

Implementing the

REACHING EVERY DISTRICT APPROACH

A Guide for District Health Management Teams



REVISED AUGUST 2008



World Health
Organization

REGIONAL OFFICE FOR

Africa

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ACRONYMS

| | |
|-------------|---|
| AD | Auto-disable syringes |
| AEFI | Adverse Events Following Immunisation |
| AFRO | Africa Regional Office, WHO |
| BCG | Bacillus Calmette - Guérin |
| CBO | Community-based Organisation |
| CSO | Civil Society Organisations |
| DHMT | District Health Management Team |
| DTP3 | Third dose of Diphtheria, Pertussis and Tetanus |
| EPI | Expanded Programme on Immunisation |
| GAVI | Global Alliance for Vaccines and Immunisation |
| GIVS | Global Immunisation Vision and Strategy |
| HepB | Hepatitis B |
| HF | Health Facility |
| Hib | Haemophilus Influenzae Type b |
| IEC | Information, Education and Communication |
| ISS | Immunisation Services Support |
| ITNs | Insecticide-Treated Nets |

| | |
|------------------|--|
| M & E | Monitoring and Evaluation |
| MLM | Mid Level Management |
| NGO | Non-Governmental Organisation |
| NID | National Immunisation Day |
| OPV | Oral Polio Vaccine |
| PIRI | Periodic Intensification of Routine Immunisation |
| PHC | Primary Health Care |
| RED | Reaching Every District |
| RI | Routine Immunisation |
| SNID | Sub-National Immunisation Day |
| TT | Tetanus Toxoid |
| UNICEF | United Nations Children's Fund |
| VVM | Vaccine Vial Monitor |
| WHO | World Health Organisation |
| YF | Yellow Fever |

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1

INTRODUCTION

1.1

BACKGROUND

The role of immunisation is widely recognised as critical to achieving Millennium Development Goals (MDGs). The Global Immunisation Vision and Strategy (GIVS) spells out the contribution of immunisation to MDG-4: a two-thirds or greater reduction in global childhood deaths and illness due to vaccine preventable diseases by 2015 as compared to 2000.

Many countries in the Africa Region successfully increased immunisation coverage during the Universal Childhood Immunisation (UCI) decade of the 1980s, only to see it decline again in the 1990s after UCI support ended. As a result, routine immunisation coverage (as measured by DTP3 coverage by one year of age) had fallen to 54% in the WHO Africa Region as a whole by the end of the decade.

In 2002, WHO and its partners developed the Reaching Every District (RED) approach to increasing and sustaining high levels of routine immunisation. Since then, most African countries have introduced the RED approach in some form. Technical and financial support for RED has come from WHO and others; GAVI's Immunisation Services Support (ISS) funding has also been used by many African countries to fund their RED activities.

The Global Immunisation Vision and Strategy 2006-2015 developed by WHO and UNICEF envisions a world in which every child, adolescent and adult has equal access to immunisation services. It also calls for:

“At least 90% national vaccination coverage [in all countries] and at least 80% vaccination coverage in every district (or equivalent administrative unit) by 2010 or sooner.”

This ambitious goal was ratified by the 56th session of the Regional Committee for Africa in 2006, and is set forth in the Africa Regional Strategic Plan for the Expanded Programme on Immunisation (EPI), 2006–2009.

In 2007, with an eye toward the new GIVS goals, WHO and its partners conducted a comprehensive evaluation of the RED approach in nine countries in the Africa region. The findings were positive: Immunization coverage had improved in all but one of the countries, the number of outreach sessions had

increased in all districts visited and supervision was found to be frequent in all but two countries. Based on these results and the challenges ahead, the 15th meeting of the African Regional Task Force for Immunisation (TFI) in 2008 recommended that WHO and its partners update the existing RED guidelines and use them to encourage countries that have not already taken RED to scale to do so. The TFI also endorsed the evaluation team's recommendation that a standard set of indicators for monitoring RED implementation be developed and included for country use. This revised RED Guide has been prepared in response to those recommendations.

The revised Guide also reflects the spirit of the 2008 Ouagadougou Declaration on Primary Health Care (PHC) and Health Systems in

Africa and GIVS goal #4. In the Ouagadougou Declaration, Ministers of Health from across the Region reaffirmed their commitment to the “principles of the Declaration of Alma-Ata” and called upon all Member States to “use priority health interventions [including immunisation] as an entry point to strengthen national health systems”. As such, the RED approach described in this Guide not only provides a framework for planning, managing and reaching all women and children with life-saving vaccination services, but also for using immunisation and the RED approach as a platform for the delivery of other essential PHC services.

WHO/AFRO believes that a renewed commitment to the RED approach could be an important step toward achieving both the GIVS and Millennium Development Goals. Although immunisation coverage is again on the rise in the Africa Region, WHO/UNICEF estimates that only 16 of the 46 countries in WHO's Africa Region had achieved 90% routine immunisation coverage by the end of 2007. While this is an improvement, much work remains to be done to achieve immunisation targets.



Photo Credit: IMMUNIZATIONbasics

1.2

PURPOSE AND TARGET AUDIENCE

The purpose of this Guide is to stimulate interest in improving and sustaining high levels of immunisation coverage in all districts and to give health program managers (governmental and non-governmental), supervisors and health

workers practical information about the RED approach.

The Guide is intended for adaptation and use by national immunisation programmes, as one of several resources that can be used to introduce district health teams and immunisation partners to the RED approach. Once adapted, it can also be used by district health teams and health workers as a quick reference to the five RED components and core monitoring indicators. Another important use for the Guide may be in explaining RED to local officials and other potential supporters of immunisation and PHC services.

1.3 CONTENT AND ORGANISATION

The following chapters describe the RED approach, its five components and the operational issues that must be addressed if RED is to succeed. Each chapter includes references and links to resource materials and other tools that may be of interest to those who are planning training sessions and preparing other materials for RED implementation. This edition of the Guide also includes two new chapters, the first focusing on monitoring and evaluating RED and the second on adapting the Guide to meet country needs. Annexes to the Guide include sample tools for microplanning and charting immunisation coverage and drop-outs; a new RED Monitoring Tool for use by health facilities, district health teams and national programme managers; a generic supportive supervision form; an analysis of access and drop-outs; and a quick reference handout on the five RED components. The Guide has also been updated to reflect an emphasis on better planning and management of resources (thus this component is now presented first) and a renaming of the “re-establishing outreach services” component to “reaching the target populations” so that all eligible populations (women and children) can be reached using an array of country-specific strategies.

1.4 ADAPTATION

The Guide incorporates “best practices” and “lessons learned” during implementation of the RED approach in different African countries. Although there are many similarities across countries, there are also some very important differences that must be addressed before a guide such as this can be understood and used at the country level. In fact, careful adaptation of the Guide should be one of the first steps when introducing or revitalising the RED approach in any country. For more details, see Chapter 10.

2

THE REACHING EVERY DISTRICT APPROACH

2.1 AIM

The aim of the RED approach is to improve the organisation of immunisation services, maximise the use of available resources and guarantee sustainable and equitable immunisation coverage for every eligible woman and child. The RED approach strengthens national routine immunisation programmes—it does not replace them.

2.2 STRATEGIES

The RED approach focuses on those steps in planning, managing and monitoring health services that, if carried out appropriately, will improve immunisation coverage and impact. The primary implementation level for RED is the district (or the equivalent administrative unit). Empowering districts to plan, implement and monitor their own immunisation services is an important objective of the RED approach. RED also promotes partnerships between districts, health workers and communities to improve the population's access to and utilisation of services, and emphasises the continuous use of programme data to monitor progress and solve problems.

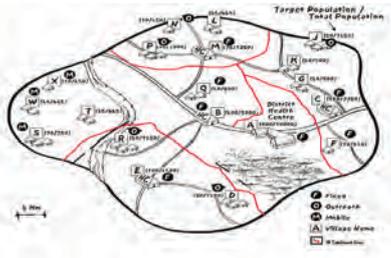
2.3 COMPONENTS

Attention to each of the five RED components is important to improve immunisation coverage. Many of the components contain intentionally overlapping content. The components are:

THE FIVE RED COMPONENTS

1. **PLANNING AND MANAGEMENT OF RESOURCES** – better management of human and financial resources.
2. **REACHING TARGET POPULATIONS** – improving access to immunisation services by all .
3. **LINKING SERVICES WITH COMMUNITIES** – partnering with communities to promote and deliver services.
4. **SUPPORTIVE SUPERVISION** – regular on-site teaching, feedback and follow-up with health staff.
5. **MONITORING FOR ACTION** – using tools and providing feedback for continuous self- assessment and improvement.

The chapters that follow describe each of the five components, plus the cross-cutting operational issues that must also be addressed for RED to succeed. See Annex 5 for a RED quick reference.

| 1. Planning and Management of Resources (Human, material and financial) | 2. Reaching the Target Populations |
|---|---|
| <p>At the district and facility levels, planning should identify what resources are needed to reach all target populations in a way that can be managed well and thus maintained. Good planning involves: (a) understanding the district/health facility catchment area (situational analysis); (b) prioritizing problems and designing microplans that address key gaps; (c) as part of microplanning, developing a budget that realistically reflects the human, material and financial resources available; and (d) regularly revising, updating and costing microplans to address changing needs.</p> | <p>“Reaching the target populations” is a process to improve access and use of immunisation and other health services in a cost-effective manner through a mix of service delivery strategies that meet the needs of target populations.</p>  |

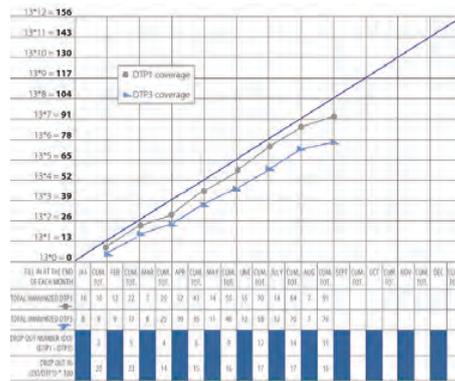
3. Linking Services with Communities

This RED component encourages health staff to partner with communities in managing and implementing immunization and other health services. Through regular meetings, district health teams and health facility staff engage with communities to make sure that immunization and other health services are meeting their needs.

4. Supportive Supervision (Regular on-site teaching, feedback, and follow-up with health staff)

Supportive supervision focuses on promoting quality services by periodically assessing and strengthening service providers' skills, attitudes and working conditions. It includes regular on-site teaching, feedback and follow-up with health staff.

5. Monitoring for Action (Self-monitoring, feedback and tools)



District health teams and health facility staff need a continuous flow of information that tells them whether health services are of high quality and accessible to the target population, who is and is not being reached, whether resources are being used efficiently and whether strategies are meeting objectives. Monitoring health information involves observing, collecting, and examining programme data.

“Monitoring for Action” takes this one step further, by not only analyzing data but by using the data at all levels to direct the programme in measuring progress, identifying areas needing specific interventions and making practical revisions to plans.

INTEGRATION

Many countries in the Africa Region have policies encouraging the “integration” of health services. While definitions vary from country to country, integration usually means that essential health services, including immunisation, are managed and delivered together. Stand-alone immunisation programmes may also be used as platforms for delivering other essential maternal and child health services. Services that are frequently delivered together during immunisation sessions include Vitamin A supplementation, malaria prevention (e.g., distribution of insecticide treated nets [ITNs]), growth monitoring, antenatal care and de-worming.

Countries with stand-alone immunisation programmes and those with integrated MCH programmes have both used the RED approach successfully. With adaptation, the five RED components and operational issues can be expanded for use with multiple interventions. RED microplanning techniques, for example, can be used to identify eligible populations, estimate commodity needs, allocate human resources and develop service delivery and supervision schedules regardless of the package of interventions. RED’s supportive supervision and monitoring for action techniques can also be expanded for use with multiple interventions.

Delivering multiple services is more complex than delivering immunisation services alone, but it can also be more cost-effective and more sustainable over time. Financing and managing the logistics of multiple commodities is perhaps the greatest challenge. In settings with limited health personnel, managers must also be aware of the potential burden on health facility staff. Supportive supervision can be helpful in preparing and supporting health workers in their new roles in this context. Other ways in which RED can help in the context of integration are listed in the box below.

HOW CAN RED BE USED TO ORGANISE AND MANAGE INTEGRATED PHC SERVICES

LOGISTICS – Use RED microplanning and EPI logistics management tools to estimate commodity needs; build on the existing EPI supply chain to improve the delivery of other supplies.

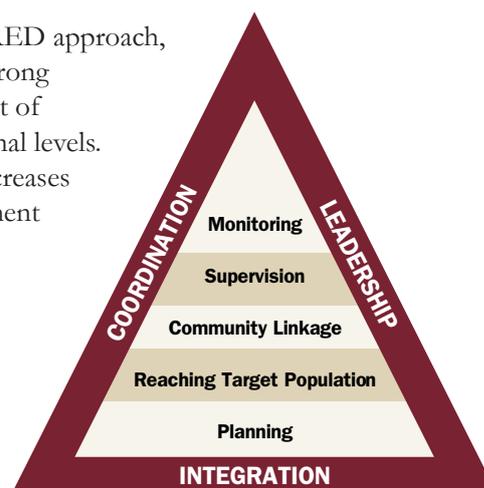
HUMAN RESOURCES – Provide RED training and use microplanning and monitoring for action techniques to build staff capacity at district and facility levels.

MICROPLANNING – Target eligible populations and the underserved, then use complementary fixed, outreach and periodic intensification strategies to achieve immunisation and other PHC goals.

MONITORING FOR ACTION – Improve district disease surveillance capacity and include use of data for action in malaria, pneumonia, diarrhoea and other essential health interventions.

LEADERSHIP

Although not explicitly part of the RED approach, RED's success is dependent upon strong leadership and the active engagement of authorities at national and sub-national levels. Good leadership and governance increases programme ownership and involvement in planning, resource mobilisation and budgeting. It also encourages transparency and accountability at all levels. These are important ingredients if scarce resources are to be available when needed and used efficiently and effectively.



COORDINATION

Collaboration and coordination are other important contextual factors that must be considered when introducing the RED approach. Within Ministries of Health, collaboration between programmes or divisions (i.e., immunisation, malaria, nutrition, child health, etc.) is extremely important, particularly if multiple PHC services are to be planned and delivered together. How the health sector works with other sectors such as agriculture, education, water and sanitation, and others can also be important, particularly at the district level. Finally, a strong Interagency Coordinating Committee is needed to harmonise the contributions of the Ministry of Health, Ministry of Finance, donors and non-governmental organisation (NGO) partners to immunisation and related RED activities.

