THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

UGANDA NATIONAL EXPANDED PROGRAMME ON IMMUNISATION (UNEPI)

IMMUNIZATION PERFORMANCE REPORT

Prepared and Submitted by

Uganda National Expanded Programme on Immunization (UNEPI)
World Health Organization (WHO)
United Nations Children's Fund (UNICEF)
Clinton Health Access Initiative (CHAI)
Programme for Appropriate Technology in Health (PATH)
African Field Epidemiology Network (AFENET)

Introduction

2020 has been marked by unprecedented crisis caused by COVID-19 disease. Uganda declared the first case of Covid-19 in March 2020. Though the longer-term trajectory of the pandemic remains uncertain, evidence shows that immunisation services in Uganda have been disrupted. Uganda had the opportunity to re-allocate or re-programme existing HSS to respond to immediate needs presented by the COVID-19 pandemic. Although the Country developed and implemented a short-term recovery plan for immunization, evidence shows that the number of un and underimmunised children remain high. If effective recovery plans are not developed and implemented, the cumulative number of children who miss vaccinations will increase, likely leading to resurgence of VPDs, further exacerbating existing inequities and putting the most marginalised and vulnerable communities at greater risk.

As a platform to plan in the context of Covid-19, in place of Joint Appraisals, a Multi Stakeholder Dialogue (MSD) was planned. It is particularly critical for 2020 review as a forum for engagement on how the Gavi Alliance partners and other stakeholders can support countries as they deal with the different phases of the COVID-19 pandemic and seek to maintain and restore primary health care, including immunisation services that have been disrupted. This dialogue reviewed the immunisation programme performance in the last quarter of 2019 (and the whole of 2020 in light of COVID-19 pandemic), the impact of the COVID-19 pandemic on immunisation, discussed the needs for maintaining and restoring immunisation services in the context of primary health care, plan for short-term catch-up activities and, created a roadmap for further re-allocation/planning within the country's recovery plan.

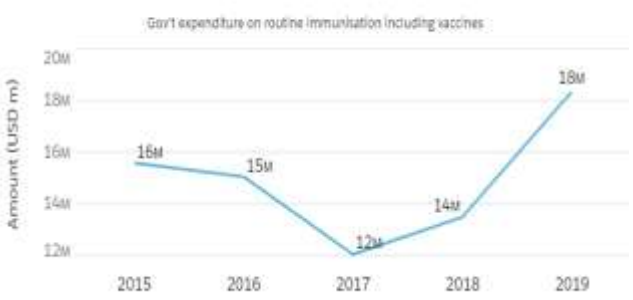
1. Country situation pre-COVID-19

Contextual Information

PEF Tier: Tier 1 | Fragility Status: Non-fragile | 1. Initial self-financing

Indicator Name	Year	Source	Value
GNI per capita	2019	World Bank	780
Health Centres per 100k population	2013	WHO - GHO	3.9
Nurses/Midwives per 1000 population	2018	WHO - GHO	12
Population	2020	UNPD	45,741,000
Surviving Infants	2020	UNPD	1,599,420
Under-5 mortality (per 1000)	2018	UNICEF	46

Health financing (and trends)



While Uganda's GNI per capita for 2019 was **$780**, which is a 4% increase from 2018, it was $750 in 2018 which a 1.35% increase from 2017[1].

In the last 3 years there has been some improvement in the financing of routine activities and vaccine procurement immunisation by GoU. Approximately 70% percent is for procurement and co-financing of vaccines and 30% to operational cost including staff salaries[2]. Despite the increased financing there still remains funding gaps in the areas of

- Vaccine and logistics delivery and Cod chain maintenance at operational level
- Equitable immunisation services to the community
- Supervision and monitoring
- Data tools procurement
- Sustained demand creation

1.1. **Overview of performance of vaccine support** (end of 2019/early 2020; pre-COVID-19)

Year	Introduction Date	2017 (coverage %)	2018 (coverage %)	2019 (coverage %)
DPT-Hib-HepB	**06-2002**	**93**	**93**	**93**
PCV	**04-2013**	**90**	**91**	**92**
HPV	**11-2015**	**59**	**75**	**65**
IPV	**04-2016**	**70**	**84**	**88**
Rotavirus[3]	**06-2018**		**36**	**88**

Currently, Gavi provides in-kind support for 6 vaccines in Uganda including: DPT-Hib-HepB, Pneumoccocal Conjugate Vaccine, Human Papilomavirus Vaccine, Inactivated Polio Vaccine, Rotavirus vaccine and the Rubella Component on Measles-Rubella Vaccine. The Measles – Rubella Vaccine was introduced in Oct-2019 and its use doesn't apply to the precovid-19 vaccine period. Generally, except for DPT-HiB-HepB that stagnated at 93%[4] for three years, vaccination Coverage for other vaccines improved progressively from introduction date until 2019.

[1] World Bank national accounts data, and OECD National Accounts data files, 2020
[2] Gavi country reports 2020
[3] Introduced in June 2018
[4] EPI Administrative data 2019

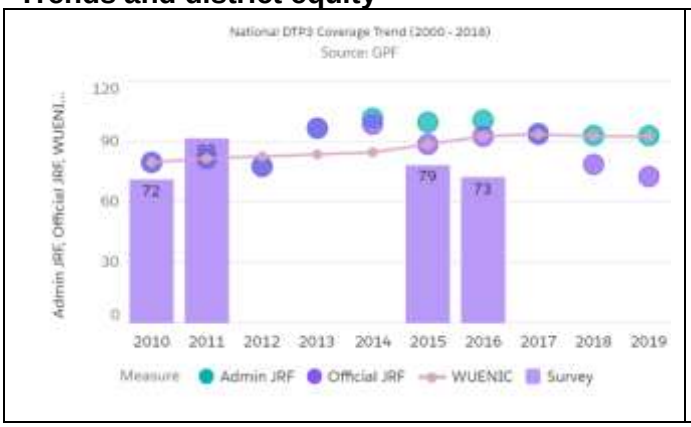
Performance against Alliance KPIs

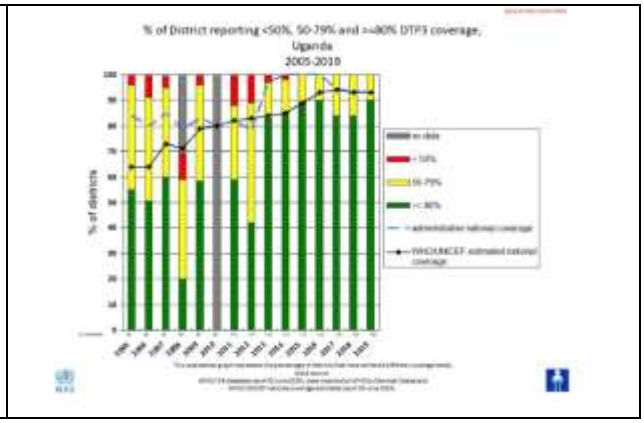
Indicator	Source Name	Year	Value	Previous Value	Trend
Pentavalent 3 coverage at the national level (Penta 3)	WUENIC	2019	93	93	→
Drop-out rate between Penta1 and Penta3	WUENIC	2019	6.1	6.1	→
Difference in Penta3 coverage between children of urban and rural residences	Survey	2015	-1.8	4.6	▲
Difference in Penta3 coverage between the highest and lowest wealth quintiles	Survey	2016	0	0	→
Penta3 coverage difference between the children of educated and uneducated mothers/care-takers	Survey	2016	0	3.1	▲
EVM	EVM	2018	87.6	68.7	▲
# of Underimmunised Children	Calculated	2019	123647.93	120993.6	▼

Comparing performance in Alliance KPIs for the pre - COVID-19, we observe that while drop-out rate between penta1 and penta3 stagnated at 6.1%, difference in coverage between urban and rural as well as among educated and uneducated mothers decreased hence reducing inequities associated with rural/urban and educated/uneducated characteristics. In addition, the composite EVM score improved from 69% in 2014 to 88% in 2018. However, the number of underimmunised children increased. It is important that the numbers of unimmunized children are reduced in line with the reduction of zero dose children strategy. Some of new interventions that will be used to address these challenges are:

- Coverage and equity to reduce the un and underimmunised through:
  - Focusing on zero dose, underserved and marginalized communities
  - Implementation of urban strategic interventions
  - Strengthen supervision mechanisms at regional, district and health facility
- Demand creation and community mobilization
  - Revamp tracking mechanisms using Parish chiefs and their lower levels structures
  - Use of LC, VHTs and Parish Chiefs for registration of children, defaulter tracking and creation demand/awareness
- Improving vaccine and logistic equity
  - Implement Last Mile Delivery of vaccines to health facilities
  - Continued advocacy for additional funding for vaccines procurement and distribution
  - Map cold chain equipment to ensure improved equitable access to communities
- Improving data utilization for action at health facility to identify zero dose and underimmunised children
  - Through rolling out the immunization apps in DHIS2 and triangulate with surveillance data
  - Advocate for government support in procurement of data tools

Trends and district equity





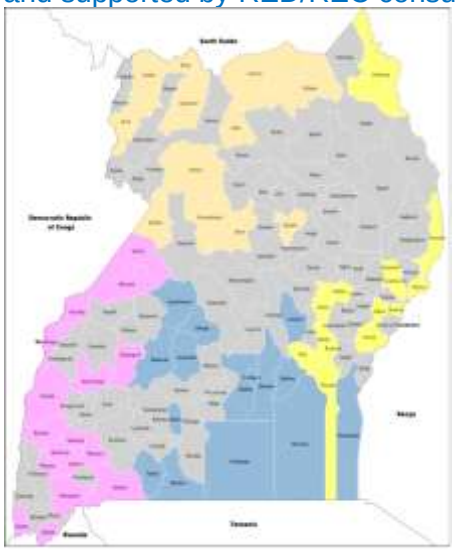
While the survey estimates of coverage at national remained below 80% between 2015 and 2019, the WUENIC and Official estimates remained above 90% over the same period. Over the years, the proportion of districts achieving over 80% improved until 2016, after which it declined in 2017

and 2018 with observable improvement in 2019. The decline in 2017 and 18 is associated with a data quality improvement activity that was implemented. From 2015 to 2019, no district achieved below 50% coverage.

