management and data quality
- High workload at large facilities making it difficult to document all children – perceived need for technology – 'SPT' roll out
- Absence of guidance on how to document transit children in immunization registers
- Very few HFs monitor coverage and drop out
  - Immunization monitoring charts needs to be visible, correctly charted **and** up-to-date

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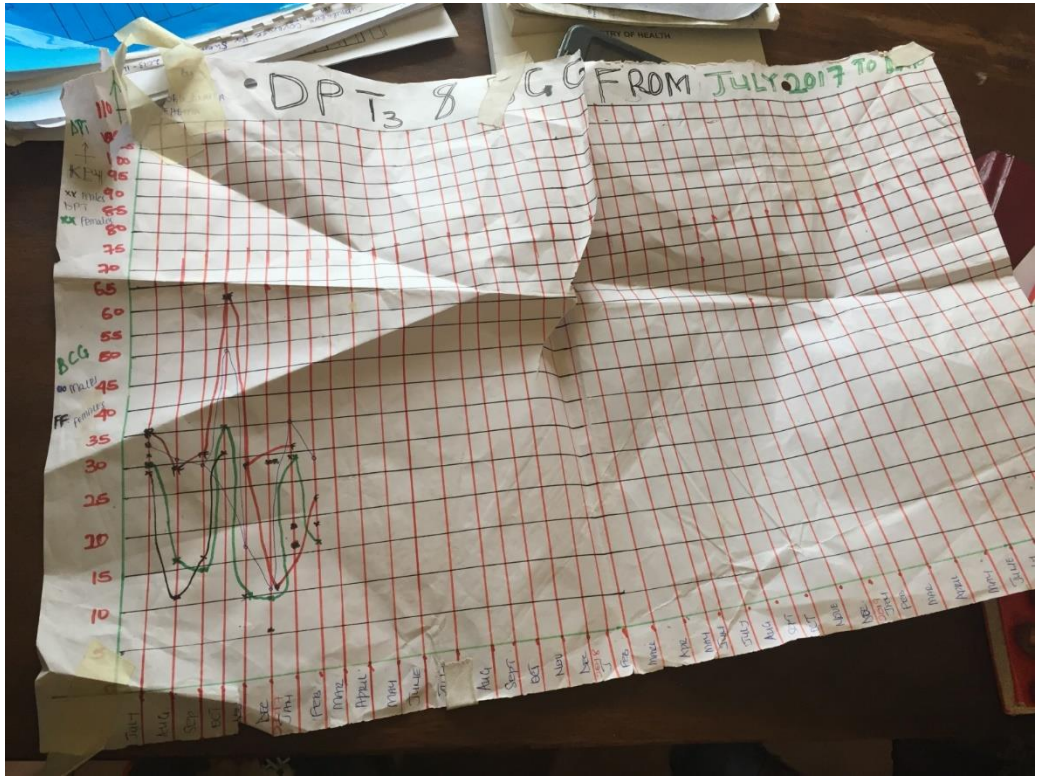
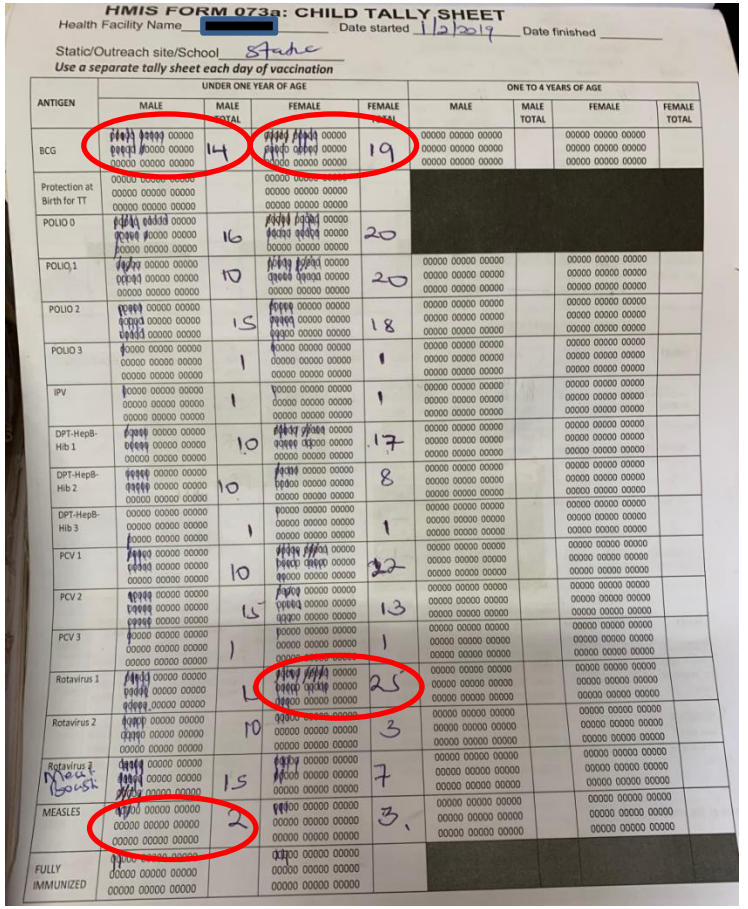
Lessons learned (2)