3

PLANNING AND MANAGEMENT OF RESOURCES

Planning is a vital management function that helps to systematically improve effectiveness of the RED Approach. It facilitates identification and prioritisation of programme needs to improve performance. Planning can strengthen partnerships among stakeholders at different levels and facilitate resource mobilization.

Planning within the context of health service delivery should be integrated by taking into consideration essential health interventions, as per national guidelines. The planning process helps to expose all the problems associated with integrated service delivery, including immunisation, and to develop appropriate strategies for resolving them.

3.1

KEY ISSUES

One of RED's "best practices" is microplanning for routine immunisation. Microplans were introduced in planning for polio campaigns, but the RED approach popularised their use in routine immunisation. The microplanning process helps to expose problems with service delivery and then guides district health teams and health facility managers in developing appropriate strategies for solving those problems.

Depending on national guidelines, microplanning for immunisation may be integrated with planning for other PHC services such as Vitamin A supplementation, de-worming, ITN distribution, antenatal care and growth monitoring, among others. Whether for immunisation alone or a package of PHC services, the principles and steps in microplanning are the same.

Microplanning takes into consideration the situation in an entire district, including past performance, current staffing and the characteristics of the catchment areas of all health facilities. The most effective microplans are developed with health facility staff and with the input of community representatives. In fact, in most settings, health facilities should be required

to develop their own microplans, which are then aggregated into a district's plan. Likewise, a district's microplan should be adequately budgeted and then incorporated into a provincial and/or national health sector plan and budget.

A generic “plan” that is developed and disseminated from a higher level down will cover generic activities but will lack the specific and more complex range of challenges facing districts and health facilities. Because generic plans are not developed in a participatory way, a lack of ownership may also contribute to health staff being unaware of their details or uncommitted to their implementation.

Each of the other RED components (reaching the target populations, linking services with the community, supportive supervision, monitoring for action) and the cross-cutting operational issues summarised later in this document (logistics, communication, coordination) require attention during microplanning. This is one of the reasons that the planning and management component has been moved from the fifth to the first component. Readers should also bear in mind that many of the topics covered in Chapter 8: “Operational Considerations” are closely linked with this component.

3.2 THE MICROPLANNING PROCESS

A well-formulated microplan aims to reach all target populations with immunisation services. It also considers and includes actions to improve the quality of those services. And, where drop-out and/or missed opportunity rates are high, it proposes actions to reduce them.

Microplans should propose realistic solutions to those critical issues and to the challenges that programme managers encounter in specific districts and health facilities.

In microplanning, health teams use a problem-solving approach that focuses attention on past achievements, current barriers to increasing the coverage and quality of services, and available resources (time, human, material and financial). They also prioritise activities, set realistic targets with milestones, address sustainability issues and include regular reviews of implementation and achievement to facilitate timely revision. The “Reaching the Target Populations” component also discusses some of the following steps in microplanning.



Photo Credit: Amos Bassi, JSI

STEP 1: PREPARATION

Before starting the microplanning process, participants should be oriented on the RED approach and its importance in increasing and sustaining immunisation coverage. If services are to be integrated or combined, this should include a description of the service package and refresher orientation, if necessary, to ensure that planners are up-to-date technically and managerially on the requirements of each service.

Annex 1 contains samples of many standard microplanning forms updated for this revision of the Guide. These and other sample forms are contained in the planning module of the Mid Level Management (MLM) modules and can be adapted/expanded for use with other essential health interventions in settings where national or local policies support integration.

STEP 2: SITUATION ANALYSIS AND MAPPING



Use these Annex 1 tools to better understand the landscape:

- Tool 1a – Socio-demographic characteristics
- Tool 1b – A detailed health facility map/ health district map

Before developing the actual microplan, planners should know as much as possible about the eligible population and past immunisation trends. Population data, immunisation programme reports and updated catchment area maps are starting points in the microplanning process.

Detailed maps of districts and health facility catchment areas should be drawn. District maps should show all health facilities (public and private), major population settlements, roads, distances, rivers, current outreach sites, etc. A health facility map should show these same details plus the borders of its catchment area, the location of any hard-to-reach areas or areas with large numbers of unimmunised children, plus any major barriers to service delivery (i.e., seasonal flooding, mountains, rivers, etc.).

Population data is normally provided by Ministry of Health planning departments or local authorities, based on estimated growth rates since the last census. Where population estimates are unreliable (i.e., higher or lower than the reality), planners often use informal headcounts or records from national immunisation days (NIDs) and other campaign-style activities to refine those estimates before including them in their microplans.

Analysis of immunisation data (and other health service data where planning is integrated). Data from two or three prior years should be reviewed during a situation analysis. As part of district or health facility microplanning, managers should review and analyse the following immunisation programme indicators:

- Vaccination coverage rates (all antigens).
- DTP1-DTP3, DTP1-Measles drop-out rates.
- Numbers of unvaccinated children by health facility/community.
- Service delivery strategies and results: frequency of fixed, outreach, mobile and other immunisation services and results when compared to targets.
- Management indicators: frequency of supportive supervision visits and monitoring/review meetings, presence of updated monitoring charts in health facilities.
- Vaccine supply: frequency of vaccine stock-outs, overstocks, vaccine wastage rates.
- Cold chain and logistics: health facilities without adequate cold chain, syringe stock-outs, temperature monitoring, transport material, etc.
- Surveillance data: cases of vaccine-preventable diseases, deaths, locations of epidemics.
- Community involvement: frequency of review meetings with the community, presence of defaulter and newborn tracking, types of health education materials and activities, quality of health worker communications with communities and families.
- And others...

Where immunisation is part of an integrated package of care, the situation analysis should include a review and analysis of a similar set of indicators for all included services.

STEP 3: SET ANNUAL OBJECTIVES AND TARGETS



Use these Annex 1 tools to identify problems, look at solutions, and set priorities:

- Tool 2a –Situation analysis, problem identification and priority setting
- Tool 2b – Cause of problems and solution analysis

Objectives and targets should be associated with the five immunisation operations (vaccine supplies and quality, logistics, service delivery, surveillance, advocacy and communication) followed by the three pillars that support these operational components (management, funding and capacity building). Objectives should be SMART (Specific, Measurable, Achievable, Realistic and Time-bound).

STEP 4: IDENTIFY STRATEGIES, DEVELOP ACTIVITIES AND TIMELINES



Use this Annex 1 tool to better understand immunisation coverage by strategy:

- Tool 3: Immunisation coverage objectives and targets

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

STEP 5: SELECT KEY INDICATORS FOR MONITORING AND EVALUATING ACTIVITIES

Monitoring requires the regular collection and analysis of data to verify that activities are being implemented as planned, and results are being achieved. Managers select and use indicators to monitor and evaluate progress. They also review progress with stakeholders and provide feedback through regular meetings that involve health workers and community members. Chapter 7: “Monitoring for Action” and Annex 2: RED Monitoring Tool describe the monitoring and evaluation process. Annex 2 also lists potential core and supplementary indicators that might be considered, tailored to local strategies and included in microplans.

STEP 6: ESTIMATE RESOURCE NEEDS AND PREPARE A DETAILED BUDGET

In determining what resources will be needed to implement an immunisation microplan, the following questions should be answered:

- Who will carry out the proposed immunisation activities?
- What resources are needed to carry out the proposed activities?
- What resources are available for these activities and from whom?



Use these Annex 1 tools for vaccine and supply forecasting and budgeting:

- Tool 4a – Vaccine and other supplies forecast
- Tool 4b – Injection material forecast

The plan should state how much of each resource (human, material, financial and time) will be required for each of the proposed activities. This includes the quantities of vaccines and other supplies, including waste management supplies, required for immunisation services. Other important items to cost in immunisation microplans include: transport costs for regularly collecting or delivering vaccines and supplies; costs of registers, family records, reporting

forms and coverage monitoring charts; health worker costs to attend planning and review meetings, participate in mobile immunisation or integrated health clinics; costs of community meetings; etc. (see Annex 1, Tool 7).



Once budgets are complete, planners often find that their plans do not fit the resources they have available. When this is the case, they may have to revise the microplan to fit the resources available. Although it is beyond the scope of this Guide to address strategies for resource mobilisation, when resources are scarce, fundraising is sometimes necessary. Advocacy to raise additional support from government and donors, and or partnerships with community leaders, NGOs or private enterprise to increase support are common approaches to increasing available resources for immunisation programmes.

Photo Credit: IMMUNIZATIONbasics

STEP 7: USE THE MICROPLAN AS A MANAGEMENT TOOL; UPDATE IT REGULARLY

The district microplan should be part of the overall district health plan. Likewise, the health facility microplan should be integrated into the overall health facility plan and both should be used as advocacy tools to gain support from local governments, other government agencies, NGO partners and stakeholders. Microplans are dynamic documents that require regular review and periodic updating (at least every six months) to reflect the changing environment. For example, the failure to reach a quarterly target may require a rethinking of strategy and revisions to the microplan. Unexpected changes in the political or financial environment, logistical problems, new national health initiatives requiring staff time, civil unrest and other catastrophic events that cause shifts in population all have implications for the organisation of immunisation and other PHC services and should be reflected when updating microplans.

3.3

MANAGING RESOURCES

Managing immunisation and other PHC services requires human, financial, and material resources. Financial requirements are often stated, but in reality may be difficult to meet. This is particularly true when there are competing needs and funding is unpredictable. In situations where there are “adequate” resources, however, making sure that those resources get to where they are needed is an important part of the management function.

The 2007 RED evaluation¹ conducted in nine countries in the Africa Region did not produce sufficient data to determine the full funding package for routine immunisation (RI) or RED. Nonetheless, the evaluation showed that government budgets, particularly at the district level, are covering many of the recurrent costs of

¹ <http://www.afro.who.int/ddc/vpd/routine/red-2007.pdf>

the RED approach, and that GAVI Alliance ISS funding has been an important new source of funding for RED and for the strengthening of national immunisation programmes in general.

District health managers must be able to prioritise the many activities for which they are responsible. They must also be prepared to allocate available staff, supplies and funding to meet the most pressing health needs of their beneficiary populations. The following paragraphs touch very briefly on some of the considerations when allocating human, financial and material resources.

WHAT TO CONSIDER IN MANAGING HUMAN RESOURCES

- Staff orientation, managerial capacity building and training on immunisation and other integrated essential health interventions, and deployment.
- Pre-service and refresher/in-service training, on-the-job training using the opportunities of supportive supervision, and capacity building as part of monitoring.
- Staff motivation:
 - Supportive supervision.
 - Recognition of performance.
 - Management of staff placement, including planning for training of new personnel (e.g., pre-service, in-service refresher, on-the-job and other types of training, taking into consideration integration aspects).
 - Financial and non financial incentives.

WHAT TO CONSIDER IN MANAGING FINANCIAL RESOURCES

- Review available financial resources (by source) and identify funding gaps.
- Determine how to utilise existing coordination mechanisms at district level to raise additional funds.
- Explore pooling of resources from different areas to take advantage of integration (e.g., transport shared with different programmes or a minimum package for outreach and/or mobile services which includes Vitamin A supplementation, distribution of ITNs, etc.), without compromising service quality.
- Determine how activities can be jointly conducted to avoid duplication when they involve the same person and the same time frame.

WHAT TO CONSIDER IN MANAGING MATERIAL RESOURCES

- Demand for integrated health interventions including immunisation services.
- Infrastructure and equipment gaps.

For further detail, see Section 8.1 on Logistics.

CORE INDICATORS FOR “PLANNING AND MANAGEMENT OF RESOURCES”

Adapt and use the following process indicators—taken from the RED Monitoring Tool—to monitor “planning and management of resources” across districts and health facilities.

- % of **DISTRICTS** with RI microplans updated at least (**every 6 months**)
- % of **DISTRICTS** with stock-out of any antigen in district store in last (**month**)
- % of **DISTRICTS** with AD syringe stock-out in district store in last (**month**)
- % of **DISTRICTS** with at least one staff trained on RI in the previous (**year**)
- % of total health funds disbursed for RI activities during the last (**quarter**) at **DISTRICT** level
- % of **HEALTH FACILITIES** with RI microplans updated at least (**every quarter**)
- % of **HEALTH FACILITIES** with stock-out of any antigen in HF in the last (**month**)
- % of **HEALTH FACILITIES** with AD syringe stock-out in HF in the last (**month**)
- % of **HEALTH FACILITIES** with at least one staff trained on RI in the previous (**year**)

These core indicators are intended to remind district and health facility teams (and inform those at higher levels of the health system) of the importance of using location-specific data to make timely adjustments in immunisation and other PHC services. They measure the level of effort that districts and health facilities put into planning, vaccine management, injection safety, capacity building and financing.

Because this component is so broad, supervisors may also want to incorporate additional “supplemental” indicators from the RED Monitoring Tool that more accurately reflect key technical areas that your country may wish to monitor and take action on (see Annex 2 for more details).

3.4

RESOURCES

WHO/AFRO/EPI, Mid-Level Management Course for EPI Managers. Module 1. A problem-solving approach to immunisation services management. March 2004 – Draft 2.

http://www.afro.who.int/ddc/vpd/epi_mang_course/pdfs/english/Mod%201.pdf

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http://www.afro.who.int/ddc/vpd/epi_mang_course/pdfs/english/Mod%204.pdf

Immunization in Practice.

Module 5. Planning immunization sessions to reach every infant. WHO/IVB, World Health Organization, Geneva, January 2004.

<http://www.who.int/vaccines-documents/DoxTrng/b4iip.htm>

4

REACHING THE TARGET POPULATIONS

“Reaching the target populations” is a process to improve access to and utilisation of immunisation and other health services in a cost-effective manner through a prioritised mix of service delivery strategies that meet the needs of target populations (children and women).

4.1

KEY ISSUES

To achieve and sustain high levels of coverage in target populations, service delivery strategies must be used that are appropriate to the needs of those populations. To develop the right mix of strategies, health officials must identify where the eligible groups are located, including those who are hard to reach; the number of eligible groups by location; the reasons (if any) why they have been underserved or why they under-utilise services; and the ways in which they can be reached. Identifying and understanding these factors are key to increasing access and reducing drop-out rates and missed opportunities.