MoH and partners conducted a coverage and equity analysis in 2018. The analysis identified 22 districts with inequities; Apac, Bududa, Bukomansimbi, Bulambuli, Bushenyi, Dokolo, Kaliro, Kampala, Kitgum, Kyotera, Mayuge, Mbarara, Mitooma, Ntungamo, Nwoya, Pallisa, Rubirizi, Sheema, Tororo, Wakiso, Iganga and Amudat districts. Among these districts, there are 4 urban districts namely Kampala, Wakiso, Iganga and Mbarara. Additional 36 districts with large numbers of unimmunised, hard to reach/island communities, refugee hosting districts and urban settlements were also prioritized to ensure equity immunisation services in order to sustain and improve immunisation coverage. Previous experience shows shifting inequities if previously supported poorly performing districts that had shown improvement derail to poor performance if sustenance measures are not instituted. A total of 58 districts were supported during the period 2019/2020 through UNICEF namely:

Inequities /Unimmunised Apac, Bududa, Bugiri, Bugweri, Buhweju, Buikwe, Bukomansimbi, Bukwo, Bulambuli, Bullisa, Bushenyi, Buyende, Dokolo, Gulu, Hoima, Iganga, Kaliro, Kamuli, Kassanda, Kitgum, Kyankwanzi, Kyotera, Luuka, Mbale, Mitooma, Mubende, Mukono, Namutumba, Ntoroko, Ntungamo, Pallisa, Rakai, Rubirizi, Sheema,Tororo
Hard to reach/Islands/unimmunised Kabale, Kaboong, Amudati, Bundibugyo, Kapchorwa, Kasese, Kisoro, Buvuuma, Kalangala, Mayuge, Namayingo
Refugee /Inequities Nwoya, Kyegegwa, Lamwo, Moyo, Yumbe, Adjumani, Arua, Isingiro, Kamwenge, Kikuube, Kiryandongo,
Urban / unimmunised /Inequities Kampala, Jinja, Mbarara, Wakiso

58 districts identified with inequities and supported by RED/REC consultants



The inequities identified include:

Affected group	Inequity identified
Urban poor settlements	Few public HFs, paid costs, transport costs, busy caretakers and mobilisers
Migrants tribes	Fixed posts, low mobilisation, not attached to VHTs

Ethnic minorities	Not included in plans, poor road network, low mobilisation
Some religious groups/sects	Lack of communication, low mobilisation & sensitization
New settlements	Not included in micro plans
Fishing communities	Mobile, Not included in micro plans
Refugee communities	Communication & Language, forecast and planning
Remote communities	Not included in micro plans, poor access, inadequate funds

The districts have been supported in REC microplanning, supportive supervision and mentorships, re-establishing Health Unit Management Committees, community mobilization using Village Health Teams (VHTs), and bridging financial gaps identified in the micro plan. Some of the lessons learnt in implementation in the districts with inequities include:

- Need to strengthen integrated health service delivery with immunisation for optimal resource utilization
- Use of blended onsite mentorship with group face to face learning sessions to scale quickly and share new ideas across all health facilities
- Facilitating defaulter tracking through child registration by VHTs; solves the denominator problem, allows for child follow up and creates demand and awareness for immunisation
- Good district leadership is a key driver to good routine immunization performance. Operationally the performance of EPI focal persons is greatly influenced by their immediate supervisors (District Health Officers, In-charges health facility)
- Periodic dissemination of national routine immunization performance via different platforms (i.e. newspapers, emails, SMS alerts and regional performance review meetings) provides a great opportunity to strengthen participation and involvement of non-health stakeholders at all levels of service delivery
- For mountainous regions like Bukwo, Kapchorwa, Bulambuli and some parts of Mbale, mobilization of the community is best done using a megaphone rather than sending radio messages or phone calls as some slopes don’t get signals.

Progress against indicators and targets achievement

Vaccine Programme	Source (2019)	Intermediate results Indicator	Reported actuals	Rel. % change
PNEUMO	Admin (JRF)	Number of surviving infants who received the first recommended dose of PCV vaccine (PCV1)	1,728,523	4%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of PCV vaccine (PCV3)	1,597,264	4%
PENTA	Admin (JRF)	Number of surviving infants who received the first recommended dose of pentavalent vaccine (Penta1)	1,792,632	7%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	1,616,454	4%
MCV	Admin (JRF)	Number of children in the target population who received the second recommended dose of measles containing vaccine (routine) (MCV 2)	NA	NA
	Admin (JRF)	Number of surviving infants who received the first recommended dose of measles containing vaccine (MCV1)	1,506,849	12%
IPV	Admin (JRF)	Number of surviving infants who received the first recommended dose of IPV	1,523,291	9%
All others	EVMA Reports	Effective Vaccine Management Score (composite score)	NA	NA
	JRF	Occurrence of stock-out at national or district level for any Gavi-supported vaccine	No	NA
	Admin (JRF) & Survey	Percentage point difference between Penta 3 national administrative coverage and survey point estimate	NA	NA

Relative % change refers to the percentage increase/decrease of the reported value from the year prior.
The cell is green when the relative change increased, yellow when it remained the same and red when the relative change decreased.

Based on the Admin Joint Report Format for 2019, there were improvements in all the indicators relative to achievements in previous years.

1.2. **Overview of HSS grant implementation** (end of 2019/early 2020; pre-COVID-19)

HSS implementation summary (as of 31 December 2020)

	Grant Amount	Recipient	Funds Disbursed	Expenditure	Country cash balance
HSS2 – Core	$30 600 000 + $841,387	MoH	$3 881 006	$4,322,710 (Note A)	(441,703)
		UNICEF CO	$11 224 220	9,334,515 (Including PSC)	1,889,705
		UNICEF SD (CCEOP Country JI)	$1 806 887.41	$1 806 887.41	NA
		UNICEF SD (COVID Reallocation)	$201 978	$201 978	NA
		Edes (FMA)	$1 169 834.38	$1 169 834.38	NA
HSS2 – C&E	$8 993 272	MoH	$1 664 602	-	$1,664,602
		UNICEF SD (COVID Reallocation)	$1 928 356.14	$1 928 356.14	NA
		UNICEF SD (Boats procurement)	$799 170	$799 170	NA
HSS2 – PBF	$1 456 000	MoH	$1 455 999	$1,199,479	$256,424
Total	**$41,049,272**		**$24,132,053**	**$20,762,929**	

Note A: The country has spent more funds on HSS2 program than what was disbursed by Gavi. The funds were drawn from the funds for the HSS2-C&E grant whose activities were delayed. The C&E funds will be replenished when Gavi disburses HSS2 funds.

HSS key milestones achieved in 2019

	Process Indicators			Intermediate Results		
	Indicator name	Value	Rel. % change	Indicator name	Value	Rel. % change
OBJ-1	Percent of health facilities offering integrated outreach including immunisation in the target areas - 29 districts (HSS additional)	NA	NA	Number of children vaccinated with Penta3 through outreach sessions	499938	NA
				Proportion of children vaccinated with DTP3 in the months in which CH days are conducted in relation to the total in the year	17	0%
OBJ-2				Full availability of vaccines	NA	NA
OBJ-3	Number of HF reporting through SPT and linked to DHIS2 (HSS additional)	22	NA	Percent of defaulter children traced and vaccinated in the selected 60 districts (HSS additional)	NA	NA
	Percent of facilities that submit HMIS reports on time	98	5%	Proportion of districts with consistent yearly variation of DTP3 coverage data (Compared to previous year)	77	NA
				Proportion of health facilities reporting data without outliers (internal data consistency)	NA	NA
OBJ-4				Implementation of audit recommendation	60	NA
OBJ-5	Number of community mobilisation rounds performed by van in selected districts (HSS additional)	0	NA			
	Number of recipients from target population who received USSD mobilisation messages (HSS additional)	0	NA			
	Number of VHTs supported to conduct mobilisation and registration of the target population in their catchment areas	NA	NA			
OBJ-6	Percent of Performance review meetings conducted at district level	NA	NA	Percentage of Staff who were appraised as 'good' or 'very good' or 'excellent'	NA	NA

Relative % change refers to the percentage increase/decrease of the reported value from the year prior.
Value cell color is green if target has been >= 90% met, yellow if 70-90% met, and red < 70% met.

The relative change was Not Applicable for most indicators due to the fact that the indicators were not measured in 2018. Most of the indicators we related to the coverage and equity grant which had not been implemented in 2018. The implementation of audit recommendations has been low. This was attributable to the instability of office bearers for Project Accountant and Grants coordinator. New office bearers were however recruited and implementation of audit recommendations remained an area of focus in 2020 and 2021.

Indicator type	Semi-standard indicator	Value	Rel. % change
Core	Percent of functional cold chain equipment	93	NA
	Percent of health facilities offering immunisation services	60	NA
	Percent of outreach sessions conducted against planned	79	NA

Color coding:
Value cell is green if target has been met and red if not.

Indicator type	CCEOP indicator	Value	Rel. % change
Core	CCE replacement/rehabilitation in existing equipped sites	23%	NA
	CCE extension in unequipped existing and/or new sites	15%	NA
	CCE expansion in existing equipped sites	3%	NA
	Percent of functional cold chain equipment	93%	NA

Color coding:
Value cell is green if target has been met and red if not.

Improvement in cold chain functionality and space remains an area of focus in Uganda's immunization system. Targets for all indicators were achieved. This is attributable to continuous improvements in cold chain arising from new investments through CCEOPI and HSSI grants.

1.3. Overview of other Gavi support, such as VIGs, OPS, PBF, switch grants, transition grants etc. (as applicable)

				In US$				
Grant	Start Date	End Date	Recipient	Grant Value	Disbursed	Expenditure	Cash balance	Status Update
CCEOP	2017	2021	UNICEF SD	10,911,038	6,642,472	6,642,472	0	UNICEF
MR (catchup) Op Costs	2019	15 Jul 2021	WHO	11,181,873	11,181,873	12,128,583	605,550	The balance was reprogrammed towards COVID response
MR 1st dose VIG	2019	15 Oct 2020	WHO	1,552,260	1,552,260			
MenA Op Costs	2016	15 Jul 2021	WHO	4 366 265	4 366 265	3,769,937	596,428	The balance was reprogrammed towards COVID response

1.4. Compliance, absorption and other fiduciary risk matters

- **Comments on financial absorption as of [31 Dec 2020]:**

Grant	Grant Amount	Funds Disbursed (Including Unicef & FMA)	Funds Absorbed	%age of absorption against funds disbursed	Summary of activities implemented.
HSS 2-Core	31,441,387	18,283,925	16,835,924	92%	• USD 11.1 used to procure various CCE by UNICEF. • USD 0.2M reprogramed towards C19 response. • USD 4.3 includes disbursements to Districts for routine immunization, ICHDs, and central level administrative expenses • USD 1.2M disbursed to FMA
HSS 2-C&E	8,993,272	4,392,128	2,727,526	62%	• USD 1.9 reprogrammed towards C19 Response. • USD 0.7M used to procure ambulance boats
HSS 2-PBF	1,456,000	1,455,999	1,199,479	82%	• USD 0.38M disbursed to NMS. • USD 0.67 used to implement Oct 2020 ICHDs • USD 66K used to carryout asset verification.
	41,890,659	**24,132,052**	**20,762,929**	**86%**	

- **Compliance with financial reporting requirements (periodic/annual financial reports, audits):**

Annual external audits are carried out by the Office of Auditor General and the report for financial year 2019/2020 was submitted to Gavi on 22 January 2021. In addition, UNEPI prepares and submits quarterly finance reports to Gavi.

- **Compliance with programmatic reporting requirements (GPF):**

Programmatic reporting is submitted via the Gavi country portal. The country has consistently provided update including updates on vaccine stock status.

- **Other financial management and fiduciary risk comments:**

The revised Grant Management Requirements issued by Gavi in June 2020, indicated that the Government of Uganda had addressed most of the GMRs. As a result, Gavi agreed to disbursement HSS and all other cash support through the Government of Uganda Systems. The Ministry of Health with support from the FMA is addressing the following outstanding GMRs:

- Conduct periodical performance assessments of the ICC and TCC to ascertain that their functioning as expected
- Optimisation of the the use of IFMIS to account for all funding under Gavi grants.
- Strengthen and develop an appropriate logistics management information system to allow better analysis of logistics data for decision making, and forecasting.
- Share with Gavi an Annual Cold Chain Equipment Maintenance Plan and an Annual UNEPI Cold Chain Supervision Plan

The oversight over immunization funds is provided by the Immunization Board/ICC which was established by the Immunization Act, 2017. Operational oversight is provided by the Technical Coordination Committee (TCC). These two structures meet on a quarterly to discuss matters relating to the immunization program. The Ministry has requested CHAI to conduct a performance assessment of these two structures.