Need for continuous training & mentorship…..





HMIS FORM 073a: CHILD TALLY SHEET

Health Facility Name [redacted] Date started 1/2/2019 Date finished

Static/Outreach site/School Stadie

Use a separate tally sheet each day of vaccination

ANTIGEN	UNDER ONE YEAR OF AGE				ONE TO 4 YEARS OF AGE			
	MALE	MALE TOTAL	FEMALE	FEMALE TOTAL	MALE	MALE TOTAL	FEMALE	FEMALE TOTAL
BCG	14		19					
Protection at Birth for TT								
POLIO 0	16		20					
POLIO 1	10		20					
POLIO 2	15		18					
POLIO 3	1		1					
IPV	1		1					
DPT-HepB-Hib 1	10		17					
DPT-HepB-Hib 2	10		8					
DPT-HepB-Hib 3	1		1					
PCV 1	10		22					
PCV 2	15		13					
PCV 3	1		1					
Rotavirus 1	15		25					
Rotavirus 2	10		3					
Rotavirus 3 Dear Lousi	15		7					
MEASLES	2		3					
FULLY IMMUNIZED								

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Conclusions

- System-level change is **not immediate** and happens over a period of time – pressure to achieve rapid impact
- **Improvements** in some districts have been observed in knowledge, skill, and practices between Round 1 and Round 2 time points
  - There is some improvement in **data congruence** across different immunization reporting and recording tools
- The **use of child register** was low across the 2 time points
- Reach of DIT was high – all 128 districts and almost all immunizing health facilities (>90%) have been reached, presenting a great opportunity for capacity building
  - **Sustainability discussions** for subsequent phases

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Recommendations

- **Continuous mentorship** and training are needed to improve data quality and use, given high staff turnover
- **Routine supportive supervision** including EPI data quality checks should be considered
- **Guidelines/SOPs** need to be provided to health workers on how to use child registers
- **Further studies** needed to better understand factors impacting immunization data quality
- **Sustainability** is key – integrate activities in District Work Plans

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Acknowledgement

- Uganda MOH – UNEPI & DHI
- District Health Offices/ Local Government staff
- US Centers for Disease Control & Prevention
- GAVI
- WHO
- UNICEF
- Partners – JSI, CHAI, PATH, Makerere School of Public Health

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THANK YOU!

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Closing remarks

Riitta Dlodlo

Senior Advisor, The Union

The Union

International Union Against Tuberculosis and Lung Disease

Health solutions for the poor

CDC

Centers for Disease Control and Prevention

Thank You

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International Union Against Tuberculosis and Lung Disease

Health solutions for the poor

CDC

Centers for Disease Control and Prevention