In the past, this component of RED was called “re-establishment of outreach services.” It has been renamed to emphasise that a mix of outreach and fixed services² may be needed, as well as mobile or occasional campaign-style activities (sometimes called “periodic intensification of routine immunisation”). It overlaps with other RED components, particularly planning and management of resources, monitoring for action and linkages with communities.

To reach target populations, health officials need to consider the following:

- What are the characteristics and needs of the different target populations within a district or within the catchment area of health facilities?
- What is the appropriate mix of fixed and outreach services necessary to reach target populations and minimise barriers to immunisation, given the limits of financial, human and material resources? Are other strategies that require more resources also needed, such as mobile or periodic campaigns?

² “Fixed services” refers to services offered at the health facility. “Outreach” refers to services in the community that health workers can both go to and return from in the course of the working day. “Mobile services” are those that require a trip of more than one day; mobile teams typically spend several days visiting a circuit of remote areas.

- What steps are needed to ensure that the quality of services is high enough for target populations to make full use of them? What other services should be offered along with immunisation?
- What innovative and problem-solving approaches can be used to reach left-outs and defaulters or drop-outs, particularly within hard-to-reach or under-served populations?

An innovation and RED “best practice” has been the prioritisation of districts for RED introduction based on their absolute numbers of un-immunised children relative to other districts. For a detailed description of the criteria used to prioritise districts for RED, see Annex 4.

4.2

PROCESS FOR REACHING THE TARGET POPULATIONS

Reaching target populations through a mix of service delivery strategies involves a thorough planning process. The process should include identifying the characteristics and needs of the target populations, the ways that they can be reached with immunisation and other essential health interventions, and the resource requirements. As part of the microplanning process described in the previous section (with forms in Annex 1), the following steps can be useful:

STEP 1: MAP DISTRICT AND REVIEW DATA

- Map the locations of the various health facilities and target populations (both large and small).
- Assign or update the catchment area for each facility, based on location and other considerations such as physical or cultural barriers faced by target populations.
- Review immunisation coverage figures to find out if there are problems with:
 - Low DTP1 coverage, indicating left-out populations with low access to services.
 - Low DTP3 coverage and high DTP1-DTP3 drop out (>10%), indicating defaulters and problems with the quality or reliability of services.
- Review information from other sources in order to obtain additional information about target populations with low immunisation coverage, for example, recent NIDs or SNIDs (Sub-National Immunisation Days), catch-up campaigns, child health days or weeks, reports of special projects, NGOs, etc.

STEP 2: DECIDE ON SERVICE DELIVERY STRATEGIES

- Estimate in broad terms which populations can be reached with fixed services and which require outreach services. In rural areas, outreach services are often provided for populations that are located 5-15 km from health facilities. In urban areas, outreach is often provided in heavily-used locations in the community that are easy for target populations to reach such as marketplaces, community centres and schools. Although calculating these estimates is largely a health facility-level step, because of budget implications districts will need to have an idea of the estimates for all of the health facilities in their catchment areas.
- Determine if some populations can only be reached by mobile services. Mobile services usually require extra resources from the district or regional level, including dedicated teams of vaccinators, vehicles and fuel, and special logistical preparations.
- Clarify if there are any special campaign-style activities planned for the year such as child health days or weeks, estimate how much they can contribute to reaching targets for routine immunisation coverage, and plan activities with those targets in mind.



Photo Credit: Arturo Sanabria, JSI

STEP 3: DEVELOP INDIVIDUAL MICROPLANS WITH HEALTH FACILITIES

- Review immunisation coverage from past years to understand whether there are problems with left-outs (low DTP1 coverage), drop-outs (high DTP1-3 drop-out rates), and seasonal variations.
- Identify target populations in the facility catchment area that are not being reached. This may require updating the health facility catchment area map.
- For those underserved groups, identify reasons for low utilisation of services and determine if this is due to problems with supply or demand.
- Meet with community leaders of those groups to better understand the barriers they face and develop strategies for reaching them. This may include changing the times for fixed services, deciding on times and locations for outreach or taking particular steps to improve the quality of services.

- Consider special issues such as providing extra outreach before the rainy season or harvest, or locating outreach in high-traffic, convenient areas such as markets.
- Based on the above, decide on the number and frequency of vaccination sessions for each strategy and develop a schedule for them. Keep in mind that because outreach services take staff out of the facility, services at fixed facilities may need to be offered less often. Also consider how frequently to provide outreach to a given location. While there must be a minimum of one month between outreach sessions, if that interval is increased to two months, it allows health facilities to provide outreach to more locations.
- Budget the resource requirements for the schedule of fixed and outreach sessions, including human resource and transportation requirements. If the mix of services is too costly or not feasible, modify it to make it more realistic.

STEP 4: IMPLEMENT AND MONITOR

- Coordinate with community leaders to prepare for outreach sessions. This includes clearly informing communities when and where outreach will take place and discussing ways in which the community can contribute.
- Conduct vaccination sessions as planned and monitor coverage.
- Monitor whether vaccinations sessions are being conducted as planned.

ASSURING THE QUALITY OF SERVICES DURING A VACCINATION SESSION

For services to be effective, safe, and appealing to caretakers, it is essential to:

- Provide the right quantity of vaccines and other supplies.
- Maintain vaccines at the proper temperatures at all times: during storage, transport and vaccination sessions.
- Assure the safety of immunisation, including reconstitution of vaccines, vaccine administration, discarding reconstituted vaccines within six hours and waste management.
- Correctly record the doses administered on tally sheets and registers.
- Provide caretakers with key information: date, time, and place for next immunisation, number of visits still needed for the child or woman, what to do if there is an adverse event following immunisation.
- Monitor whether vaccinations sessions are being conducted as planned.

Immunisation services provide an important opportunity to address the health needs of children and their caretakers. This is particularly true during outreach and mobile vaccination sessions because the populations attending these sessions often have very limited access to fixed health services.

Many child health days and other campaign-style activities now provide other health services in addition to immunisation. Integration of services also occurs at many health facilities and outreach sessions on a routine basis. Some considerations to keep in mind when looking for opportunities to link immunisation and other health services are shown on the following chart.

CRITERIA TO CONSIDER IN LINKING IMMUNISATION AND OTHER INTERVENTIONS

| Related to the intervention | Related to health system context |
|--|---|
| <p>A health intervention or service has good potential for combining with routine immunisation if it ...</p> <ul style="list-style-type: none"> • Has a similar target group and target age • Requires similar timing or frequency • Has similar logistical requirements • Has a similar level of acceptance among patients, communities and health workers • Requires that health workers have a similar skill level | <p>Another health intervention or service has a good chance of being successfully combined with immunisation if ...</p> <ul style="list-style-type: none"> • Political will exists to promote integration and coordination among different program managers • National policies support both interventions • Financial support is secure for each intervention • Existing primary health care structures support the delivery of both interventions • Responsibility for supporting and monitoring each intervention is clearly defined among programs • Health workers are “multi-purpose”, not designated for only a single intervention • Combining the interventions does not disrupt or create an unrealistic burden for service delivery |

Many countries have adopted approaches to intensify the delivery of immunisation and other services through occasional campaigns. These activities go by different names in different countries, including Child Health Days/Weeks, Sustained or Enhanced Outreach Services (SOS/EOS), Immunisation Plus Days, etc. In general, they are called “periodic intensification of routine immunisation”. While they differ widely from country to country, some common features include:

- The immunisation doses administered are usually considered routine, not supplementary (as with NIDs or SNIDs).
- Other services are provided, most commonly Vitamin A, de-worming and ITN distribution.
- In many countries, they are conducted at least twice per year.
- For communities and political leaders, they increase the visibility and importance of immunisation and other essential health services.
- They provide an opportunity to reinforce to communities the need for routine immunisation to complete the vaccination schedule.

CORE INDICATOR FOR “REACHING THE TARGET POPULATIONS”

Adapt and use the following process indicator—taken from the RED Monitoring Tool—to monitor “reaching the target populations” across health facilities. The best way to monitor this component is simply by measuring vaccination coverage at decentralised (district and health facility) levels [see also “Monitoring for Action” component].

% of outreach sessions conducted versus planned by
HEALTH FACILITIES in a given (month*).

This core indicator will remind district health teams and health facilities (and inform those at higher levels of the health system) to monitor and prioritise resources based on vaccination coverage by strategy type. (fixed, outreach, mobile). The core indicator reflects how effectively plans are being carried out, but does not address gaps in reaching eligible populations by strategy type. In order to do this your country will need to start tallying and reporting data according to service delivery strategy.

Supplemental indicators in the RED Monitoring Tool (Annex 2) provide additional ideas for how to track coverage by strategy type.

** frequency based on national guidelines*

Technical Resources

WHO/AFRO/EPI, Mid-Level Management Course for EPI Managers. Module 5. Increasing Immunisation Coverage. March 2004 – Draft2.
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Increasing immunization coverage at the health facility level. WHO/V&B/02.27, World Health Organization, Geneva, December 2002
http://www.who.int/immunization_delivery/systems_policy/www721.pdf

Immunization Essentials: a Practical Field Guide. Chapter 3. Delivery of Immunization Services, pp. 43-59.
http://www.pbnip.com/portfolio/pub_examples/immunizationessentials.pdf

Country Example

Guidelines for Mobile Brigades (Mozambique MOH, Project HOPE, CHANGE Project), 2005.
http://www.immunizationbasics.jsi.com/Resources_Immunization.htm#Outreach

5

LINKING SERVICES WITH THE COMMUNITY

District health teams and health facility staff engage with communities to make sure that immunisation and other health services are meeting their needs. This RED component encourages health staff to partner with communities in managing and implementing immunisation and other health services—and in the process to build demand for services and community confidence in the safety, effectiveness and reliability of those services.

5.1

KEY ISSUES

One normally thinks of a community as a group of people living in the same geographic area. While this is true, people who identify strongly with the same religion, political party or economic situation can also be considered a “community” for immunisation and other PHC services.

To reach all eligible woman and children, community leaders and community-based groups of different types should be engaged in planning, organising and generating demand for immunisation services. Effective partnerships between health workers and communities are particularly important for reaching hard-to-reach populations and reducing immunisation left-outs and drop-outs.

The community’s role in “increasing demand” for immunisation is often cited as the purpose of community involvement. However, lack of motivation or desire for immunisation may be only one of several reasons why women and children are not fully vaccinated. In fact, research shows that when services are available at a convenient time and place, and service delivery is of good quality, most mothers/caretakers are very willing to have their children vaccinated.

Understanding the reasons for low immunisation coverage becomes much easier when district and health facility staffs establish a rapport with the community and involve community members in planning, promoting implementing and monitoring services. The community has an important role to play in informing mothers/caretakers about the benefits of immunisation and the availability of immunisation services.

5.2

BUILDING EFFECTIVE COMMUNITY PARTNERSHIPS

To establish effective partnerships with communities, **health teams** must be trained and able to:

- Identify community-based organisations, community leaders (political, religious and other leaders) and other residents with a role to play in improving immunisation and other PHC services.
- Communicate the dangers of vaccine-preventable diseases and the availability of immunisation and other PHC services to these groups.
- Motivate community groups to play a role and ensure their ownership by involving them in planning, generating demand for and conducting immunisation sessions.
- Advocate with community leaders to increase their support for immunisation and other PHC services.
- Train and retrain health facility staff and community educators to communicate correct information and motivate communities.
- Develop agreements between communities and health staff, outlining their collaboration and responsibilities to each other.
- Keep a community's leaders informed about the status of its immunisation and other PHC indicators.
- Monitor and acknowledge community contributions to improved services.
- Report vaccine-preventable diseases or adverse events following immunisation.

5.3

COMMUNITY-FRIENDLY SERVICES

Community input is often required to make services more user-friendly. Steps in making services more accessible and acceptable to all community members may include:

1. Getting to know the population—Where are they? What do they do? Where are the hard-to-reach groups? Who are they? Who are their leaders? Who do they listen to regarding health matters?
2. Soliciting community input to determine vaccination schedules and venues. As noted previously in the “Reaching the Target Populations” component, this may involve meeting with community leaders to better understand the barriers they face and developing strategies for reaching them.
3. Working together to decide when and where outreach will take place and discussing ways in which the community can contribute. This may involve offering immunisation and other PHC services at times that are convenient for the population. For example:

- Immunisation sessions held in the evening, on market days or on one Saturday or Sunday afternoon a month to ensure that working parents are able to bring their children.
- In areas where mothers/caretakers are busy in the fields or selling at the market in the morning, another strategy might be to move service hours from early mornings to late afternoons.

Even if it is not possible to accommodate the needs of all community members when adjusting schedules, by consulting with communities through meetings, interviews and group discussions, health staff will discover community preferences. This will help in developing a schedule that meets the needs of majority community residents.

5.4

INVOLVING COMMUNITIES IN SERVICE DELIVERY

Communities can assist with immunisation and other PHC sessions in a number of ways. In many countries, community members are enlisted to:

- Motivate others to use immunisation and other PHC services.
- Arrange a clean outreach site (school, community meeting room, etc.).
- Transport vaccines and health workers, particularly for outreach sessions.
- Inform other community members when a health worker or team arrives at the outreach site.
- Register patients, control crowds and make waiting areas more comfortable on the day of a fixed or outreach session (by providing shade and organising space and seating).
- Deliver appropriate health education messages, including dispelling rumours about immunisation.
- Assist with newborn and defaulter tracking.
- Arrange home visits when children are behind schedule, to explain immunisation and to motivate caregivers.
- Provision of equipments and even financial support

5.5

THE ROLE OF COMMUNICATION

Study after study shows that health workers are the most common source of health information in most communities. More effective communication between health workers and communities may be needed to improve the quality and utilisation of immunisation and other PHC services.

Effective communication for health means listening to, understanding, encouraging and working with individuals and communities to improve their health and the services available to them. Simply giving people information, without a back-and-forth exchange, is not enough.

Health workers, parents and the community need to understand:

- What vaccine(s) are to be given and what they are for (e.g, DTP protects babies from the diseases of diphtheria, tetanus and pertussis)—while bearing in mind there may not necessarily be a strong correlation between parents' knowledge of the disease that the vaccines protect against and getting their children vaccinated.
- Possible side-effects of each vaccine and how to manage them if they occur.
- The date, place, and time of the next immunisation.
- That even ill children should be brought for immunisation.
- Total number of visits to complete immunization schedule
- That only fully immunised children are best protected from vaccine-preventable diseases.
- The importance of keeping immunisation cards in a safe place and always bringing them to the immunisation clinic.