The budgets for Gavi grants are captured in the National Budget and planning follows the Government of Uganda budgeting cycle. Ministry of Health communicates to the districts indicative planning figures for the activities to be implemented at district level to enable inclusion of the grants in the respective district budgets. UNEPI with support from the FMA monitors compliance with the approved budgets.

The Ministry of Health uses the Government Integrated Financial Management System (IFMIS) to account for Gavi funded Grants. MoH also uses the E-Cash module to pay allowances and per diem for trainings, and meeting events using mobile money. MoH with support from FMA is working with the MoFPED to optimize the use of IFMIS to support reporting and management of advances.

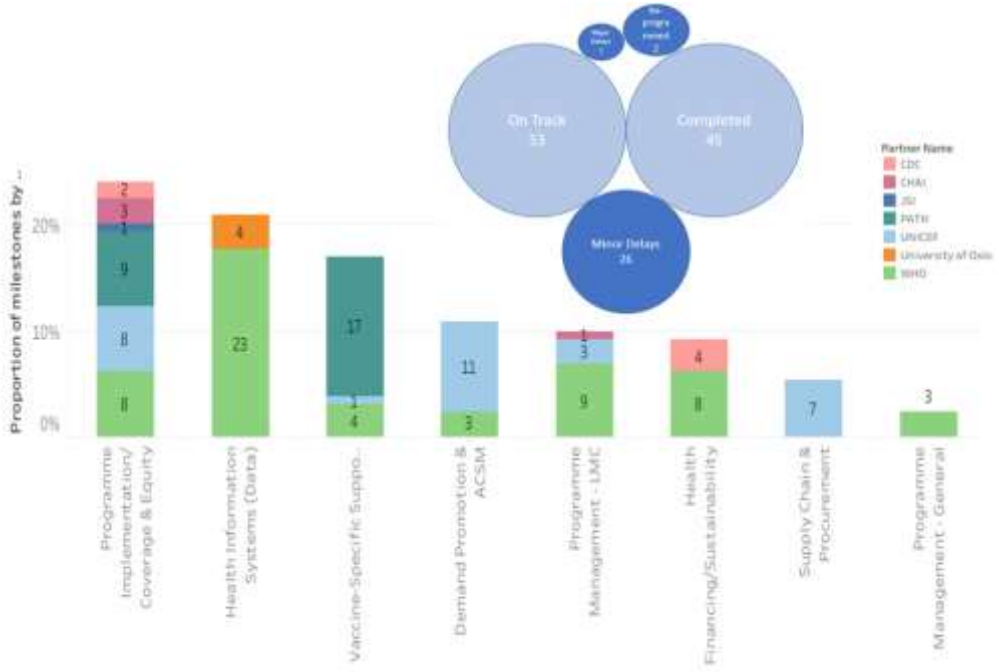
Disbursements to districts, Partners and MoH officers are captured as advances until they are accounted for and retired. The MoH signs MoUs with all subrecipients and provides financial management guidelines for use and accountability of funds. However, there are challenges of delayed submission of accountabilities by districts and other Implementing Partners. UNEPI with support from FMA, is actively monitoring implementation and accountability of funds disbursed to all districts and other sub recipients.

The Gavi grants are audited by the Office of the Auditor General (OAG), in accordance with Article 163(4) of the Constitution. The Internal Audit General is also required to perform internal audits of the Gavi funded Program, however, these internal audit reviews were not performed.

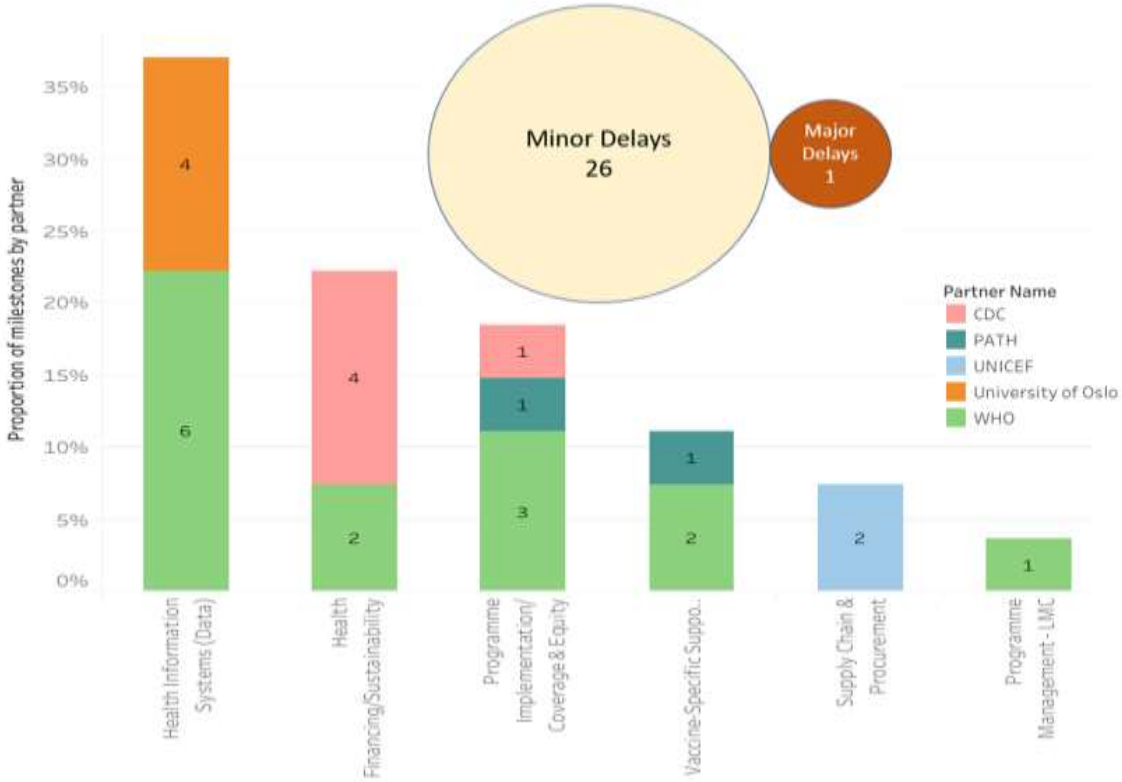
Gavi appointed a Financial Management Agent (FMA) in March 2017 to enable MoH to comply with Gavi's requirements for sound financial management in accordance with Gavi's Transparency and Accountability Policy (TAP), Gavi's Financial Management and Audit Guidelines and other Gavi requirements and guidelines. The FMA, continues to support the MoH's efforts to develop stronger financial management systems and capacity at UNEPI needed to effectively manage Gavi funds.

1.5. Overview of PEF TCA progress (end of 2019/ early 2020**)**

1) Total Milestones from June 2019-June 2020, per partner, per programmatic area



2) Delayed milestones from June 2019-June 2020, per partner, per programmatic area



Please provide any additional comments -as relevant- on the implementation of the TCA plan (e.g. progress in key areas, challenges, constraints, reallocations, no-cost extensions)

SNO	Activities	Implementation Status
Core partners		
WHO Supported Activities		
1	Develop and present an investment case for vaccines for RI and new vaccine introductions (such as Men-A and 2nd dose MR, booster Td dose), I) Engage the School of Public health (Mak SPH) to conduct operational research to identify operational barriers including GDP and per capita income to delivery of immunization services II) Provide technical support to MoH to monitor the roadmap for implementation of Addis Declaration on immunization	i) Concept note for the investment case has been finalized ii) a local consultant is being solicited through the organization procedures to undertake this piece of work that is anticipated to be completed within 3 months. iii) The work is still ongoing i) **The operational research** was contracted out to Makerere School of Public Health ii) Several meetings were conducted to review the methodologies iii) it was integrated with the EPI review. The EPI review had a total of 29 districts and 58 health facilities selected from 14 sub regions. One community located within 5-10 KM of each health facility was selected for the operations research iv) data collection was completed in November 2020. v) Data cleaning and analysis is still ongoing
2	Conduct EPI Review and develop comprehensive multi-year plan 2021-2025	i) contracted Makerere School of Public Health to undertake this piece or work ii) weekly engagements involving country and regional stakeholders reviewed the concept notes and methodology iii) steering committee was established to review the processes iv) National desk review was conducted v) Field data collection completed from 29 districts vi) Data analysis is completed vii) Draft report was shared with all stakeholders and has been circulated to stakeholders for final review and edits **Next steps**: Finalize the report, print copies for stakeholders and disseminate results to all districts viii) The findings from the EPI review, operational research MNTE PVA will be used to develop the next cMYP 2021 -2025. It is hoped that it will be finalized by February 2021.
3	Provide administrative support for top up allowance and provision of data bundles for teams at the surveillance sites to transmit data from the new vaccine sentinel sites to produce data that will monitor and evaluate new vaccine introduction (Rota, PCV and Penta), and data analysis for timely use	i) All monthly reports were shared on time with all stakeholders ii) Key performance indicators were attained by all sites iii) no reported case of HIB iv) There is a drastic reduction of SP cases since introduction of the vaccine. The number of rotavirus cases has also reduced **Next steps:** i) Continue with support for the sentinel surveillance sites, ii) continue with the data collection for the impact study of rotavirus
4	Conduct in service training to roll out the vaccine Pharmacovigilance at the HF level including VAEMIS with close collaboration with NDA	i) Forty (40) Master TOTs were established who also form the investigation team of AEFIs ii) A total of 2,719 health facilities drawn from 48 districts have at least a focal person trained on AEFI basics. The overall total number of participants was 5607 health workers while the DHT members were 313. iii) In 2020 a total of AEFIs were reported. **Challenges:** inadequate resources to cover the remaining districts **Next steps:** mobilize resources to cover the remaining districts and follow up trainers
5	Provide Technical support in coordination of partners, mapping of partners by region using the 4W matrix of who is doing what, where, when and for how long and link them to the district and Health facility annual work plan for	i) Hepatitis B birth dose - revision of UNITAG recommendation reached in 2017 in light of any new evidence was conducted ii) Strategies to improve efficiency of immunization service delivery through partners particularly at Local Government level are being finalized iii) Review the Immunisation Financial Sustainability Plan and recommend how to implement it effectively is also ongoing iv) interim recommendation of