To improve community understanding and utilisation of services, districts should include strategic communication and advocacy activities in their annual work plans and budgets. They should also train and retrain health workers to improve their interpersonal communication and community partnering skills. At the district level, managers have an important advocacy and feedback role to play by informing district leaders and organisations regularly on the performance of the immunisation programme.

Communities can help in planning, implementing, and monitoring immunisation and other PHC services. When health staff consult communities about service locations and timing, immunisation sessions

often become more convenient for the intended users. When health staff give information and feedback to communities about coverage and disease outbreaks, and solicit community input to solve problems, communities feel greater ownership of their health services and this alone will increase their use. To work effectively with communities, health managers and health workers must understand community dynamics, have strong communication skills and recognise the role that community partners can and should play in improving services.



Photo Credit: Harvey Nelson, Courtesy of Photoshare

CORE INDICATORS FOR “LINKING SERVICES WITH THE COMMUNITY”

Adapt and use the following process indicators—taken from the RED Monitoring Tool (Annex 2)—to monitor “community linkages” across districts and health facilities.

% of **DISTRICTS** that conduct at least (one) meeting per (quarter) in which immunisation and other PHC services are discussed with leaders of community-based organisations, local authorities, religious leaders, etc.

% of **HEALTH FACILITIES** that conduct at least (one) meeting per (quarter) in which immunisation and other PHC services are discussed with representatives of community-based organisations, political leaders, religious congregations, etc.

These core indicators will remind health facilities and district health teams (and inform those at higher levels of the health system) that it is important to involve communities in immunisation and other PHC services.

In addition to determining whether community meetings are held or not, supervisors will also want to know who is participating in such meetings, the quality of information flow and the degree to which communities are working with health facilities to improve services.

5.6

RESOURCES

Technical Resources

WHO/AFRO/EPI, Mid-Level Management Course for EPI Managers. Module 3. Communication for immunisation programs. March 2004 – Draft2.
http://www.afro.who.int/ddc/vpd/epi_mang_course/pdfs/english/Mod%203.pdf

Immunization in Practice. Module 8. Building Community Support for Immunization. WHO/IVB, World Health Organization, Geneva, January 2004.
<http://www.who.int/vaccines-documents/DocTrng/b4iip.htm>
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Strengthening Immunization Programmes: The Communication Component. BASICS II/USAID. Arlington, Virginia, USA, May 2004.
<http://www.basics.org/documents/pdf/Immunization%20CBC%20document.pdf>

Country Examples

Bringing Immunization Services Closer to Communities: The Reaching Every District Experience in Ghana. WHO/Ghana. March 2005.
http://www.who.int/countries/gha/publications/RED_approach_in_Ghana.pdf

Community Problem Solving and Immunization Strategy Development – Linking Health Workers with Communities. UNEPI Ministry of Health of the Republic of Uganda, Kampala, Uganda, August 2003.
http://www.basics.org/documents/pdf/Community_Problem_Solving_Uganda.pdf
http://www.basics.org/documents/pdf/Facilitators_Guide_Consultation%201.pdf
http://www.basics.org/documents/pdf/Facilitators_Guide_Consultation%202.pdf

6

SUPPORTIVE SUPERVISION

Supportive supervision, a key component of the RED approach, focuses on promoting quality provision of services by periodically assessing and strengthening service providers' skills, attitudes and working conditions. It includes regular on-site training, feedback and followup with staff to ensure that routine and newly-introduced action points are being addressed correctly.

6.1

KEY ISSUES

Supportive supervision is recognised as a vital approach to improving the quality of services and programme management. Supportive supervision should be described in national policies and conducted on a regular basis among all levels.

Supportive supervision refers to the process in which experienced technical staff, designated and trained as supervisors, assess other staff members' job performance, give positive and negative feedback and then work cooperatively with the staff to improve weaker performance areas. This process is a key activity intended to improve the safety, efficiency and impact of immunisation services. It can and should be complemented by additional performance-improvement strategies such as:

- Pre-service training
- In-service training
- Mentoring
- Exchange visits (peer to peer)
- Reference documents (manuals, web sites)
- Job aids.
- Programme actions intended to improve job satisfaction: enhancing employee benefits, giving staff public recognition, improving the work environment, filling vacancies, etc.

6.2

MAKING SUPERVISION SUPPORTIVE

Supportive supervision involves observation of performance, with provision of documented feedback that leads to collaborative problem-solving. To be effective, supervisors not only need good technical and observational skills, but also good interpersonal skills, the ability to build trust and a sympathetic attitude towards immunisation staff.

HOW SHOULD SUPPORTIVE SUPERVISION BE PLANNED?

In collaboration with health facility staff, district teams should plan their supportive supervision activity as part of their annual district microplan. The activity schedule should indicate priority supervision sites with clear terms of reference (see microplan sample, Annex 1). Where feasible, district teams should plan, at minimum, the frequency of visits recommended in national guidelines.

WHO SHOULD SUPERVISE AND HOW OFTEN?



In health facilities that have more than a few staff, the designated head of the facility should observe staff at least monthly in a structured way, using a supervision tool. In addition, supervisors from the district level should supervise each health facility at least quarterly. Provincial and national staff should also supervise EPI activities in districts and provinces, respectively, at least quarterly. While every facility should be visited at least the number of times recommended by country guidelines each year, it also makes sense for district teams to give increased attention (supervisory visits and other support—see bullets in “Key Issues” above) to those facilities with the weakest performance.

Photo Credit: Jenny Sequeira, JSI

WHAT SHOULD SUPERVISION CONSIST OF?

Supportive supervision should be considered as capacity building, not as evaluation and giving sanctions. A supervision session consists of:

- Assessment of practices (through observations including immunisation sessions, discussions and review of records and graphs).
- A participatory discussion of observations, highlighting both positive and negative findings.
- A discussion on a small number of weaker areas that everyone agrees they can improve.
- A discussion of the strategy and steps for implementation, including what the facility staff themselves will try to do, what the district staff will try to do and, in some cases, what national staff or systems must do; and a written record of the joint agreements on changes (improvements) that all are committed to, to be followed-up the next time.

HOW SHOULD STANDARDS BE ESTABLISHED?

Supervision should assess how well providers are meeting national EPI technical standards as well as practices that reflect positive attitudes. It is highly recommended that a participatory process be utilised that involves all levels of health staff in reaching consensus on the EPI responsibilities (tasks) and performance standards (quality of performance) for each type of worker involved in EPI. Then program managers need to prioritise key tasks and standards for on-site and outside supervisors to assess. A supervision tool (see section Annex.3) should reflect priority technical standards and attitudes, guiding the supervisor to assess such things as:

- Availability and quality of vaccine/supply stock and cold chain equipment.
- Indicators such as measles and DTP3 coverage, drop-out rate, planned versus conducted sessions (fixed and outreach/mobile), missed opportunities and number of children under five sleeping under ITNs, etc.
- Use of data for decision making.

SHOULD SUPERVISION COVER ALL SERVICES OR JUST EPI?

Supervision that focuses on one service such as EPI can be much more detailed and focused than integrated supervision, which can be of limited value because it often covers many technical areas superficially. However, many health systems do not have the personnel or funding for vehicles and fuel to support separate supervision for each program, so some degree of integration is often necessary. The best solution is a combination of on-site and outsider supervision visits that focus on one to three technical areas in any one visit. Supportive supervision visits should be planned so that any one technical area, such as immunisation, is assessed in-depth at least three times per year, hopefully more often.

WHAT TOOLS FACILITATE SUPPORTIVE SUPERVISION?

A tool similar to the one described in Annex 3 is recommended. The tool leads supervisors and providers supervised through a constructive, participatory process aimed at identifying areas needing attention, discussions of causes and implications of weaker areas, joint problem-solving and clear agreements on next steps and responsibilities. Supervision visits should last at least a few hours, ideally longer, so that they are not pro forma exercises in filling out checklists but are rather joint team-building work sessions. Finally, an important step in developing a good supportive supervision system involves using a participatory process to agree on definitions of what each item (practice assessed) means. This step allows various supervisors (on-site as well as external) to use the same criteria in assessing each practice and for the tabulation of findings on a district or other level to be more valid.

HOW SHOULD THE INFORMATION COLLECTED BE USED?

Supervision findings are primarily for use by health providers and facility directors, so they become aware of problems and have a roadmap for developing solutions. The outside supervisor uses the checklist and agreement forms in his/her next visit to assess progress or lack thereof and reasons. The district team and provincial and national staff can track indicators across health facilities (or districts or provinces) and take steps—such as training, job aids, new procedures, policies or job expectations—to address low indicators that are not improving.

WHAT ARE SOME TIPS FOR EFFECTIVE SUPPORTIVE SUPERVISORY VISITS?

- Allow enough time to make visits meaningful, particularly when integrated.
- Follow-up on the recommendations from previous supervision visits.
- Observe delivery of immunisations and other health interventions.
- Conduct exit interviews to get feedback from caretakers.
- Acknowledge publicly good performance and correct errors in techniques and procedures in private.
- Provide on-the-job training, including updating on current policies and technologies and identifying future training needs and career prospects for staff.
- Collaboratively review major findings, possible solutions and action points, including assessing status of work plans.
- Record observations, feedback and agreed-upon follow-up actions in the supervisory logbook (see sample Supervisory Logbook format, Annex 1, and generic supportive supervision format in Annex 3).
- Agree on the next supportive supervision visit date based on the support supervision activity plan.

National and district programmes should consider developing and using a supervision format similar to the one in Annex 3. It is designed specifically to both assess important indicators of programme quality and to facilitate a supportive, team-building, problem-solving process during supervision visits.

CORE INDICATOR FOR “SUPPORTIVE SUPERVISION”

Adapt and use the following process indicator—taken from the RED Monitoring Tool (Annex 2)—to monitor “supportive supervision” across districts.

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

This core indicator is intended to remind districts teams (and inform those at higher levels of the health system) of the importance of conducting regular supportive supervision at each health facility according to national guideline frequency.

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

6.3

RESOURCES

Technical Resources

WHO/AFRO/EPI, Mid-Level Management Course for EPI Managers. Module 21. Supportive Supervision by EPI Managers. March 2004 – Draft 2. www.afro.who.int/ddc/vpd/epi_mang_course/pdfs/english/Mod%2021.pdf

Marquez, L. and L. Kean, “Making Supervision Supportive and Sustainable: New Approaches to Old Problems,” MAQ Paper No. 4, Supplement to Population Reports, Volume XXX, No. 4. USAID, 2002. www.maqweb.org/iudtoolkit/service_delivery/maqpaperonsupervision.shtml

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

Country Example

PATH and National EPI, Vietnam. “Improving Immunization Through Supportive Supervision.” Seattle: PATH, 2007. www.path.org/files/CP_vietnam_supportive_sup_fs.pdf

7

MONITORING FOR ACTION

Monitoring health information involves observing, collecting and examining programme data. “Monitoring for Action” takes this one step further, not only by analyzing data but by using the data at all levels to direct the programme in measuring progress, identifying areas needing specific interventions and making practical revisions to plans.

7.1 KEY ISSUES

District health teams and health facility staff need a continuous flow of information that tells them whether health services are of high quality and accessible to the target population, who is and is not being reached, whether resources are being used efficiently, and if strategies are meeting objectives.

Immunisation data collected at the health facility level should primarily be used by health facility staff themselves, as well as by supervisors, programme managers and community leaders. Too often, information is passed up the health system in reports and is not used by health staff to monitor their own performance or to solve problems. Health facility staff should use their own data without waiting for supervisory visits (self-assessment).

District health teams and health facility staff can quickly become overburdened by data—particularly in areas with limited human resources. Determining which items of data are essential for programme monitoring is important to lessen the burden of data collection and reporting.

Supportive supervision and regular review meetings are needed to train and mentor health facility staff in the collection and use of monitoring data. During visits to health facilities, district health teams must have adequate time to review data and conduct on-the-job training for health facility staff. Where supervision is integrated, an immunisation-focused supervisory visit may also be necessary from time to time to ensure that supervisors are able to review immunisation data with health staff. In order for districts to provide support to the health facilities in their catchment areas, they in turn require mentoring and support from the level above them.

To monitor the effectiveness of service delivery strategies, data should be tallied and reported according to whether vaccinations are given at fixed, outreach or mobile immunisation sites. If your country is not already collecting and monitoring immunisation data in this way, this should be added as part of the RED approach.

Inaccurate or outdated census counts, population migrations, and unforeseen changes in birth rates and infant mortality often distort the size of a target population and make interpretation of immunisation coverage rates difficult. In these cases, which are very common, national immunisation programmes should work over the long term with health planning units and local authorities to correct census figures. Over the short term, local headcounts (such as those conducted prior to polio or measles campaigns) may have to be used as the “unofficial” denominators for coverage tracking purposes (see also the “Planning and Management of Resources” component, as the microplanning process includes identifying all target populations).

7.2

THE MONITORING FOR ACTION PROCESS

Monitoring and using data for action is a cyclical process, including the five steps listed and described below.

STEPS IN MONITORING FOR ACTION

- STEP 1: Setting Performance Standards
- STEP 2: Selecting Indicators & Targets
- STEP 3: Data Collection and Submission

STEP 1: SETTING PERFORMANCE STANDARDS: NATIONAL LEVEL

Performance standards describe national norms and expectations for the immunisation program. They must be adapted to reflect past performance and available resources, and should be put into writing to guide performance monitoring.