SNO	Activities	Implementation Status
	resource mobilisation and accountability	allocation framework of COVID-19 vaccines was developed **Next step:** Continue with financial support of UNITAG activities
6	Provide technical support to the monthly EPI sub committees of Data/Surveillance, Program management and service delivery	Continued to provide administrative and technical support to the committee meetings Next step: Continue
7	Enhance the regional EPI/IDSR structure for capacity building, monitoring and accountability for the investments, TCA/PEF support shall be aligned within the 14-regional operational frame work based on institutional capacity, the operational frame work will cover the 5 immunisation system components (vaccine, logistics & cold chain, data and VPD surveillance, service delivery, social mobilization, service delivery) ents	i) A complete training package including each core component of EPI is developed ahead of trainings including on-line modules ii) 30 trained National-level EPI officers oriented on all core components of EPI and ready for deployment to support regions iii) A pool of 420 trained Regional Immunization Monitoring and Supervision Teams (RISMTs) – 30 per RRH created to support the districts to implement and improve immunisation services using the MoH HSSII funding and other partner funds iv) One regional training conducted. **Next steps:** i) Finalise printing for the remaining 4 regions ii) conduct the remaining six regional trainings. iii) conduct an end of activity review of the functionality conducted, and recommendations disseminated for implementation
8	Provide Technical support in coordination of partners, mapping of partners by region using the 4W matrix of who is doing what, where, when and for how long and link them to the district and Health facility annual work plan for resource mobilization and accountability	i) Concept note for Partner mapping developed and shared with MoH ii) Developed an electronic online tool that has been shared with all stakeholders to populate the relevant information. Next steps: i) Follow up with assistant district health officers to fill in the online survey ii) Analyse the data gathered from the database iii) Share the findings with MoH through a report
9	Support the health manpower development centre to conduct Inservice training for DHMTs in 30 Districts	Due to lack of consensus on the modality to undertake, WHO did not implement this activity as there was need for consensus among partners on the approach and training materials.
10	Establishing of e-health system- e-Child register	The current discussions in Uganda are around utilization of Smart Paper Technology (SPT) and this has been piloted in some health facilities in Mukono district over the past 5 years. Next steps: Therefore, this activity of establishing an e register was deferred and hence there is need to finalize the direction to be undertaken by GOU regarding reports so that support can be provided.
11	Strengthening of national health information system (HIS) and establishing of robust and sustainable integrated systems, focusing on implementation of tools and building capacity for better quality and use of immunisation data - Immunization data analysis, Data Quality Apps & Scorecards built on DHIS2	A one (1) day orientation (07th June 2019) was conducted for some few TOT comprising of UNICEF, MOH M&E officers, WHO and DHTs aimed at introducing the DHIS2 Health Apps to the group. It was anticipated that the TOT would be zoned to support Regional trainings in districts in the DHIS2 Health Apps (Dashboards, Scorecards, Immunisation Analysis and Quality Apps. Not completed implementation. **Challenge:** The DHIS2 System had not yet been upgraded to the higher version. The DHIS2 has since been upgraded. The DHIS2 Health Apps were developed but still in development server. Discussions with HISP Uganda on configuration and migration in new instance are on-going. Next steps: Utilize the COVID-19 DHIS2 framework to focus on the entire immunization system data strengthening approach in DHIS2.

SNO	Activities	Implementation Status
12	Support the review and roll out of the national planning guidelines that incorporate the adaptation the revised 2017 integrated RED/REC approach to increase coverage and equity in all communities	i) MoH adopted the RED tool as a costing tool in the development of the annual workplan ii) A new Job aid to RED approach was developed and distributed 6000 copies to all health facilities iii) Districts incorporated RED/REC approach into their district annual plans Challenges: Creation of new districts on annual basis hence the need for continuous capacity building Next steps: monitor the status of implementation of agreed upon approach to integrate RED/REC approach into the district annual work plans
13	Implement strategies to reduce missed opportunities for vaccination (MOV)	i) A national pool of 40 trainers was created ii) Supported MOV cascade in 54 districts **Challenges:** Inadequate funding to cover all districts ii) COVID-19 pandemic made it impossible to conduct community engagements as earlier planned hence the use of radio talk shows. **Next steps:** Mobilize additional resources to rollout MOV in the pending districts ii) conduct follow up visits to assess the level of implementation of MOV in the targeted districts
14	Establish and strengthen the second year of life (2YL) immunization platform for introduction of vaccines in the second year of life (MR and booster doses)	Sensitization of EPI stakeholders in the country on the need to establish a 2YL platform was done using the WHO guidance documents. The MR2 application process was an added advantage used to review the status of establishing the platform, key roles of different stakeholders and the need to review the current immunization policy, data collection tools. Not completed yet. **Next steps:** i) UNEPI should identify a 2YL focal person ii) a 2YL committee should be established prior to MR2 introduction
15	To undertake an assessment efficiency in use of immunization resources, identify bottlenecks and develop strategies to be undertaken to address them	Study is still ongoing, and results will be presented at a later stage. **Next steps:** Use the results of this assessment that should identify key inefficiencies and their implications, as well as proposed policy options.
UNICEF Supported Activities		
1	Provide technical and financial support to 14 Regional referral hospital community health departments to conduct mentorship and supervision of the districts in the region.	ii) TA through UNICEF personnel, including 4 RED/REC consultants, to support poorly performing districts iii) Supported implementation of costed micro plans in the priority poorly performing districts iv) Conducted Training of 32 National Regional Referral Hospital (RRH) Trainers of Trainers to conduct trainings of Regional mentors and supervision teams v) Disbursed funding to 7 RRHs (Mbarara, Fort portal, Hoima, Gulu, Arua, Moroto, Jinja) to conduct trainings of mentors/supervisors for the districts vi) Ongoing technical and financial support to poorly performing districts **Next steps:** – Complete the ongoing trainings of Regional mentors and supervision teams – MoH and Partners to sustain RRH supervision and Mentorship in the regions
2	Support the capacity strengthening, regulation, monitoring and supervision of the private health care facilities providing immunization services in the Urban settings (Wakiso, Iganga, Kampala and Jinja).	i) Technical and Financial support provided to the urban districts in immunisation heath facility mapping and functionalisation of static and outreaches immunisation **Next steps:** – In process of hiring UPA to support private health care facilities and conduct review meetings – MoH and Partners to use lessons earnt and sustain Urban immunisation

SNO	Activities	Implementation Status
3	Strengthen the advocacy, communication and social mobilization to maximise 'reach' of target population in urban settings through:	ii) Consultant hired to develop Urban Health communication guideline and implementation plan iii) Training of VHTs in 11 districts conducted iv) Ongoing Child registration, defaulter tracing, awareness creation and mobilisation by VHTs in 11 districts **Next steps:** – Implement the Urban Health communication guideline – MoH and Partners to support chid registration and defaulter tracing to reach the zero dose and under immunised
5	Support Advocacy, Social Mobilisation and Communication through engagement of decision makers at national, district and community level to improve immunisation coverage:	i) Nationwide media messages and radio talk show on routine immunisation and HPV immunisation conducted including during ICHDs ii) In process of hiring UPA to support private health care facilities and conduct review meetings **Next steps:** – Sustain demand and awareness creation through media and community engagement
4	Implementation and monitoring the EVM improvement plan at all levels (national, district and health facility levels)	i) Technical support provided to strengthen EVM indicators at district and health facility level (Temperature monitoring, timely vaccine forecasting, vaccines distribution / utilization / wastage) - Monthly vaccine management meetings - Transport provided to support urban districts (KCCA, Wakiso) to distribute vaccines and vaccine supplies - Conducted vaccine and logistics forecasting meetings - Support provided in procurement of CCEOP/HSSII equipment's Ongoing planning to conduct - Annual Vaccine & Logistics review meeting - Training and Capacity enhancement of 20 newly recruited DCCTs/DCCAs **Next steps:** Working with the RRHs and Regional Cold Chain teams to continuously monitor and build capacity in KPI EVM indicators
5	Work with UNEPI and NMS to develop SOPs/guidelines for Sustainable waste management of used immunisation waste and implementation of the plan. The activity implementation will mainly cater for transport from districts to disposal sites.	i) Activity is being planned for implementation through National Medical Stores. **Challenge** Activity delayed due to slow transition of the Cold Chain function to NMS
CDC Supported Activities		
1	Continue technical assistance to determine the cost and cost effectiveness of different approaches to DTP booster dose introduction; school-based delivery, facility-based delivery, single cohort approach, and multiple cohort approach. Includes dissemination of the findings.	**Then** study has been completed by Healthnet consult that worked in collaboration with WHO and CDC Final report to be shared by the end of Mar 2021 **Challenge:** Covid-19 pandemic delayed implementation of the study Next steps: Develop a model to estimate the health and economic effects of introducing the doses.
Expanded Partner supported Activities		
AFENET Supported Activities		
1	Review and adapt materials for next phase of Data Improvement PIN implementation, following completion of DIT end of Round 2 implementation (2016-2020)	Ongoing. Immunization data quality improvement materials are being updated in preparation for use in the next phase of implementation.

SNO	Activities	Implementation Status
2	Building capacity of Regional Community Health Department (CHD) from 14 Regions of Uganda on immunization data quality improvement using revised materials as per new DIP	Not done. The key challenge faced was the prolonged contract finalization process, which was completed in late December 2020 just before the end of year festive break. The first tranche of implementation funds was received on the 16th January 2021. This has subsequently affected the planned start of activities, and will require re-planning with adjustment of implementation timelines for planned activities.
3	Building capacity of District Data Managers from 135 Districts of Uganda on immunization data quality improvement using revised materials as per new DIP	Not done. The key challenge faced was the prolonged contract finalization process, which was completed in late December 2020 just before the end of year festive break. The first tranche of implementation funds was received on the 16th January 2021. This has subsequently affected the planned start of activities, and will require re-planning with adjustment of implementation timelines for planned activities.
4	Support supervision by Regional and District level for health worker Peer to Peer on-the-job mentorship at district and facility-level	Not done. The key challenge faced was the prolonged contract finalization process, which was completed in late December 2020 just before the end of year festive break. The first tranche of implementation funds was received on the 16th January 2021. This has subsequently affected the planned start of activities, and will require re-planning with adjustment of implementation timelines for planned activities.
PATH Supported Activity		
1	Support rollout of ODKX CCE inventory management.	The ODKX tool was presented to the Health information innovation and research subcommittee and technical working group and feedback shared with the developer. The tool is undergoing development and expansion to include all CCE data extract from CCEM and health facilities lists as extracted from DHIS2. Challenge: Prolonged contract finalization process, which was completed in late 2020. Next Step: Reengage MoH for implementation of the application/solution
CHAI Supported Activities		
1	Conduct district-based training of health workers on the new DHIS2 tools in 14 focus districts	Done and follow ups conducted throughout the year and this has raised TMC reporting to 85% and brought HFs experiencing freeze excursions to under 10%
2	Support development of a costed UNEPI AWP for 2020 and related quarterly reviews	Done with 98% of the activities having identified funding. All quarterly reviews have been conducted. Activity completion rates are just above 50% though dues to the covid19 pandemic disruptions
3	Assess district uptake of integrated work planning and the related tools (HMIS020)	Done and report shared. The most widely used form of integrated work planning is through the PBS and its related tools although there are significant challenges on handling off budget funds as well as timely disbursements and accountabilities
4	Conduct quarterly sub county performance review meetings targeting sub county community leader to increase demand for immunisation services in 14 focus districts	Ongoing. Community leaders engaged at the smallest administrative unit (village) to identify unique challenges affecting those communities and mitigate with customised interventions – this is ramping up immunisation services utilisation at specific community level
5	Conduct quarterly on-Job mentorship and support supervision in 14 focus districts:	Done. HFs in the focus districts have been supported to identify local solutions to increase static immunisation sessions. At the moment 49% of the target HFs are conducting 5-7 static immunisation days up from 22% in 2019
6	Conduct CCEOP Post-installation and Site Selection Follow-on Impact Assessment:	Done. Report available and disseminated. Lessons learnt from newly equipped sites documented and CCE network extension strategy updated.

Living Goods Partnership

- Living Goods are funded through Gavi's Private Sector Matching Fund for the project "Increasing Immunisation Coverage and Equity through Digitally-Empowered Community Health Workers". The project was due to conclude in October 2020.
- Due to COVID-19 related delays, Living Goods was granted a no-cost extension until the end of 2020 to conclude programmatic activities. In addition, they were granted a 3-month

extension for Monitoring and Evaluation activities (specifically the end-line survey), which is now due for completion in mid-2021.

- Living Goods wishes to strengthen engagement with the government to ensure alignment of programmatic activities with MoH priorities.

2. COVID-19 impact on immunisation (in 2020): current situation

In Jan-Feb 2020, a Supply chain resilience assessment was conducted. Two key risks were identified; i) vaccine supply shocks and ii) accumulation of unimmunized children. The following mitigation measures for vaccine supply were identified and implemented:

Vaccine supply shocks:

- Expedite payment of the country obligation for co-funding Cost Estimates 2020 for vaccines.
- The UNEPI and NMS with support from UNICEF frontloaded 6 months' worth of stocks to avert any vaccine stock out crisis.
- Provided for the incremental shipment cost due to the use of cargo planes
- Agreed with NMS to continuously distribute vaccines and related supplies during the pandemic and lockdown

Accumulation of unimmunized children

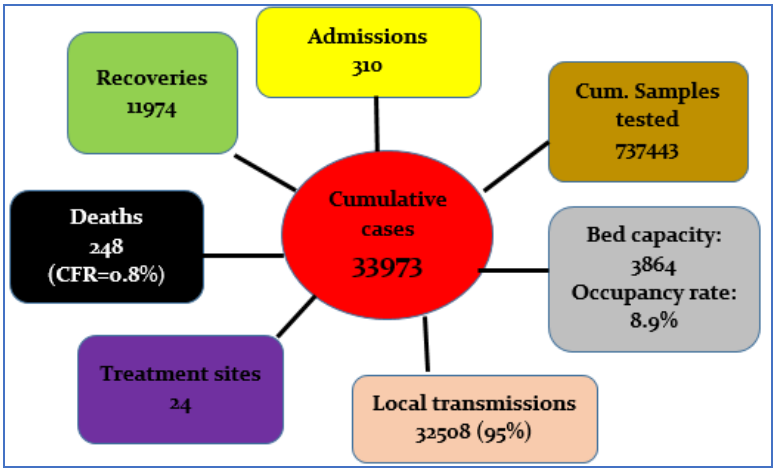
Provided particular guidance to health workers to ensure:

- Children were vaccinated in the health facilities and outreach posts as they arrive without allowing for a build-up of numbers at the vaccination post (not more than 10 people).
- Handwashing with soap, sanitizers or disinfectants was/is mandatory for the clients and health workers at the vaccination posts
- adequate social distancing of the waiting area (at least 2m between persons)
- Health workers who were providing immunization services were provided with information materials to continue sensitizing care givers on COVID- 19.
- Involved regional teams comprising of MOH officials and partners to conduct on job training and support to ensure seamless provision of health services continue amidst COVID-19 Pandemic

Uganda identified it first case on 21st March 2020 and the president announced a lock down.

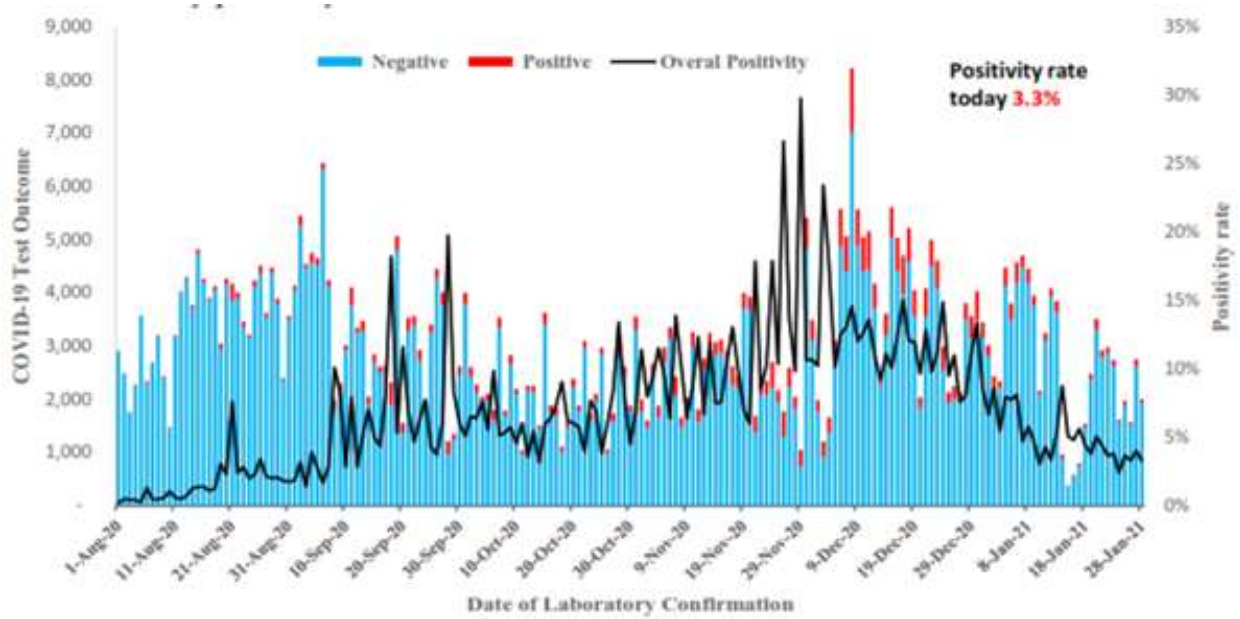
The representation below shows the cumulative numbers by 27th Dec 2020.

2.1 COVID-19 cases and deaths (as of COVID-19 as 0f 27th December 2020) weekly epidemiological bulletin



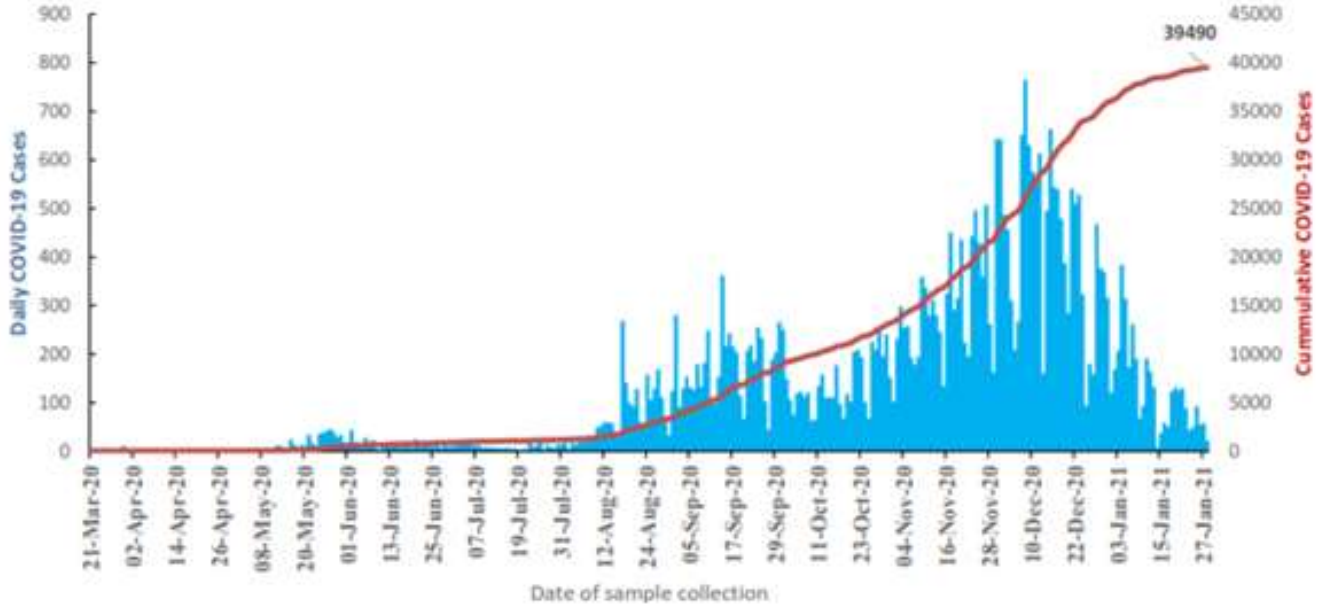
By 27th Dec 2020, had 33,973 cases and 248 deaths (CFR = 0.8%). Ninety five percent (95%) of the cases were from local transmissions. Uganda by this point had entered phase 4 (Community Transmission).

Daily Positivity Rate Trend



While overall positivity rate peaked in November 2020, the total number of positives per day peaked in December 2020. The positivity has since declined. The Ministry will continue to monitor these trends.

National trend of confirmed cases by date of laboratory confirmation



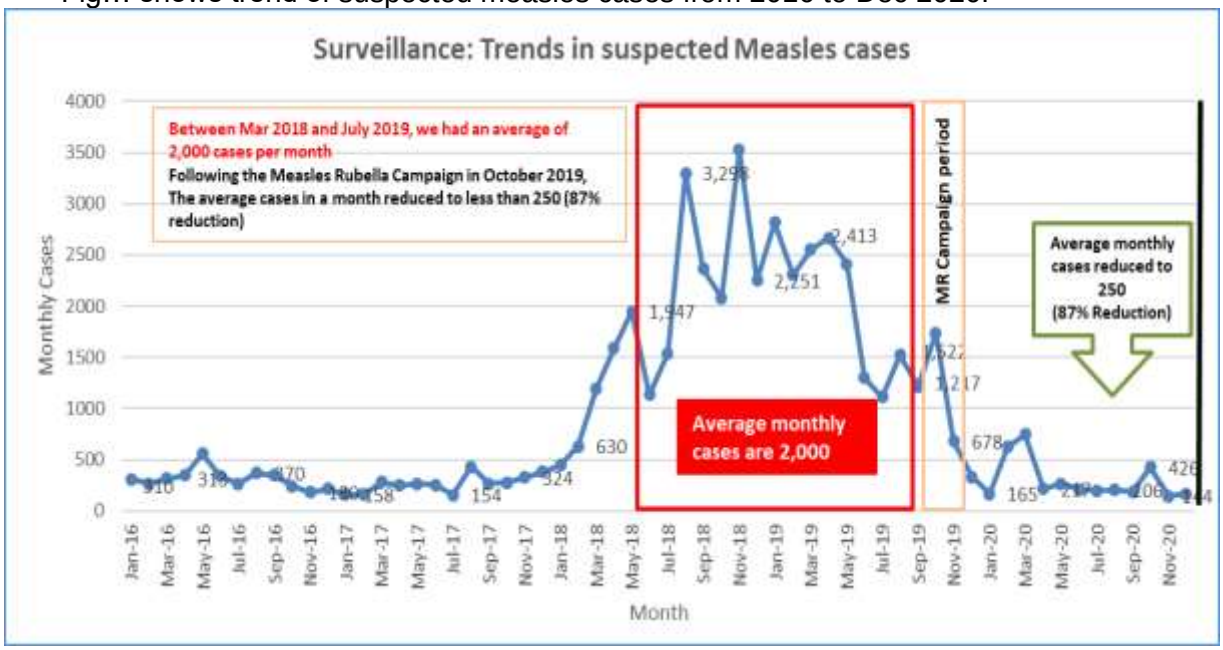
In line with the positivity rate in fig…., (above), the cumulative number of confirmed cases appears to slightly plateau in January 2021. The ministry of Health will continue to monitor the trends as plans for Covid-19 vaccinations are implemented.