STEP 2: SELECTING INDICATORS AND SETTING TARGETS: NATIONAL LEVEL FOR INDICATORS; ALL LEVELS FOR TARGETS

Many different indicators may be used to monitor district and health facility performance, but immunisation coverage indicators are the most common. Immunisation coverage indicates the proportion of the target population (children under one year of age or pregnant women) that has been vaccinated. Countries use different coverage indicators to monitor different aspects of programme performance. The most commonly used coverage indicators are:

- **DTP1 or BCG coverage rates** are used to monitor a population's access to routine immunisation services. High coverage with either of these antigens means that routine vaccination services were available, accessible and used at least once during the year by most of the target population.
- **DTP3 or routine measles coverage rates** are used to monitor the health system's capacity to deliver immunisation services in a way that is accessible and acceptable to the target population. When this indicator is low, further investigation is always required to determine whether the supply of immunisation services or the population's use of the available services is the underlying reason.
- **Drop-out rates** measure the population's utilisation of immunisation services and can be constructed in multiple ways. The most commonly used drop-out rates are from DTP1 to DTP3 and DTP1 to measles vaccination. Regardless of the indicator chosen, however, high immunisation drop-out (>10%, as defined by WHO) rates are a problem that may be related to a combination of factors, including low demand for vaccinations, client dissatisfaction with available services or the perceived quality of those services, and or an inconsistent supply of services. Finding the causes of high drop-out is an important step in addressing the problem.
- **Number of “unimmunised” or under-immunised children.** An innovation and RED “best practice” has been the prioritisation of districts for RED introduction based on their absolute numbers of unimmunised children relative to other districts. For a detailed description of the criteria used to prioritise districts for RED see Annex 4 and page 7 of Increasing immunisation coverage at the health facility level (WHO/V&B/02.27).

Targets may be set against all of these and other performance indicators related to the RED components and operational issues. For a comprehensive list of suggested indicators, see the RED Monitoring Tool in Annex 2.

STEP 3: DATA COLLECTION AND SUBMISSION: ALLSUB-NATIONAL LEVELS

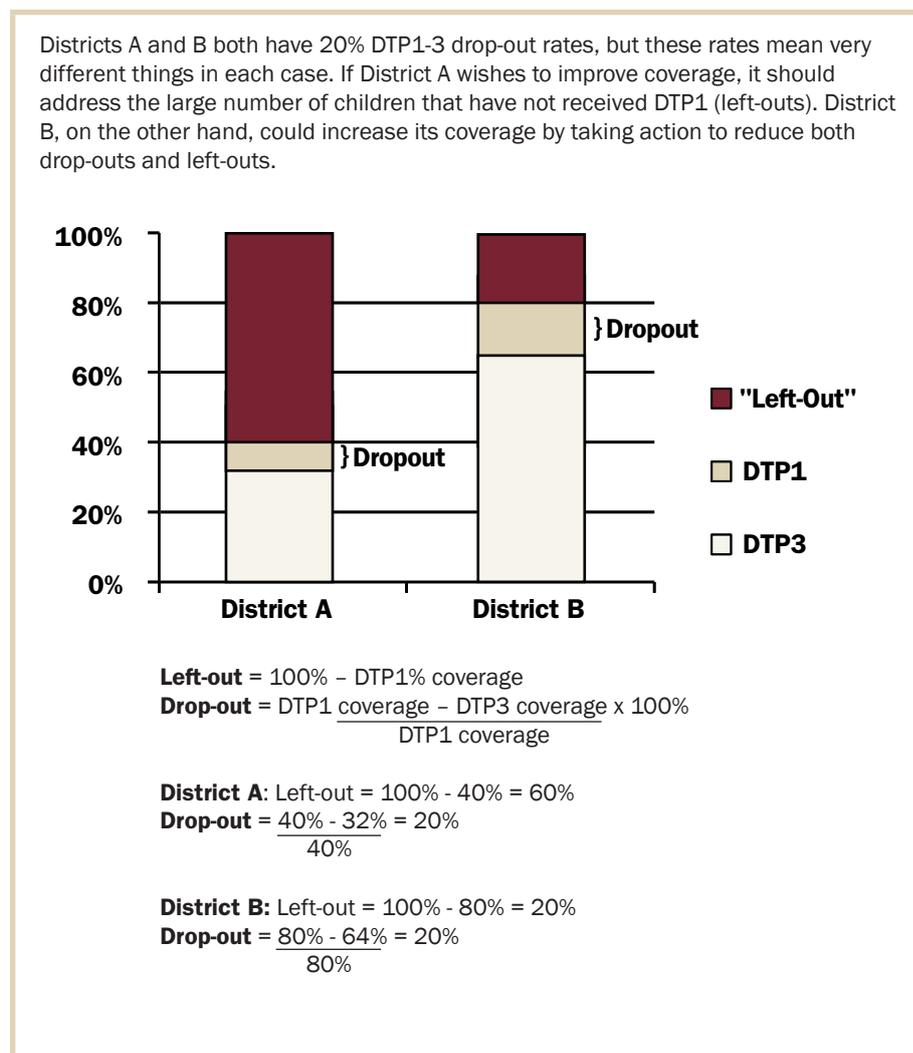
Effective monitoring requires a well-functioning health information system—one that provides accurate, timely and consistent data on immunisation coverage, drop-out and other key indicators. Immunisation data may be collected by an immunisation programme, an integrated health information system, or both. The RED approach focuses on improving the timeliness and accuracy of immunisation data through whichever type of information system is used. The standard monitoring chart used at health facility level helps to monitor, track, and use data.

STEP 4: ANALYSIS AND FEEDBACK: ALL LEVELS, WITH HEALTH FACILITIES “FEEDING BACK” THEIR OWN INFORMATION INTERNALLY TO FACILITY STAFF AND EXTERNALLY TO COMMUNITIES/STAKEHOLDERS

Regular analysis and review of data at all levels is essential, as are written feedback and follow-up. Tools that are sensitive to sudden changes and more subtle trends in coverage, including monitoring charts and detailed catchment area maps for each health facility, are also important.

To determine whether there are continuing problems with left-outs (low DTP1 coverage) or drop-outs (high DTP1-3 drop-out rates) or both, immunisation managers must compare coverage trends over several years. They must also learn to interpret drop-out rates in light of actual coverage, as shown in the example in Figure 1 below.

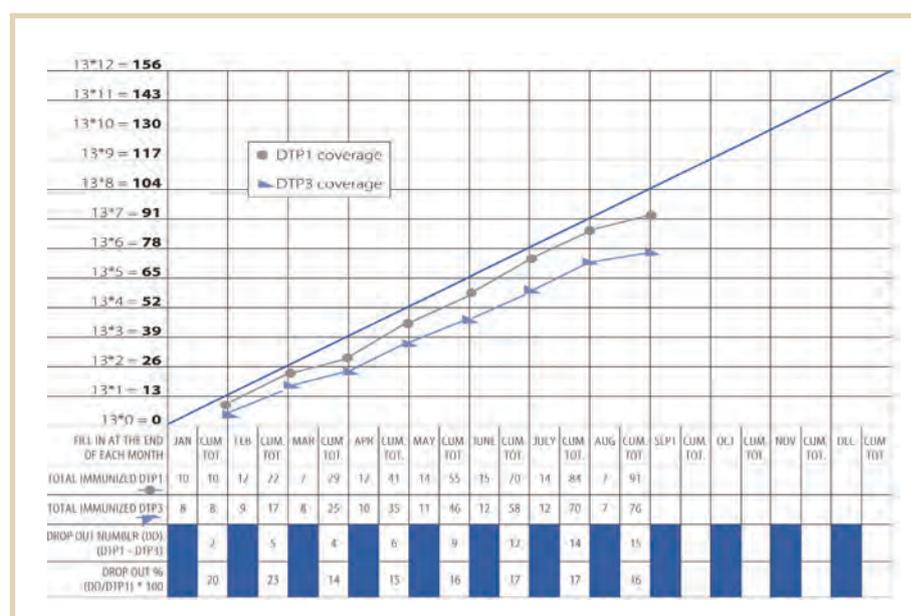
Figure 1: Example: Interpreting Drop-Out



All levels of the health system are encouraged to regularly provide data-related feedback to lower levels. Typically, this entails districts budgeting for and conducting routine review meetings (frequency may be based on national guidelines) with health facilities to share and discuss data trends and problem-solving, including peer sharing of practical experiences. Other types of formal feedback can include assessments of data quality (e.g., data quality self-assessments), reports of actions taken at district or higher levels and specific guidance for health facilities to take action.

Health facility in charges should also review their own data and ensure that staff and key stakeholders in the community are informed about immunisation program performance. Evidence shows that when communities are included in planning and monitoring immunisation coverage and disease incidence and deaths, they are more likely to assist health facilities in implementing strategies to improve access to and utilisation of immunisation services. Visibly displaying immunisation drop-out and monitoring charts on health facility walls can be a useful tool in helping health staff to track their progress in reducing drop-outs and minimising left-outs. In order for monitoring charts to be most effectively, they must be kept up-to-date, drawn correctly and visibly displayed.

Figure 2: Sample Immunisation Drop-out and Monitoring Chart for DTP1 and DTP3



Source: *Immunization in Practice, Module 7: Monitoring and using your data (WHO/IVB/04.06)*

STEP 5: LEARNING AND TAKING ACTION: ALL LEVELS

In reviewing and analysing their data, district health teams and health facility staff should seek explanations behind data that stand out or don't make sense. This requires relying on experience, as well as knowledge of the catchment area (and sometimes even intuition). In order to effectively assist health facility staff, district health teams also need support from higher levels in reviewing their data. They also need facilitation skills to mentor lower levels in problem-solving and other aspects of "monitoring for action".

CORE INDICATORS FOR “MONITORING FOR ACTION”

Adapt and use the following process indicators—taken from the RED Monitoring Tool (Annex 2)—to monitor “monitoring for action” across districts and health facilities.

% of DISTRICTS that conduct at least (one) review meeting per (quarter) in which data, trends, and monitoring for action are discussed with health facilities.

% of total immunisation reports that DISTRICTS receive (monthly) [Note: reports received from health facilities must be both on time and complete to qualify].

% of HEALTH FACILITIES that have immunisation monitoring charts up-to-date, correctly drawn, AND visibly displayed at HF per (quarter) [Note: all three criteria must be met to qualify; definition of “up-to-date” to be determined at national level].

These core indicators measure the level of effort districts and health facilities put into submission, review, and updating of immunisation data. They are intended to remind health facilities and district health teams (and inform those at higher levels of the health system) of the importance of using location-specific data to make timely adjustments in immunisation and other PHC services.

In addition to determining whether districts and health facilities are tracking and discussing data, supervisors will also want to know if the data are actually understood and are being used in problem-solving, and how best to reach all target populations (a qualitative more than quantitative exercise). These qualitative aspects of “monitoring for action” can be assessed during support supervision, review meetings, joint district-health facility discussions during microplanning, etc.

Asking questions based on data can prompt districts and health facilities to take action. District health teams will need to provide ongoing support to health facility staff so that they have the knowledge, skills and confidence to use the data they are collecting. Districts should also consider whether to devote extra attention and resources to lower-performing health facilities, where the needs are high, or whether to use their resources to reward and help maintain high coverage in higher performing facilities, or some combination of the two. Following is an illustrative list of questions that districts and health facilities should ask when analysing coverage problems and deciding what actions to take in response.

QUESTIONS TO ASK WHEN ANALYSING IMMUNISATION DATA

- What are the main causes of low coverage in your facility or district catchment area?
- Are they access and/or utilisation problems?
- What are some of the key causes of these problems (supply, staffing, service delivery and demand for services, IEC, etc.)?
- What local solutions can best address these causes?
- What resources (existing or extra) are needed to implement solutions?
- How can you revise your plan based on the above analysis?
- Are there options in your district to conduct and document operational research to improve performance and explore innovations?
- How can you better involve communities in understanding data trends, what they mean, and how communities themselves can assist in addressing them?

7.2

RESOURCES

Mid-Level Management Course for EPI Managers. Module 20. Monitoring routine immunisation and data management. March 2004 – Draft2.

http://www.afro.who.int/ddc/vpd/epi_mang_course/pdfs/english/Mod%2020.pdf

Increasing immunization coverage at the health facility level.

WHO/V&B/02.27, World Health Organization, Geneva, December 2002

http://www.who.int/immunization_delivery/systems_policy/www721.pdf

Immunization in Practice. Module 7. Monitoring and using your data.

WHO/IVB, World Health Organization, Geneva, January 2004.

<http://www.who.int/vaccines-documents/ipp/PDF/Module7.pdf>

8

OPERATIONAL CONSIDERATIONS WHEN IMPLEMENTING RED

8.1

LOGISTICS

The Mid-Level Manager's training course, developed by WHO/AFRO contains modules addressing logistics in depth. Module 8 reviews cold chain management and Module 9 reviews vaccine management³.

Logistics typically includes planning, procurement, delivery of vaccines and supplies, management and maintenance of transport and cold chain equipment. The items needed for implementation of the minimum package of activities, particularly all immunisation operations and other essential health interventions at district and health facility levels should be in the right place, at the right time, in the right quantities, at the right quality, in the right condition and at the right cost.

Successful implementation of the RED approach depends on effective and efficient logistics, including:

- Vaccine and other supplies management (forecasting, ordering, storage and distribution), including other interventions such as Vitamin A, deworming, ITNs, etc.
- Cold and dry store management (availability of storage capacity).
- Transport and communications management, including maintenance and repair of equipment.
- Management of injection and biomedical waste.

A critical prerequisite for implementing effective and efficient logistics is the existence of a qualified Logistics Officer/Technician with professional knowledge and expertise. If such an Officer is not available, then requesting and obtaining his/her recruitment by either the Ministry of Health or the communities should be a priority for the District Health Management Team (DHMT).

³ http://www.afro.who.int/ddc/vpd/epi_mang_course/index.html

COLD CHAIN OPTIONS

The concepts of slow and fast cold chains are better described in the Mid-Level Manager's training course, Module 8—but are briefly described below.

- A slow cold chain relies on cold-generating equipment; it has more storage capacity and less transport capacity—supplies cover a month or more. A slow cold chain reduces the costs of vaccine distribution but increases the quantity of supplies in circulation.
- A fast cold chain relies on speed and does not have cold-generating equipment; it has more transport capacity and less storage capacity—supplies cover less than a month. A fast cold chain may mean higher distribution costs, but the costs are compensated for in part by placing smaller quantities of vaccines in circulation.

Note: In cases where health facilities are inaccessible to the higher level of the supply chain during several months of the rainy season, a slow cold chain would be implemented and these health facilities would receive enough vaccines and supplies (including fuel/kerosene, etc.) to cover the entire period of inaccessibility. It is necessary to make that decision in agreement with the operational level so that they are able to understand its rationale and support it. Also, during campaigns, a fast chain will affect the slow chain—whether it is desirable or not.