2.2 Disease Surveillance and Incidence

https://www.who.int/immunisation/monitoring_surveillance/data/en/]

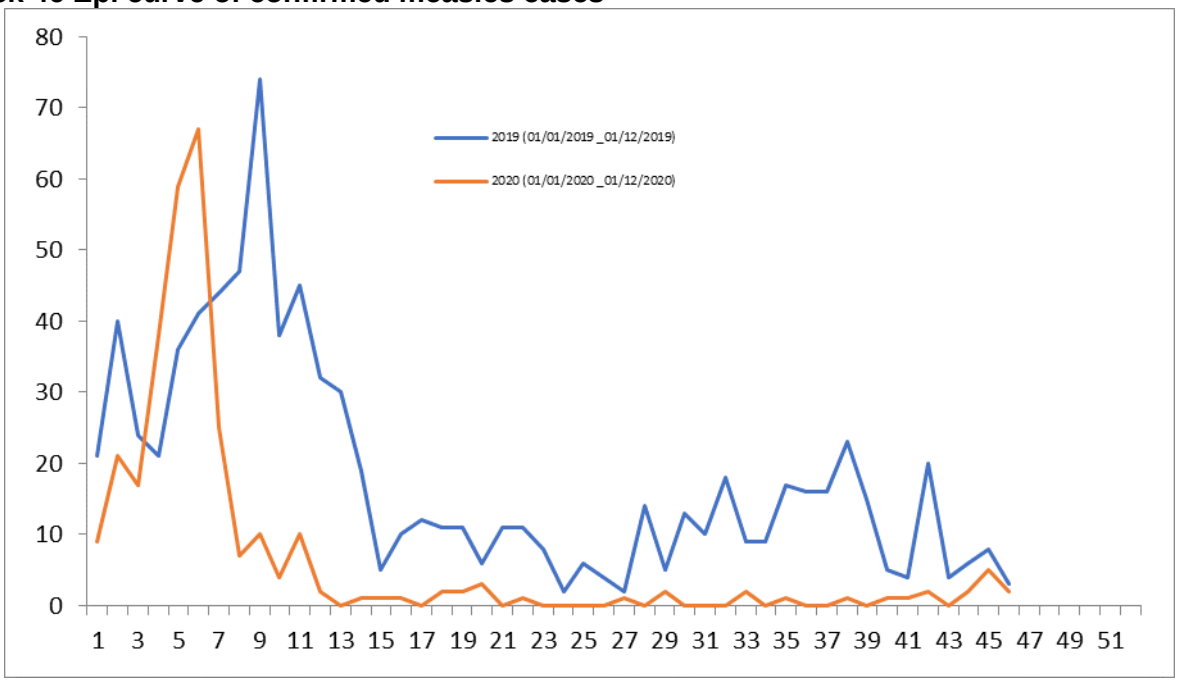
Impact of COVID-19 on disease surveillance

- Fig… shows trend of suspected measles cases from 2016 to Dec 2020.

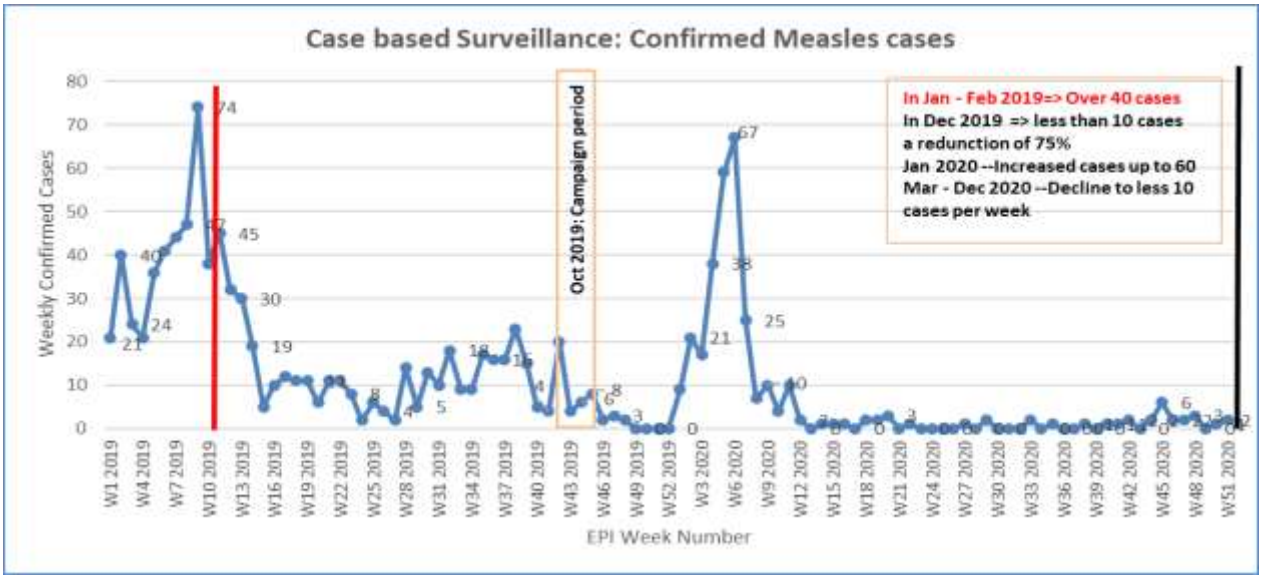


By onset of COVID in Mar 2020, the average monthly suspected measles cases had reduced to 250 from an average of 2,000 cases in the period before MR campaign which was conducted in October 2019.

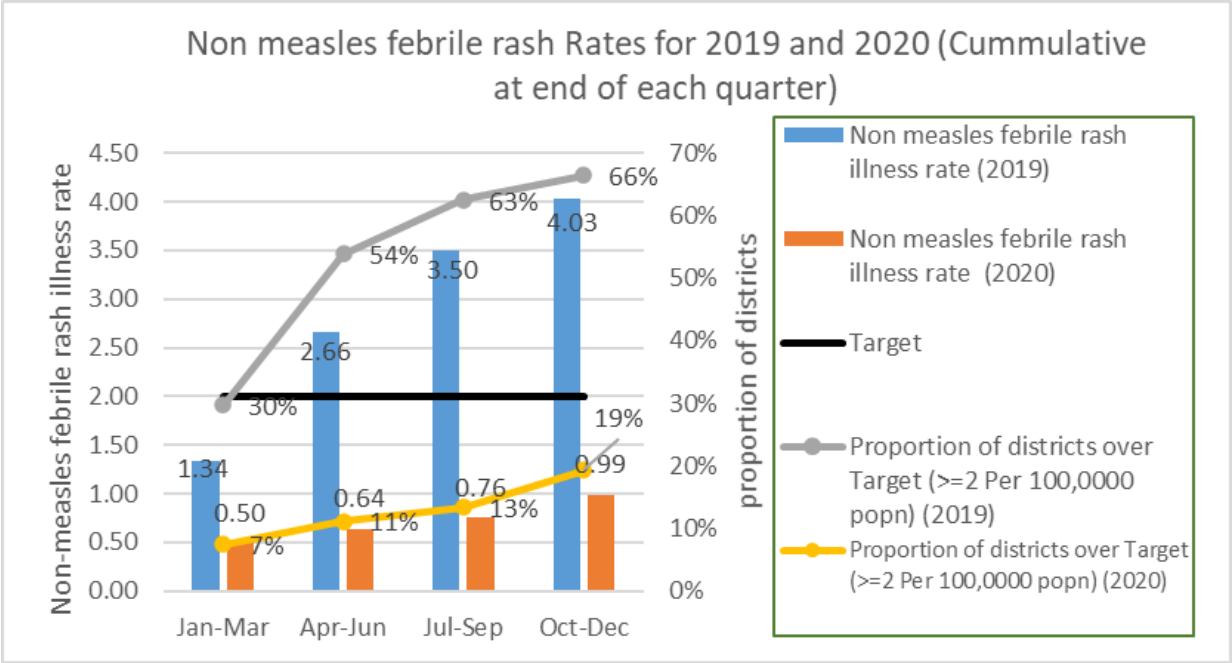
Week 46 Epi curve of confirmed measles cases



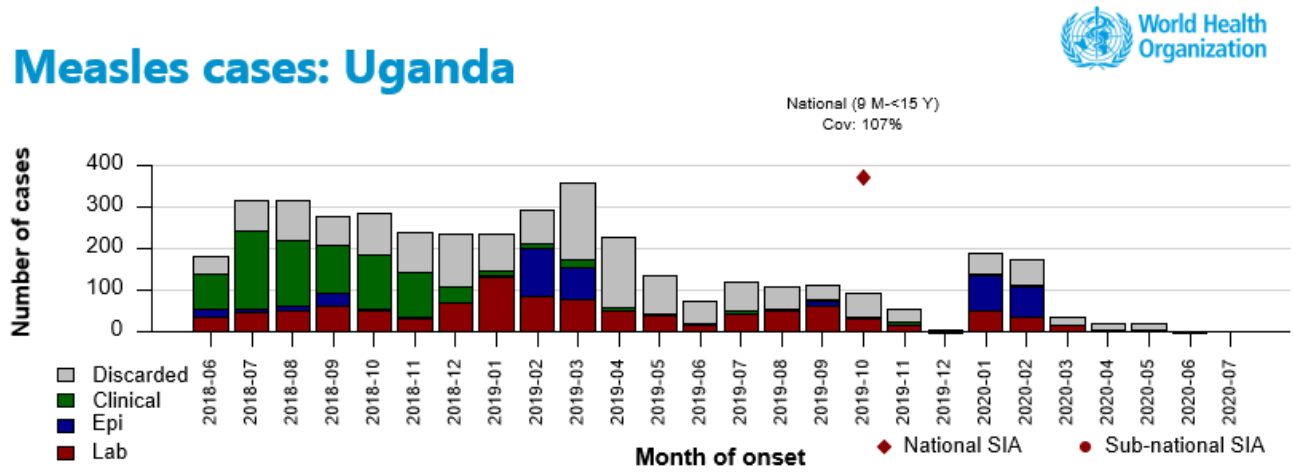
Although the number of weekly confirmed measles cases was lower in 2020 than 2019, the trend appears similar except that the number of cases declined more earlier in 2020. The low number of confirmed cases in 2020 may be an impact of Covd-19 following restrictions on movement. The trend however remained low until November 2020. This is likely associated with the continued use of the DSFPs and HSDSFPs for covid-19 surveillance. More focus seems to have shifted to covid-19 surveillance hence weakening VPDs surveillance.



The increase in the number of confirmed cases in January 2020 was rather surprising as an MR campaign for all under 15s had had been conducted in Oct 2019. Investigation of the cases revealed that majority age had not been vaccinated and some of them had been vaccinated within 30 days. The positivity was most likely associated with the vaccine that they had received.

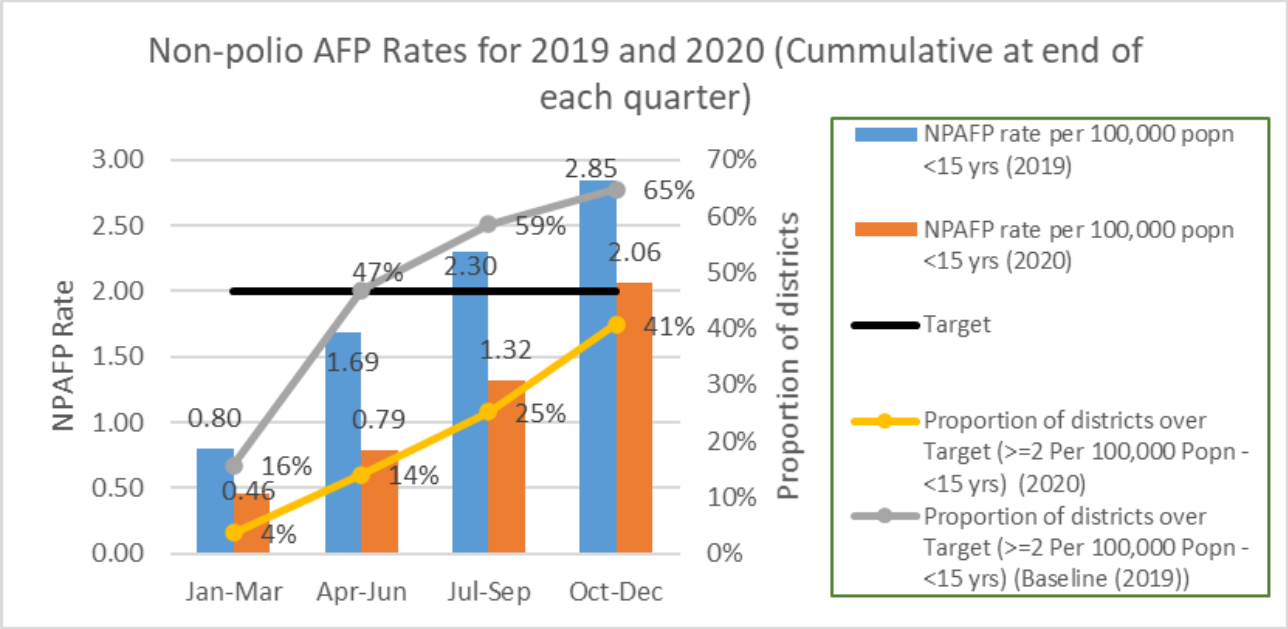


Similar to Polio surveillance, Measles surveillance reveals much lower rates in 2020 as compared to 2019. The Non-measles febrile rash illness rate was 4.03 in 2019 while 2020 the rate was only 0.99 with only 19% of districts achieving the target of 2 as compared to 66% of district achieving the target in 2019.



Comparing 2018, 2019 and 2020, the number of reported measles cases was lower in the second quarter of 2020. This shows an effect of the covid-19 pandemic.

Add for Rubella



Polio surveillance reduced in 2020 as can be seen in figure above. The National NPAFP rate was 2.85 per 100,000 children below 15 years in 2019 while 2020 achieved 2.06 slightly above the desired target. The proportion of district with NPAFP rate over 2 were 65% and 41% in 2019 and 2020, respectively. The different in proportion of districts below 2 between 2019 and 2020 is highest in Apr – Jun and Jul – September. By Oct – Dec there was a sharper improvement in some districts.

2.3 Impact of COVID-19 on immunisation

Briefly describe the impact that COVID-19 has had on your ability to effectively deliver immunisation services, including:

Constraints on routine immunisation services

Ugandan Health System's Service Delivery has been negatively impacted by the COVID-19 Pandemic due to shift of focus and prioritization towards COVID-19. Mitigation measures such as social distancing, reduce non-essential travels, lockdowns, regulation in number of travellers in vehicle have resulted in decline in access to health services including immunisation. Transport costs have increased and there is fear of infection at health facilities. Among the health workers there is reported absenteeism at workplace due to fear of infection, exposure from patients, and increasing infection among the health service providers. This has negatively impacted health service delivery including immunisation.

Among the major barriers for health workers include:

- Inadequate PPE for use during health service delivery
- Increased transport costs to travel to work and conducting immunisation outreaches
- Insufficient training in infection prevention
- Lack of adequate policy since COVID 19 is anew disease
- Inadequate handwashing and sanitisation logistics

Impact of the pandemic that may have exacerbated gender related barriers to immunisation experienced by caregivers, adolescents and/or health workers.

- Long walking distances by mothers due to increased transport costs affecting uptake of immunisation
- Reduced household income resulting in withholding of funds for more pressing needs such as food by the household head
- Increased stress and domestic violence exacerbating neglect

Impact on uptake, demand and community engagement (including impact of rumours or misinformation)

- Decreased community mobilisation and awareness driven by community mobilisers

Impact on any planned new vaccine introductions or campaigns

The pandemic has had a negative impact on planned campaigns in one area. The planned implementation of yellow fever campaign in west nile was delayed from march 2020 to August 2020.

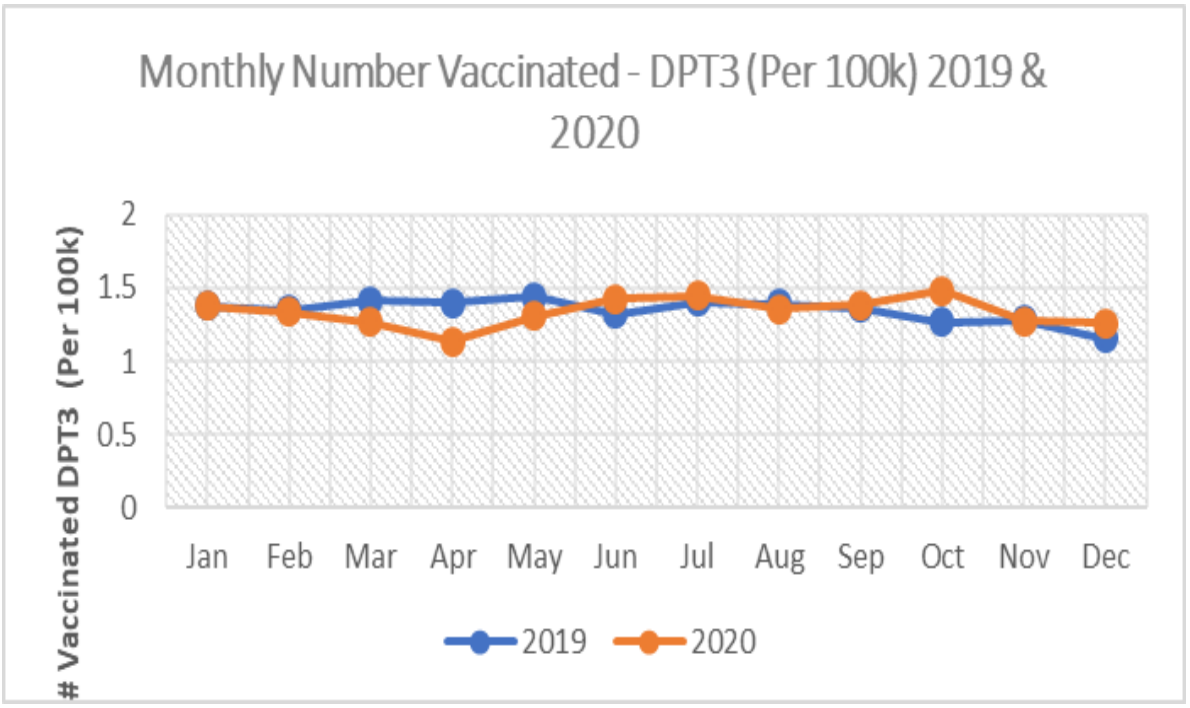
Impact on vaccine stocks (e.g. restocking of vaccines and related supplies, risk of expiry, updating dose requirements, reallocating stocks internally within the country/districts to ensure equity of supply)

- Few stock outs reported in some heath facilities due to delayed restocking
- Risk of vaccine wastage in some heath facilities due to low turn up and infrequent monitoring

Impact on health and immunisation

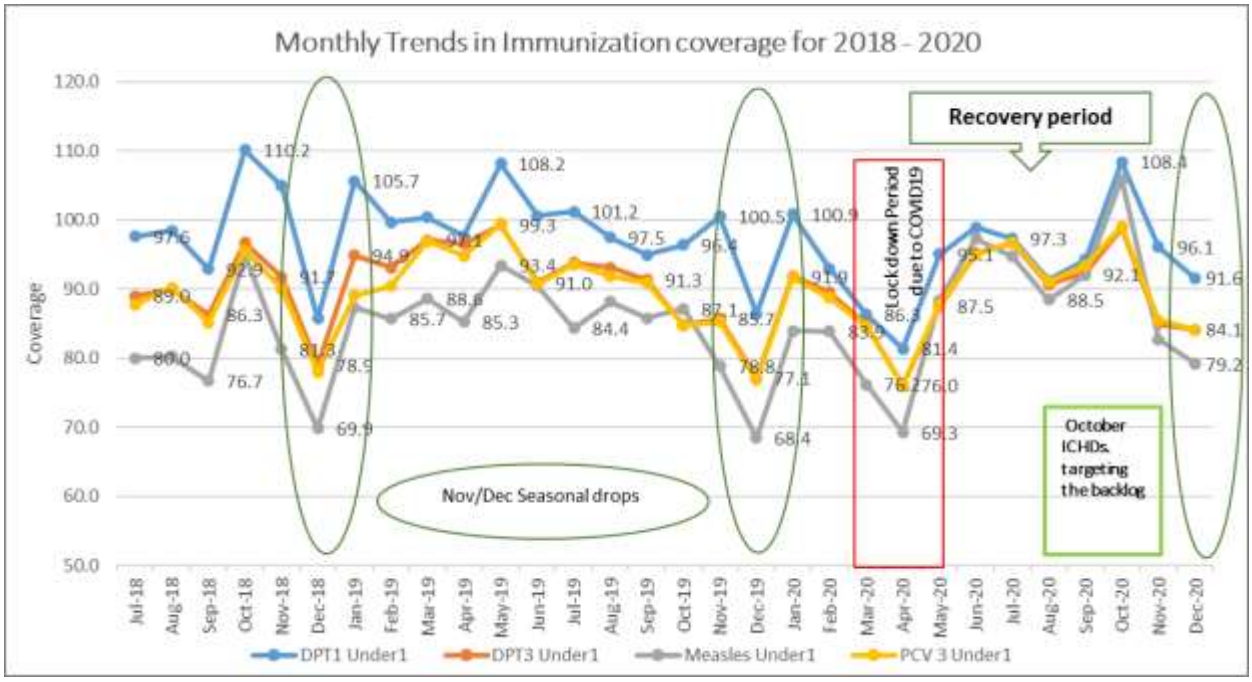
Re-purposing of funding to COVID-19 reducing funding to immunisation.

Fig…. shows the trend of number of children vaccinated with DPT3 per 100K by month in 2020.



Clearly, the number of children vaccinated in Apr 2020 reduced. This was the month in which there was strong restriction of movement of persons.

Visualizing the Impact of Covid-19 on immunization



We observe that there are seasonal factor that reduces vaccination coverage in December. The decline occurs across all the years. Apart from December the other marked decline was in April 2020. This is associated with the lockdown restrictions and its effects (social distancing, in travel, curfew that affected health worker mobility, transport costs, banning boda-boda from carrying people, IPC shortages, fear of infections by health workers and communities, etc) imposed to prevent spread of covid-19 in the country. The improvement in June – Aug 2020 is associated with orientation of health workers on IPC following dissemination of covid-19 guidelines.

The delay in implementation of outreaches, yellow fever campaigns and supervisions due to restrictions led to reduced absorption of finances.

2.4 Already agreed budget reallocations of HSS grant for COVID-19 response

	COVID-19 activity	Amount reallocated	Status of implementation
Activity 1	Immunisation Risk Communication Assessment		
Activity 2	Infection prevention and Control		
Activity 3	Epi Surveillance, Coordination, Points of Entry		
Activity 4	Support to COVID-19 laboratory services	3,120,539	• UNICEF procured and delivered Covid 19 Diagnostic kits amounting to USD 2,124,018. • The procurement for test kits under WHO is ongoing

2.5 Already agreed modifications in Technical Assistance (if applicable)

Partner	Type of Modification to TCA-2019	Activities Affected
CDC	No-Cost Extension	Technical assistance to determine the cost effectiveness of different approaches to DTP booster dose introduction; school-based delivery, facility-based delivery, single cohort approach, and multiple cohort approach.
WHO	No-Cost Extension	Implement strategies to reduce missed opportunities for vaccination (MOV)
WHO	No-Cost Extension	Capacity building and mentorship of all health facilities (5,280) on vaccine pharmacovigilance

2.6 Unspent funds and savings from Gavi support, available for re-allocation

[Brief narrative and/or table. Considering that some activities have been cancelled, delayed or modified, this is an overview of funds available to be re-allocated.]