LOGISTICS ACTIVITIES AT DISTRICT AND HEALTH FACILITY LEVELS

Modules 8 and 9 of the WHO/AFRO Mid-Level Manager's training course discuss the relevance and process to ensure

- Availability of vaccines, injection materials and other supplies.
- Efficient cold chain management at district and health facility levels.
- Availability and reliability of transport and communication.
- Safe waste disposal and destruction.
- Proper equipment management and maintenance.

8.2

COMMUNICATION

Communication activities and strategies that are integrated into immunisation program functions will help to link the program with the community and target audiences. It is important that communication with partners be included in RED planning and implementation. Immunisation technical experts need to work with a mix of communication professionals, including communication program managers, multimedia and advertising specialists, community leaders and experts in social science and behaviour change.

Strategic communication interventions for RED must be:

- **Data-driven** (set objectives and indicators).
- **Community-oriented** (plan communication interventions with communities—taking into account the needs of the people that are being served; monitor and evaluate communication activities with communities).
- **Results-based** (evidence-based planning and implementation and use of data).
- **Human rights-oriented** (to “activate” community members to take control of their own health/development).

To achieve this, provinces/districts should:

1. Establish and implement a comprehensive advocacy, information, and communication strategy that encourages investment and support for immunisation and meets the needs of routine EPI and vaccine-preventable disease control.
2. Provide communication technical support to strengthen the quality of communication plans and their implementation, and to ensure their integration with GAVI initiatives and disease-specific interventions.
3. Strengthen coordination among government, partner agencies, and communities for communication, information and data on immunisation indicators and vaccine-preventable diseases.
4. Develop strategic communication work plans that have clear objectives, activities, targets and indicators. These should be integrated with and revised through systematic annual, quarterly or other reviews of the RED strategy. A communication work plan should include the type of support to be provided at the facility and community levels as well as a budget for materials, training activities, transport and support and operational costs.
5. Integrate communication indicators with existing immunisation monitoring forms and as part of RED evaluation at all levels.
6. Document, share, and disseminate lessons learned, tools, and activities.



Photo Credit: Lauren Goodsmith, Courtesy of Photoshare

The decision to integrate immunisation with other PHC services (and which services to combine) is one that each country makes on its own. Each of the sections below highlights the opportunities and challenges that may be encountered when integrating immunisation and other PHC services. They also suggest ways in which the RED approach and its five components might be adapted to meet the needs of an integrated package of PHC services.

PLANNING AND MANAGING RESOURCES

When services are combined or integrated, programme managers must focus considerable attention on the coordination, planning and monitoring of resources. Logistics and supply needs are extremely important. In settings with limited health personnel, programme managers must also take care to balance any additions to the service package so that they do not overburden health facility staff. The RED microplanning techniques described in Chapter 3 of this Guide can be adapted and used to overcome some of these challenges.

REACHING TARGET POPULATIONS

In many African countries today, vaccinations are provided with some combination of vitamin A supplements, de-worming medications, insecticide treated bednets, pre-natal care, iron folate capsules for pregnant women, growth monitoring, health education and other services and products. The integration of services happens during Child Health Days, measles follow-up campaigns, and other periodic intensification efforts. It also occurs on a routine basis at many health facilities and during outreach sessions. When eligible populations are the same, the RED techniques for identifying and organising services to reach them will be the same, although the services themselves may require different schedules.

LINKING SERVICES AND COMMUNITIES

Integrated service delivery often stimulates more active community participation. The way in which services are integrated should fit local health needs, therefore, when developing an integrated PHC package, health staff should consult communities about their strongest “felt needs”. Priority health problems can be assessed with communities as part of the RED situation analysis and microplanning process (see Annex 1), as well as during regular community meetings. Providing multiple interventions during the same contact can be challenging for district or health facility staff, but community members can relieve some of the burden on health staff by helping to organise outreach sessions, assisting with record keeping and defaulter tracking and providing a community venue or meals for the health team.

SUPPORTIVE SUPERVISION

Supervision of various services or programmes can and should be integrated in many settings. However, this needs to be planned and implemented in a way that ensures that each service is addressed with sufficient depth and frequency so that the supervision is useful. It is not worthwhile for a supervisor to simply fill out a long checklist covering several technical areas if he or she does not also have sufficient time to give feedback, prioritise problems with health staff and carry out (or lay out) remedial actions in a constructive manner. In short, the key characteristics of supportive supervision described in Chapter 6 of this Guide must be preserved.

MONITORING FOR ACTION

In countries with integrated information systems, collecting, reporting on, analysing and using data about immunisation and other services should be easy, but this is not always the case. In countries where different programmes use different information systems, compiling data on interventions that are delivered together but managed separately can be a major challenge. Important steps to ensure that districts and health facilities have the information they need to monitor an integrated package of care include:

1. Assessing the existing information system or systems (tools, procedures and data flow).
2. Selecting a few core indicators for each service or intervention.
3. Negotiating necessary modifications to tally sheets, registers, reporting forms and feedback mechanisms.
4. Producing these monitoring tools for use in fixed, outreach and mobile sessions.
5. Determining how data are to be stored and presented for analysis.

9

MONITORING THE RED APPROACH

9.1

WHAT IS THE RED MONITORING TOOL?

To further support the scaling up of RED in the Africa Region, WHO and its partners have developed the RED Monitoring Tool (see Annex 2). Its purpose is to help determine if all five of the RED components are being fully implemented, and if districts implementing RED are, in fact, achieving and sustaining increased immunisation coverage. The Tool consists of:

1. Illustrative performance standards for each of the five RED components that can be assessed using a set of core indicators.
2. A set of core indicators that can be measured over time.
3. A list of optional “supplemental” or alternative indicators that may be useful in particular country situations (not included in this Guide).
4. An excel spreadsheet that can be used to collect, compile and present RED monitoring data.
5. Guidelines for adapting the RED Monitoring Tool to country specifications.

The Tool is intended to help managers make better decisions—without overburdening service providers with yet more data to collect and send up through the health system. Therefore, the RED Monitoring Tool is designed for use with existing data—data collected through the routine health information or immunisation programme information system, by supervisors during regular supervisory visits, etc. The Tool may be used for “self assessment” by health facilities and districts implementing RED. Additionally, supervisors may use it to monitor key immunisation functions and results across health facilities, districts, and regions.

9.2

WHAT DO THE CORE INDICATORS MEASURE?

This Field Guide highlights the performance standards expected of each component of the RED approach. Based on the RED evaluation and experiences in the field, the key performance indicators for each component of the approach are highlighted after each RED component and consolidated in Annex 2; they show the following:

- Performance monitoring tool to be completed at health facility level (HF-specific tool) which also acts as a summary form.
- Performance monitoring tool to be completed at district level (district-specific tool) and Summary Form (with HF and district data).
- Performance monitoring tool to be completed at national level (national-specific tool).
- National Level Summary of RED Approach performance at sub-national levels.

Core indicators measure implementation of each of the RED components, as well as the expected results of RED. Like the RED approach itself, the RED Monitoring Tool focuses on the use of available immunisation data to rank districts and population groups according to their access to and utilisation of routine immunisation services. Using this methodology, districts fall into one of the four categories described in Annex 4 and on page seven of “Increasing immunization coverage at the health facility level”. WHO/V&B/02.27 (http://www.who.int/immunization_delivery/systems_policy/www721.pdf).

The core indicators also measure critical immunisation processes that can be important when it becomes necessary to adjust service delivery strategies, strengthen community linkages, fine tune logistics, update microplans, etc.

9.3

ADAPTING AND USING THE TOOL

A minimal number of core RED indicators are suggested at each level of the health system, reflecting what managers “need to know”. Supplementary or alternative indicators are included in the Tool because they may be needed in particular country situations. Some countries are already using a number of the suggested core indicators; others may be new. Supplementary indicators are further discussed in the Monitoring Tool itself. The ultimate purpose of this Tool is to enable countries and their lower levels to better understand how RED is being implemented, and then to make adjustments in programming to achieve and sustain increased immunisation coverage. This can most effectively be done if the RED Monitoring Tool remains flexible and oriented toward countries adapting it for their own use—according to unique country situations.

ADAPTING THE RED GUIDE

As highlighted in the Introduction, this Guide incorporates the “best practices” and “lessons learned” during implementation of the RED approach in different countries. Although there are many similarities across countries, there are also some very important differences that must be addressed before a guide such as this can be understood and used at the country level. In fact, careful adaptation of the Guide should be one of the first steps when introducing or revitalising the RED approach in any country.

What does adaptation of the Guide require? It requires asking and answering a list of questions and then adjusting the approach and text of the Guide to fit country circumstances. If your country has already introduced RED and you are planning to use this revised Guide in refresher training or to introduce RED in new districts only, you will want to read it carefully and then adjust the terminology so that it reflects the approach you have adopted.

For those who have not yet introduced RED or are starting over, a first important step in adapting the Guide will be to decide at what level of the health system the approach will focus and what it will be called. If your health system has only two administrative levels (i.e., national and district), you will focus the RED approach at the district level. But if you work within a larger health system—one with three or four administrative levels—you will need to decide on the operational level at which you will focus. Because that level may not be called a “district”, you may also want to call RED by a different name. At present in the Africa Region, for example, in addition to RED, the same approach is called REZ (Reaching Every Zone), REW (Reaching Every Ward) and REC (Reaching Every Child) in different countries.

Deciding what to call RED and where to focus it are two first steps in the adaptation process. The table below highlights other questions that will need to be answered in relation to each of the five RED components.

QUESTIONS TO ASK WHEN ADAPTING THIS GUIDE

GENERAL CONSIDERATIONS

- What is the operational level for RED in your country? Is it the “district” or a district-equivalent with a different name?
- Will you prioritise districts for RED support or introduce the approach in all districts?
- If you prioritise, what criteria will you use? Giving high priority to districts with large numbers of unimmunised children is one of the RED “best practices”, but serious geographic or cultural barriers and very low immunisation coverage rates have also been used in some countries.
- Will the RED approach be introduced to improve the coverage of multiple PHC services? Which services? Adaptation of each the RED components will be required to support a combined or integrated service package.

COMPONENT: PLANNING AND MANAGEMENT OF RESOURCES

- Is district health planning and budgeting integrated or immunisation-programme specific?
- What is the role of the district health team in planning for immunisation (and other PHC services)? The generic steps spelled out in the “Planning and Management of Resources” section of the Guide must be adapted to fit each country’s planning and management process. Since the intended audience for the Guide is the district health team, it must also be adjusted to fit the needs of district health teams in their support of health facilities.
- Is immunisation being delivered alone or as part of a package of PHC services? If it is being delivered as part of a package, the microplanning tools in Annex 1 will need to be revised to include other PHC health interventions. The steps in the microplanning process may also require some revision to reflect who participates in planning and management at the district and health facility levels.

COMPONENT: REACHING THE TARGET POPULATIONS

- The terms “fixed”, “outreach”, “mobile” and “campaign-style” (all used in the Guide) mean very different things in different countries. Define these terms according to your national policies and then use them consistently throughout this Guide.
- Do national policies support a district-determined service delivery strategy? If they don’t, you may need to lobby for an exception to or a change in policy before fully implementing the RED approach.

- Does the existing information system already report the numbers of vaccinations given by the type of service delivery mechanism, i.e. fixed facility, outreach site, mobile clinic, national or subnational campaign, other? If it doesn't, this may be necessary in the future.
- Are official population figures correct in most districts? If they are not and this is affecting planning and performance monitoring, what are the underlying reasons? Can they be addressed through the use of unofficial headcounts or other available information?
- Who is the audience for your final RED Guide? How will you use it with that audience? Make sure that the language in the Guide is appropriate for this use and that all recommendations are directed to the target audience(s).

COMPONENT: LINKING SERVICES WITH THE COMMUNITY

- How is “community” defined in your country? Use the terms and definitions that are commonly known and used.
- If mothers clubs, community health committees, and other community-based groups are common features in your country, use the actual names of these groups in the adapted text to make the document “yours.”
- Are community health workers or community health volunteers active in your country? If so, can they be engaged in improving understanding and utilisation of immunisation services (without overburdening them)? If they can, add a section to the district guide describing their role in immunisation and other PHC services.
- Do church groups, mosques and other religious congregations constitute an important community-based network? If appropriate, encourage districts and health facilities to involve them.
- Are there norms for the frequency of meetings between health staff and communities? Who should participate? Rewrite performance standards and monitoring indicators related to the community component to reflect these norms.

COMPONENT: SUPPORTIVE SUPERVISION

- What are the current supervision policies and practices? Identify the most common supervision problems (i.e., frequency, content, supervisory skills, documentation, etc.) and focus on those problems when adapting the Guide.
- Are there job descriptions and performance standards for supervisors, managers and vaccinators? If these don't exist, develop them before introducing this RED component, and reference them in the adapted Guide.

- Are existing supervision tools available and used? Are they effective? If they are, reference them in the Guide. If they aren't, modify and produce adequate supplies of these tools before introducing this RED component. Avoid tools that are too complex (i.e., avoid overly-lengthy checklists that take unrealistic amounts of time to complete) and too general (for example, when data are not detailed and cannot be thoroughly reviewed, compared, analysed, and used for problem solving).
- Are current supervision procedures, tools and supervisors themselves truly supportive? Have supervisors been trained to coach health facility staff? Supervisors must be knowledgeable and able to provide on-the-job training and constructive feedback. These expectations should be explicitly stated in the Guide.
- Is supervision integrated or focused on immunisation alone? If it is integrated, there may be changes required in the training of supervisors before introducing this RED component.

COMPONENT: MONITORING FOR ACTION

- Is immunisation data managed and reported “vertically” or as part of an integrated health management information system? Reflect the type of information system used in your country.
- Are there established indicators for immunisation (and other PHC services) that are commonly used to monitor performance? If there are, use them, but also consider adopting the core indicators recommended in the RED Monitoring Tool.
- Who collects reports and has ready access to immunisation data? In some countries, vaccinators and EPI managers fill out registers and tally sheets, but statisticians working in health facilities compile these data and prepare reports. Managers of cold stores may also be collecting important immunisation data that is not reflected in routine service reports. The adapted Guide should reflect the roles played by the different staff at the health facility and district level.
- Is the Data Quality Self Assessment (DQS) being used in your country? By all districts? How frequently? If the DQS is being used, reflect this in the Guide and suggest ways in which the results might be used to improve data quality and use.
- What are the norms or performance standards for use of immunisation data by district health teams and health facility staff? What should they do with the data and how often? Include these norms and an adapted monitoring indicator or indicators for tracking this RED component in the final Guide.