The Program has funds amounting to US$ 2,769,404, available for reprogramming on the HSSII program as at 31 December 2020 as summarised in the table below:

Ref	Details	Saved and unused USD	Approved Reprogrammed USD	Reprogramming request yet to be approved-USD	Available for reprograming USD
1	HSS II (Jan to June 2020)	1,524,064	626,165	264,660	633,239
2	HSS II (June 2020 to July 2021)	1,946,695	-	-	1,946,695
3	Saving on UNICEF procurements	968,610	779,140	-	189,470
	Total	**4,439,369**	**1,405,305**	**264,660**	**2,769,404**

- Gavi approved an HSS II budget amounting to USD 6,138,688 for the period January to June 2020. However, due to disruptions caused by Covid-19, the program had only utilised funds amounting to USD 4,614,625 and thus funds amounting to USD 1,524,064 were not utilised as at 30 June 2020. UNEPI has requested and received approval from Gavi to reprogram funds amounting to USD 626,165 to ICHD/coverage catch up plan leaving a balance of USD 897,899. In additional, UNEPI has requested approval from Gavi to reprogram funds amounting to USD 264,660 procure 3 additional refrigerated trucks.
- Gavi also approved a budget for the financial year 2020/2021 amounting to USD 5,916,610. However, from the UNEPI work plan for the financial year 2020/2021, funds amounting to USD 1,946,695 relating to two quarter

district disbursements will not be utilised during the financial year 2020/2021 majorly due to Covid-19 disruptions; and

- The HSS II Procurement Status Report from UNICEF of January 2021 indicated estimated materialised savings of USD 968,610. UNEPI has requested and received approval to reprogram funds amounting to USD 779,140 to procurement of ambulance boats leaving a balance of 189,470 available for reprogramming.

3. Discussions on priorities, action plan and technical assistance needs; Roadmap for further re-allocation/planning

Short/medium-term activities to maintain/restore routine immunisation

At the onset of the pandemic at national level, the MoH nominated a focal point (MoH Director Clinical Services) and a coordination mechanism to ensure the continuity of essential health services as there was a risk that attention would be diverted towards preparedness and response mechanisms which would result in negligence of other routine essential health services including immunization services. Similarly, the DHOs constituted a committe at the district level that ensured continuity of critical health services as defined by the guidelines developed for the country.

The high potential for VPD outbreaks made it imperative for the entire country to maintain continuity of immunization services under safe conditions for both the health workers and the population. Therefore, all districts were requested to ensure the following information reached all health facility in-charges during this period:

- Follow the existing guidelines on COVID-19 infection prevention measures during immunization sessions.
- Static site and outreach site immunization services and VPD surveillance were to be executed while maintaining social distancing measures and appropriate infection control precautions, equipped with the necessary supplies for those precautions.
- Temporarily suspend the conduct of planned mass vaccination campaigns due to the increased risk of promoting community circulation. This advice applied to the following vaccination campaigns that were postponed and subsequently held when the countrywide lockdown was eased.
    - The April 2020 Integrated Child Health Days campaign
    - The Yellow Fever reactive vaccination campaign that was to be held in April 2020 in the districts of: Buliisa, Moyo, Obongi, Maracha, Koboko and Yumbe.
    - Vaccines that are usually given to children in the school setting: HPV, Tetanus Toxoid were temporarily suspended since children are not in school

The programme continued to monitor its performance on a weekly basis, which results as outlined in sections 1 and 2 showed a significant decline in routine immunization both at static and outreach sites and VPD surveillance performance.

Subsequently, the discussion moved on to recovery efforts with the first opportunity to do so offered by the October 2020 Integrated Child Health Days campaign. This intervention has proved to be an effective means of reaching large numbers of unimmunized/unreached children and women with a variety of health services which include: childhood immunization, vitamin A supplementation, de-worming, growth monitoring, nutritional assessment, Human papillomavirus vaccine (HPV) vaccination for girls aged 10 years, Tetanus diphtheria for women of reproductive age, cervical screening and family planning. Screening and testing for Hepatitis B in adults aged 18 years and above was also planned for districts that received the Hepatitis B only vaccine. However, this opportunity had been missed twice; in October 2019 and April 2020 resulting in a drop in the national immunization coverage especially for school-based interventions.

Objectives of the Recovery Plan

- To support districts to conduct five community outreaches to catch up on HPV vaccination for girls aged 10 and 11 years
- To conduct catch up on routine immunisation antigens, Hepatitis B, Deworming, and Vitamin A supplementation and other maternal child survival interventions at static and community outreaches
- To support advocacy, communication and social mobilization for immunization services in the context of the COVID- 19 pandemic
- To facilitate national and district teams to monitor and supervise immunization activities and other MCH interventions
- To improve ICHD data quality through data use for action
- To ascertain availability of vaccines and related supplies at subnational level

Methodology

- National level activities
    - Top management engagement: Talk shows, advertisements and supervision:
    - Review of vaccine stock requirements allocation and distribution
    - Planning and coordination for the immunization performance recovery
- District level activities
    - District level coordination meetings
    - Community mobilization
    - Community outreaches
    - Supervision by central and district teams

- **Immunisation services: What strategies have been implemented at the service delivery points to re-activate immunisation services and to address any immunisation gaps resulting from COVID-19?**

    - Infection prevention and control protocols were put in place to minimize exposure to COVID-19 for both service providers and clients: PPE; Hand hygiene; Hand washing facilities or sanitizer; Health care workers should be up-to-date on all required vaccines
    - Administrative controls: Daily immunization at all static sites; Enrich routine education package with information on COVID-19; Continue with integrated outreach services; Enumerate cohorts of children who may have missed their vaccine doses and develop an action plan for catch-up vaccination; Enhance VPD weekly surveillance and collect blood and stool samples from suspected patients for complete investigation of case-based surveillance for measles and Acute Flaccid Paralysis cases respectively; Alert all health facilities through M-trac on proper case management and line listing
    - Environmental controls: Conduct vaccination preferably in dedicated immunization clinics or in a separate room in the healthcare facility. At all times ensure social distancing; Allocate well ventilated areas and ensure feasibility of social distancing for caretakers and children waiting for immunization.
    - Adverse Events Following Immunization (AEFIs): All districts were advised to anticipate increased risk of coincidental AEFIs due to ongoing SARS-CoV-2 transmission coinciding with vaccination

Annex 1: Table of Delayed PEF-TCA Milestones (2019 June -2020 June):
Please insert comments related to implementation status

Partner	Milestone	Activity
CDC	completed readiness assessment from all districts in at least one sub-region and independent monitoring forms/analysis from at least 10 vaccination sites	1 CDC Staff to provide TA for 30 days to ensure high quality preparation, implementation and monitoring for MR Catch Up SIA planned in 2018
CDC	Funding received, IRB protocol developed and submitted	Technical assistance to determine the cost effectiveness of different approaches to DTP booster dose introduction; school-based delivery, facility-based delivery, single cohort approach, and multiple cohort approach.
CDC	Funding received, IRB protocol developed and submitted	Technical assistance to determine the cost effectiveness of different approaches to DTP booster dose introduction; school-based delivery, facility-based delivery, single cohort approach, and multiple cohort approach.
CDC	Costing study completed	Technical assistance to determine the cost effectiveness of different approaches to DTP booster dose introduction; school-based delivery, facility-based delivery, single cohort approach, and multiple cohort approach.
CDC	Implementation of the RCT started in the last TCA cycle	Continue technical assistance to determine the cost and cost effectiveness of different approaches to DTP booster dose introduction; school-based delivery, facility-based delivery, single cohort approach, and multiple cohort approach. Includes dissemination of the findings.
PATH	Participation in district HPV review meetings completed	Ongoing quarterly district review and learning meetings (15 targeted districts) to monitor program and coverage improvements
PATH	Participation in district MOE support completed	Assistance to district MOE (15 targeted districts) to support HPV vaccination
UNICEF	80% districts reporting on the 5 EVM KPI (temp monitoring, vaccine utilization, timely ordering of vaccines, distribution reports, quartery CCE maintenance)	Build capacity for Effective vaccine management and CCE maintenance teams 1) 16 Regional Assistant Engineering officers trained and supported to mentor districts within their jurisdiction on Effective Vaccine Management 2) Cold chain and vaccine management technical capacity enhancement for 30 selected districts, including newly created districts

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University of Oslo	Functioning WHO modules and apps on national DHIS2	Implementation Support
University of Oslo	Updated status for EPI program data collection and analysis integrated into the national DHIS2 instance and recommendations for integration	Integration of EPI program
WHO	National TOT established; 40% of districts supported to review, update existing REC microplans using 2018 tool	Conduct nationwide mentorship and supervision to develop/update and utilize REC micro plans including immunization inequity and assessment findings of missed opportunities for vaccination through a uniform approach
WHO	100% of assigned districts supported to review /update REC micro plans	Conduct nationwide mentorship and supervision to develop/update and utilize REC micro plans including immunization inequity and assessment findings of missed opportunities for vaccination through a uniform approach
WHO	Three rounds of PIRI implemented in refugee affected districts	Plan and respond for refugees through routine immunization activities and surveillance strengthening
WHO	Study protocol developed and shared with the EPI program/TCC for approval	To undertake an assessment efficiency in use of immunization resources, identify bottlenecks and develop strategies to be undertaken to address them
WHO	Technical policy document to influence immunization decisions based on country need produced	To provide support to ensure functionality and effectives of UNITAG
WHO	10 districts and over 200 health facilities with a functional e-Child register submitting their Immunization facility data including vaccines management	Establishing of ehealth system- eChild register
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WHO	100% of HMIS and EPI offciers at National level, 100% of the districts having access to the Immunisation data analysis and Data quality Apps in DHIS2. 100% of National level officers (HMIS & EPI) and 50% of the districts (DHTs) trained on the use of the DHIS2 data quality and use functions. 100% of All regional referrals hospitals trained	Strengthening of national health information system (HIS) and establishing of robust and sustainable integrated systems, focusing on implementation of tools and building capacity for better quality and use of immunisation data - Immunization data analysis, Data Quality Apps & Scorecards built on DHIS2
WHO	20% of districts to have capacity built for health workers and caregivers on importance of card retention, catch up vaccination & vaccines being delivered in the 2YL	Establish and strengthen the second year of life (2YL) immunization platform for introduction of vaccines in the second year of life (MR and booster doses)
WHO	70 districts and over 1,500 health facilities with a functional eChild register submitting their Immunization facility data including vaccines management.	Establishing of ehealth system- eChild register
WHO	Action plan developed to enable monitoring of the implementation of the recommendations of the assessment	To undertake an assessment efficiency in use of immunization resources, identify bottlenecks and develop strategies to be undertaken to address them
WHO	10 districts and over 200 health facilities with a functional eChild register submitting their Immunization facility data including vaccines management	Establishing of ehealth system- eChild register
WHO	70 districts and over 1,500 health facilities with a functional eChild register submitting their Immunization facility data including vaccines management.	Establishing of ehealth system- eChild register
WHO	50% of districts to have capacity built for health workers and caregivers on importance of card retention, catch up vaccination & vaccines being delivered in the 2YL	Establish and strengthen the second year of life (2YL) immunization platform for introduction of vaccines in the second year of life (MR and booster doses)