OPERATIONAL ISSUES

- **Logistics:** What are the characteristics of the logistics systems affecting districts and health facilities? Each country's vaccine logistics and cold chain are slightly different. Most have improved those systems in recent years. Country policies related to requisitioning, handling and accounting of vaccines and other immunisation supplies, and for waste management, should be reflected in the adaptation of the Guide.
- **Communication:** What are the most common public education, advocacy and social mobilisation techniques at the district and health facility levels? Adding limited content to the Guide to reflect those techniques could be important. Country-specific tools and materials for public education, advocacy and counselling should also be referenced in the Guide.

MONITORING AND EVALUATING RED

- Guidelines for adapting and using the new RED Monitoring Tool at national, district and health facility levels are included with the Tool itself.

ANNEXES

ANNEX 1: RED MICROPLANNING TOOLS

USE OF RED PLANNING AND MONITORING TOOLS: WHO IS TO COMPLETE THEM AND WHEN

Staffs at the HEALTH FACILITY level are responsible for completing the following RED tools:

Every year:

- 1a – Situation analysis: socio-demographic characteristics
- 1b – Map of health facilities and catchment areas
- 2a – Situation analysis, problem identification, and priority setting
- 2b – Causes of problems and solutions analysis
- 3 – Immunization coverage objectives and targets
- 4a – Vaccine and other supplies forecast
- 4b – Injection material forecast
- 5a – Social mapping: stakeholder/partner analysis
- 7a – Summary activity plan and budget for Reaching Every District

Every quarter:

- 5b – Linking Immunization Services with communities: activity schedule

Every month:

- Health Facility Performance Monitoring Tool

Staffs at the DISTRICT level are responsible for completing the following RED tools:

Every year:

- 7a – Summary activity plan and budget for Reaching Every District
- District Performance Indicators Targets & Performance Categories

Every quarter:

- 6 – Supportive supervision for “Reaching Every District”: Activity schedule

Every month:

- District Performance Monitoring Tool

Staffs at the NATIONAL level are responsible for completing the following RED tools:

Every month:

- National Performance Monitoring Tool

ANNEX 1 (CONTINUED)

Health Facility

Reaching Every District Approach

Micro-plan

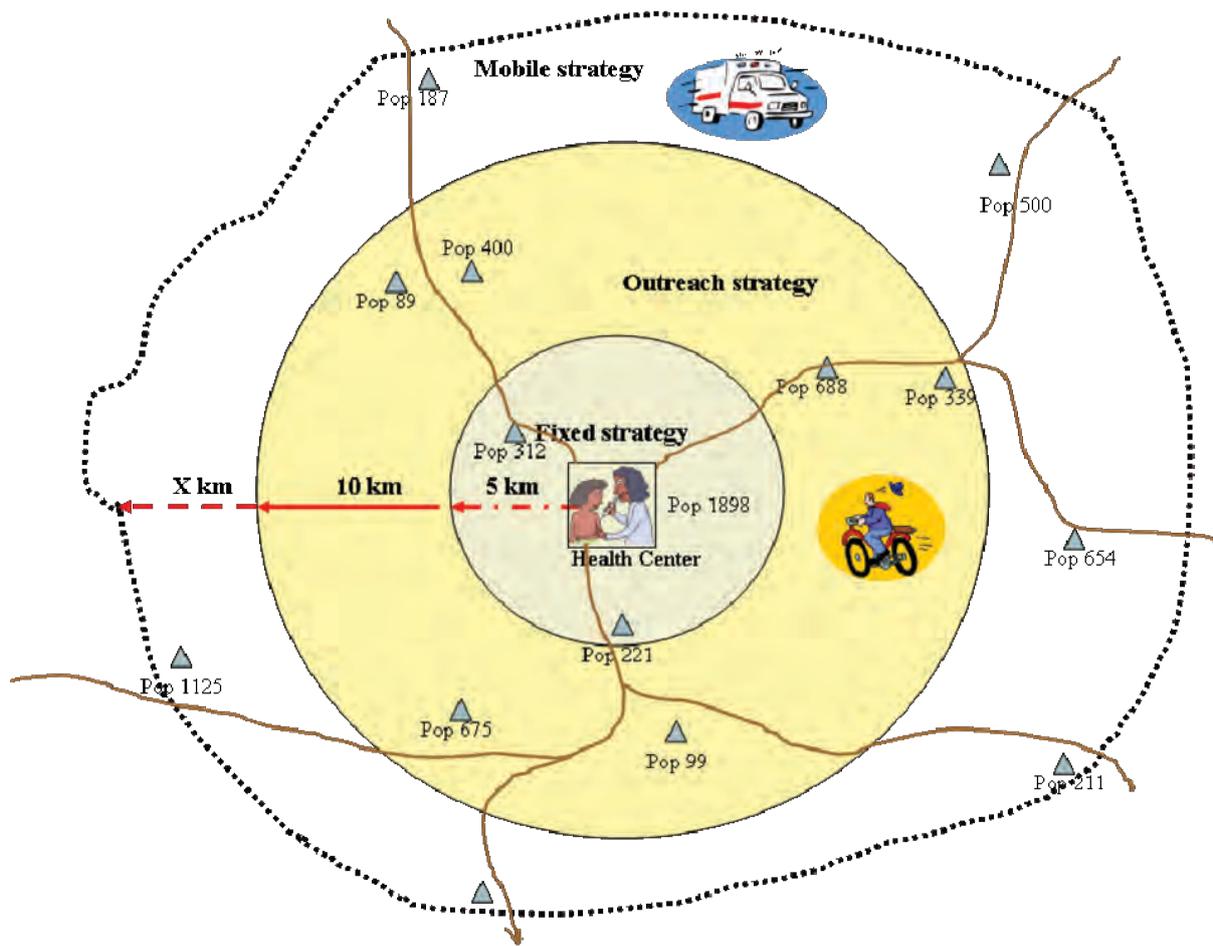
Name of Health Facility

District

Country

Year

Tool 1b: Map the district/health facilities and their catchment areas (example below)



Tool 2a: Situation Analysis, Problem Identification & Priority Setting (Childhood Vaccination)

District: _____ Health Facility: _____ Date: _____

| Catchment Area (Village, Wards, Suburbs) | Compile data on population, doses of vaccine administered Calculate immunization coverage in the previous 12 months | | | | | | | | | | Analyse problem | | | | | Prioritise |
|--|--|----------------------------------|---|---|------------------------------|---|---|-----------------------|---|-------------------|-----------------|-------------------|---|------------------------|-----------------------|------------|
| | Target Pop. <1yr (surviving infants) | Doses of vaccine administered | | | Immunization coverage (%) | | | Un-immunized (No.) | | Drop-out rate (%) | | Identify problems | | Categorise problems | Prioritise 1,2,3,4 | |
| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

Key:

F = (C/B) X100
 G = (D/B) X100
 H = (E/B) X100
 I = (B - D)
 J = B - E
 K = [(C-D)/C] X100
 L = [(C-E)/C] X100

M = POOR (DTP1 < 80%) OR GOOD (DTP1 > 80%)
 N = POOR (DTP1 - Measles > 10%) OR GOOD (DTP1 - Measles < 10%)
 O = (1) No problem: drop-out rates low, coverage high OR (2) Utilization problem: High drop-out rates, High coverage rate OR (3) Access problem: Low drop-out rates, Low coverage rates or (4) Utilization and Access problem: High drop-out rates, Low coverage rate
 P = (1) VERY HIGH or (2) HIGH or (3) MEDIUM or (4) LOW, based on the No of Un-immunized Children and Category of problem

Tool 2b: Causes of problems and Solutions Analysis (Childhood Vaccination)

District: _____ Health facility: _____ Date: _____

| System Components | Problems Identified | Causes of Problems | Solutions (with existing and extra resources) | Responsible Persons and Possible Timeline |
|---------------------------------------|---------------------|--------------------|--|---|
| Service Delivery | | | | |
| Vaccine Supply, Quality and Logistics | | | | |
| Advocacy and Communication | | | | |
| Surveillance and Monitoring | | | | |
| Programme Management | | | | |

Tool 3: Immunization Coverage Objectives and Targets⁶

District: _____ Health facility: _____ Date: _____

Immunization Coverage Objectives: (to determine the highest) % coverage for all antigens

| Catchment's area (Wards, Suburbs, Villages, etc.) | Priority As defined in Tool 2a | Population | | | | To be vaccinated per month | | | Distance (km from HF) | Strategy | Sessions (No. per year) | Transport | | | | | |
|---|--------------------------------------|------------------|---------------------------|------------------------|---------------------|----------------------------|------------------------|---|-----------------------------|----------|-------------------------------|-----------|---|---|---|--|--|
| | | Live Births C | Surviving Infants D | Pregnant Women E | Live Births F | Surviving Infants G | Pregnant Women H | I | | | | J | K | L | M | | |
| A | B | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |

- F, G & H: Target pop x Coverage objective / 12
- K: Each village should be visited at least 4 times a year
- L: Foot, bicycle, motorcycle, vehicle, boat
- M: Hire or fuel cost + subsistence allowance (if applicable)

⁶ When filling the above table, please refer to tool 2a

Tool 4a: Vaccine and other supplies forecast

| Vaccine | Target Pop. | Coverage Expected | Doses | Wastage Factor | Buffer Stock | Needs (doses) | |
|--|-------------|-------------------|-------|----------------|--------------|---------------|---------|
| | No. | % | No. | | 25% | Annual | Monthly |
| Bacillus Calmette-Guerin (BCG) | | | | | | | |
| DTP-containing | | | | | | | |
| Oral Polio Vaccine (OPV) | | | | | | | |
| Measles | | | | | | | |
| Yellow Fever | | | | | | | |
| Tetanus Toxoid (TT) | | | | | | | |
| Other vaccine | | | | | | | |
| Other vaccine | | | | | | | |
| Vit A 100,000 IU | | | | | | | |
| Vit A 200,000 IU | | | | | | | |
| Other supply (e.g. Albendazole, ITNs) | | | | | | | |
| Other supply | | | | | | | |

Tool 4b: Injection material forecast

| Injection materials | Annual vaccine needs | | | | Calculation | Syringes needs | |
|--------------------------------|----------------------|-------|----------------|--------------|----------------------|----------------|---------|
| | Doses | Vials | Wastage Factor | Buffer stock | | Annual | Monthly |
| Syringes BCG 0.05ml | | | | | 1 per dose | | |
| Syringes BCG for Dilution | | | | | 1 per vial | | |
| AD syringes for DTP-containing | | | | | 1 per dose | | |
| AD Syringes Measles | | | | | 1 per dose | | |
| Syringes Measles for Dilution | | | | | 1 per vial | | |
| AD syringes TT | | | | | 1 per dose | | |
| AD syringes YF | | | | | 1 per dose | | |
| Syringes other vaccine | | | | | 1 per dose | | |
| Syringes other vaccine | | | | | 1 per dose | | |
| Total syringes | | | | | | | |
| Safety boxes 5 litres | | | | | 1 per 100 syringes * | | |
| | | | | | | | |

* If the HF uses a needle cutter, the safety box could contain more than 100 syringes as there is no needle attached to the syringe
Wastage factor: use 1,11 as a wastage factor (10% wastage rate)
Buffer stock: use 25%

Tool 5a: Social Mapping: Stakeholders / Partner Analysis

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

| Catchment Area (Ward/ Suburbs, Villages) | School | | Opinion Leaders | Religious Institutions | | Traditional Healers | | Farmers & Businessmen | | NGOs / CBOs / Others | |
|---|--------|----------------|--------------------|------------------------|-------------------|---------------------|-------------------|-----------------------|-------------------|----------------------|-------------------|
| | Name | Head master | | Name | Contact person | Name | Contact person | Name | Contact person | Name | Contact person |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Current strengths of key partners: | | | | | | | | | | | |
| Opportunities and threats: | | | | | | | | | | | |

Tool 5b: Linking Immunization Services with Communities: Activity Schedule

District: _____ Sub-District: _____ Health facility: _____ Year: _____ Quarter: _____

| No. | Activity | Where (Location) | Responsible Officer | When (Dates) | | | Remarks |
|-----|----------|---------------------|------------------------|--------------|--------------|--------------|---------|
| | | | | Month: _____ | Month: _____ | Month: _____ | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Tool 6: Supportive Supervision for 'Reaching Every District': Activity Schedule

District: _____ Sub-District: _____ Health facility: _____ Year: _____ Quarter: _____

| No. | Activity | Where (Location) | Responsible Officer | When (Dates) | | | Remarks |
|-----|----------|---------------------|------------------------|-----------------|-----------------|-----------------|---------|
| | | | | Month: _____ | Month: _____ | Month: _____ | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

The DHMT and others to discuss with each Health facility team on the dates suitable to both parties for support supervision and follow up visits. Health facilities with sub-health facilities, should consider the same process for supportive supervision. This is also applicable for health facilities visiting communities.

Tool 7a: Summary Activity Plan and Budget for Reaching Every District

District: _____

Sub-District: _____

Health facility: _____

| S/N | Activities | Details | Start Date | Finish Date | Total Cost | Person Responsible | Remarks |
|--|------------|---------|------------|-------------|------------|--------------------|---------|
| A Planning and managing resources | | | | | | | |
| A1 | | | | | | | |
| A2 | | | | | | | |
| A3 | | | | | | | |
| B Reaching the target populations | | | | | | | |
| B1 | | | | | | | |
| B2 | | | | | | | |
| B3 | | | | | | | |
| C Linking communities with services | | | | | | | |
| C1 | | | | | | | |
| C2 | | | | | | | |
| C3 | | | | | | | |
| D Supportive supervision | | | | | | | |
| D1 | | | | | | | |
| D2 | | | | | | | |
| D3 | | | | | | | |
| E Monitoring and use of data for action | | | | | | | |
| E1 | | | | | | | |
| E2 | | | | | | | |
| E3 | | | | | | | |
| Grand Total | | | | | | | |

ANNEX 2: RED APPROACH MONITORING TOOLS

To further support the scaling up of RED in the Africa Region, WHO and its partners have developed the RED Monitoring Tool. Its purpose is to help determine if all five of the RED components are being fully implemented, and if districts implementing RED are, in fact, achieving and sustaining increased immunisation coverage. The Tool consists of:

6. Illustrative performance standards for each of the five RED components that can be assessed using a set of core indicators.
7. A set of core indicators that can be measured over time.
8. A list of optional “supplemental” or alternative indicators that may be useful in particular country situations (not included in this Guide).
9. An excel spreadsheet that can be used to collect, compile and present RED monitoring data.
10. Guidelines for adapting the RED Monitoring Tool to country specifications.

The Tool is intended to help managers make better decisions—without over-burdening service providers with yet more data to collect and send up through the health system. Therefore, the RED Monitoring Tool is designed for use with existing data—data collected through the routine health information or immunisation programme information system, by supervisors during regular supervisory visits, etc. The Tool may be used for “self assessment” by health facilities and districts implementing RED. Additionally, supervisors may use it to monitor key immunisation functions and results across health facilities, districts, and regions.

For more details, see Chapter 9 of this Guide.

The RED Monitoring Tool itself contains six forms, of which five are included in this Annex:

- A. List of core indicators, definition, unit of measurement and suggested frequency of collection
- B. Monitoring tool to be completed at health facility level
- C. Monitoring tool to be completed at district level, including summary of health facility data
- D. Monitoring tool to be completed at national level
- E. Summary of RED Approach performance at sub-national Level to be completed at national level
- F. Supplemental indicators (not included in this Guide)

| S/N | RED Component | Area | Core Indicator Standard | Core Indicator Definition, Unit of Measurement and Suggested Frequency of Collection | | |
|-----|--------------------------------------|-------------------------------------|--|--|---|--|
| | | | | HF | District | National |
| 1 | PLANNING AND MANAGEMENT OF RESOURCES | PLANNING | Microplans up-to-date | Number of HFs with microplans up-to-date / Total number of HFs <i>Measurement: percentage</i> <i>Frequency: quarterly</i> | Number of districts with microplans up-to-date / Total number of districts <i>Measurement: percentage</i> <i>Frequency: quarterly / 6 months</i> | National EPI Annual Plan up-to-date? <i>Measurement: Y/N</i> <i>Frequency: annual</i> |
| 2 | | VACCINE MANAGEMENT | No vaccine stock-outs of any antigen | Number of HFs with no vaccine stock-outs of any antigen / Total number of HFs <i>Measurement: percentage</i> <i>Frequency: monthly</i> | Number of districts with no vaccine stock-outs of any antigen / Total number of districts <i>Measurement: percentage</i> <i>Frequency: monthly</i> | Vaccine stock-out of any antigen at national level? <i>Measurement: Y/N</i> <i>Frequency: monthly</i> |
| 3 | | SAFETY | No AD syringe stock-out | Number of HFs with no AD syringe stock-outs / Total number of HFs <i>Measurement: percentage</i> <i>Frequency: monthly</i> | Number of districts with no AD syringe stock-outs / Total number of districts <i>Measurement: percentage</i> <i>Frequency: monthly</i> | AD syringe stock-out at national level? <i>Measurement: Y/N</i> <i>Frequency: monthly</i> |
| 4 | | PERSONNEL | At least one personnel trained in immunization | Number of HFs with at least one staff trained on immunization in the previous year / Total number of HFs <i>Measurement: percentage</i> <i>Frequency: annual</i> | Number of districts with at least one staff trained on immunization in the previous year / Total number of districts <i>Measurement: percentage</i> <i>Frequency: annual</i> | |
| 5 | | FINANCING | Disbursement of funds for routine immunization | Number of HFs with funds disbursed for outreach activities / Total number of HFs <i>Measurement: percentage</i> <i>Frequency: quarterly</i> | Number of districts with funds disbursed for routine immunization activities / Total number of districts <i>Measurement: percentage</i> <i>Frequency: quarterly</i> | Funds disbursed for routine immunization activities at national level? <i>Measurement: Y/N</i> <i>Frequency: quarterly</i> |
| 6 | | LINKING SERVICES WITH THE COMMUNITY | Community meetings conducted | Number of HFs with at least 1 meeting conducted with community / Total number of HFs <i>Measurement: percentage</i> <i>Frequency: quarterly</i> | Number of districts with at least 1 meeting conducted with the community (CBOs and/or local authorities) / Total number of districts <i>Measurement: percentage</i> <i>Frequency: quarterly</i> | |

| S/N | RED Component | Core Indicator Standard | Core Indicator Definition, Unit of Measurement and Suggested Frequency of Collection | District | National | | |
|-----|---------------------------------|---|---|--|---|--|---|
| 7 | REACHING THE TARGET POPULATIONS | Effective outreach* where target population for outreach sites is not well defined, use # sessions conducted / # sessions planned | Number of DPT1-containing vaccines given via outreach in all HFs / Total number of DPT1-containing vaccines planned to be given via outreach in all HFs in the month X 100; alternative if outreach target not well defined use: Number of outreach sessions conducted by HFs / Total number of sessions planned by HFs | | | | |
| | | | | | | Meas: num/denom & percentage Frequency: monthly | |
| 8 | SUPPORTIVE SUPERVISION | Supportive supervision conducted | | Number of supportive supervisory visits conducted by districts to HFs / Total number of HFs Measurement: percentage Frequency: quarterly | Number of supportive supervisory visits conducted by national level to districts / Total number of districts Measurement: percentage Frequency: quarterly | | |
| | | | | | | Timely reporting | Number of immunization reports received by districts from HFs / Total number of HFs Measurement: percentage Frequency: monthly |
| | | | | | | | |
| 10 | MONITORING FOR ACTION | Review meetings conducted | | Number of districts conducting review meetings / Total number of districts Measurement: percentage Frequency: monthly | | | |
| | | | | | | Data monitored | Number of HFs with monitoring chart up-to date and correctly drawn / Total number of HFs Measurement: percentage Frequency: monthly |
| | | | | | | | |
| 11 | | | | | | | |

| S/N | RED Component | Core Indicator Standard | Core Indicator Definition, Unit of Measurement and Suggested Frequency of Collection | District | National |
|-----|---------------|-------------------------------|---|------------------------|----------|
| | | | HF | | |
| | | | | Performance Categories | |
| 12 | ACCESS | DPT1-containing coverage rate | Number of children < 12 months immunized with DPT1-containing vaccine / Number of surviving infants < 12 months of age X 100 | | |
| | | | <i>Meas: num/denom & percentage</i> <i>Frequency: monthly (cumulative)</i> | | |
| 13 | PERFORMANCE | DPT1-containing drop-out rate | DPT1-containing coverage minus DPT3-containing coverage / DPT1-containing coverage X 100* (must be interpreted in light of actual coverage levels, such as DPT1) | | |
| | | | <i>Measurement: percentage</i> <i>Frequency: monthly (cumulative)</i> | | |
| | UTILIZATION | DPT1-containing drop-out rate | DPT1-containing coverage minus Measles-containing coverage / DPT1-containing coverage X 100* (must be interpreted in light of actual coverage levels, such as DPT1) | | |
| 14 | | | <i>Measurement: percentage</i> <i>Frequency: monthly (cumulative)</i> | | |

| MONTH | PLANNING AND MANAGEMENT OF RESOURCES | | | | | LINKING SERVICES WITH THE COMMUNITY | REACHING THE TARGET POPULATIONS | | MONITORING FOR ACTION | PERFORMANCE | | |
|-----------|--------------------------------------|--------------------|--------|-----------|-----------|-------------------------------------|---------------------------------|---|-----------------------|-------------|-----------|---|
| | PLANNING | VACCINE MANAGEMENT | SAFETY | PERSONNEL | FINANCING | | NUM/DENOM | % | | YES/NO | NUM/DENOM | % |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | |
| JANUARY | YES/NO | YES/NO | YES/NO | YES/NO | YES/NO | YES/NO | NUM/DENOM | % | YES/NO | NUM/DENOM | % | % |
| FEBRUARY | | | | | | | | | | | | |
| MARCH | | | | | | | | | | | | |
| APRIL | | | | | | | | | | | | |
| MAY | | | | | | | | | | | | |
| JUNE | | | | | | | | | | | | |
| JULY | | | | | | | | | | | | |
| AUGUST | | | | | | | | | | | | |
| SEPTEMBER | | | | | | | | | | | | |
| OCTOBER | | | | | | | | | | | | |
| NOVEMBER | | | | | | | | | | | | |
| DECEMBER | | | | | | | | | | | | |

*Note: countries to change indicator based on what is most appropriate for country; see "RED Core Indicators" tab

| MONTH | PLANNING AND MANAGEMENT OF RESOURCES | | | | | | | | | | LINKING SERVICES WITH THE COMMUNITY | | | | REACHING THE TARGET POPULATIONS | | | | SUPPORTIVE SUPERVISION | | | | MONITORING FOR ACTION | | | | SUMMARY PERFORMANCE OF ALL HHS IN DISTRICT | | | |
|-----------|--------------------------------------|----------|--------------------|----------|--------|----------|-----------|----------|-----------|----------|-------------------------------------|----------|-------------|-----------|---------------------------------|----------|-----------|----------------|------------------------|----------------|----------------|----------|-----------------------|--|--|--|--|--|--|--|
| | PLANNING | | VACCINE MANAGEMENT | | SAFETY | | PERSONNEL | | FINANCING | | COMMUNITY | | POPULATIONS | | SUPERVISION | | ACTION | | ACCESS | | UTILIZATION | | | | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | | | | | | | | |
| | HF | DISTRICT | HF | DISTRICT | HF | DISTRICT | HF | DISTRICT | HF | DISTRICT | HF | DISTRICT | HF | DISTRICT | HF | DISTRICT | HF | DISTRICT | HF | DISTRICT | HF | DISTRICT | | | | | | | | |
| | % | Y/N | % | Y/N | % | Y/N | % | Y/N | % | Y/N | % | Y/N | # visits | # reports | Y/N | % | NUM/DENOM | % (cumulative) | % (cumulative) | % (cumulative) | % (cumulative) | | | | | | | | | |
| JANUARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEBRUARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARCH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| APRIL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MAY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JUNE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JULY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AUGUST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SEPTEMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OCTOBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOVEMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DECEMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| MONTH | PLANNING AND MANAGEMENT OF RESOURCES | | | | | SUPPORTIVE SUPERVISION | MONITORING FOR ACTION | PERFORMANCE SUMMARY OF HF's IN COUNTRY | | |
|-----------|--------------------------------------|--|--|---|---|--|-------------------------------|--|---|--|
| | PLANNING | VACCINE MANAGEMENT | SAFETY | FINANCING | ACCESS | | | UTILIZATION | UTILIZATION | |
| | National EPI Annual Plan up-to date | Vaccine stock-out of any antigen at national level in last month | AD syringe stock-out at national level in last month | Funds disbursed for routine immunization activities during the last quarter at national level | Number of supportive supervisory visits conducted by national level in the last quarter | Number of monthly immunization reports received at national level from districts in last month | DPT1-containing coverage rate | DPT1-containing to DPT3-containing drop-out rate | DPT1-containing to Measles-containing drop-out rate | |
| | 1 | 2 | 3 | 5 | 6 | 7 | 9 | 10 | 11 | |
| JANUARY | | | | | | | | | | |
| FEBRUARY | | | | | | | | | | |
| MARCH | | | | | | | | | | |
| APRIL | | | | | | | | | | |
| MAY | | | | | | | | | | |
| JUNE | | | | | | | | | | |
| JULY | | | | | | | | | | |
| AUGUST | | | | | | | | | | |
| SEPTEMBER | | | | | | | | | | |
| OCTOBER | | | | | | | | | | |
| NOVEMBER | | | | | | | | | | |
| DECEMBER | | | | | | | | | | |

| MONTH | PLANNING AND MANAGEMENT OF RESOURCES | | | | | LINKING SERVICES WITH THE COMMUNITY | | REACHING THE TARGET POPULATIONS | | SUPPORTIVE SUPERVISION | | MONITORING FOR ACTION | | | SUMMARY PERFORMANCE OF ALL HFS IN DISTRICT | | | |
|-----------|--------------------------------------|--------------------|----------|-----------|-----------|-------------------------------------|---------------------|----------------------------------|------------------|---------------------------|----------------|-------------------------------|--|---|--|--|--|--|
| | PLANNING | VACCINE MANAGEMENT | SAFETY | PERSONNEL | FINANCING | Community meetings conducted | Effective outreach* | Supportive supervision conducted | Timely reporting | Review meetings conducted | Data monitored | DPT1-containing coverage rate | DPT1-containing to DPT3-containing drop-out rate | DPT1-containing to Measles-containing drop-out rate | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | | | | |
| | HF | HF | HF | HF | HF | HF | HF | HF | HF | HF | HF | DIST SUMMARY | DIST SUMMARY | DIST SUMMARY | | | | |
| | DISTRICT | DISTRICT | DISTRICT | DISTRICT | DISTRICT | DISTRICT | DISTRICT | DISTRICT | DISTRICT | DISTRICT | DISTRICT | NUM/DENOM | % (cumulative) | % (cumulative) | | | | |
| | % | % | % | % | % | % | % | % | % | % | % | | | | | | | |
| JANUARY | | | | | | | | | | | | | | | | | | |
| FEBRUARY | | | | | | | | | | | | | | | | | | |
| MARCH | | | | | | | | | | | | | | | | | | |
| APRIL | | | | | | | | | | | | | | | | | | |
| MAY | | | | | | | | | | | | | | | | | | |
| JUNE | | | | | | | | | | | | | | | | | | |
| JULY | | | | | | | | | | | | | | | | | | |
| AUGUST | | | | | | | | | | | | | | | | | | |
| SEPTEMBER | | | | | | | | | | | | | | | | | | |
| OCTOBER | | | | | | | | | | | | | | | | | | |
| NOVEMBER | | | | | | | | | | | | | | | | | | |
| DECEMBER | | | | | | | | | | | | | | | | | | |

ANNEX 3: GENERIC SUPPORTIVE SUPERVISION FORMAT

Generic Supportive Supervision Format

Name and type of health facility:

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

Name of supervisor:

Date of supervision:

Part 1: Assessment format

| Key Practices | Excellent | Acceptable | Needs Work |
|---------------|-----------|------------|------------|
| | | | |
| | | | |

... [additional rows omitted to conserve space]

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

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

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

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

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

AGREEMENT ON PRACTICES THAT NEED IMPROVEMENT

Name and type of health facility:

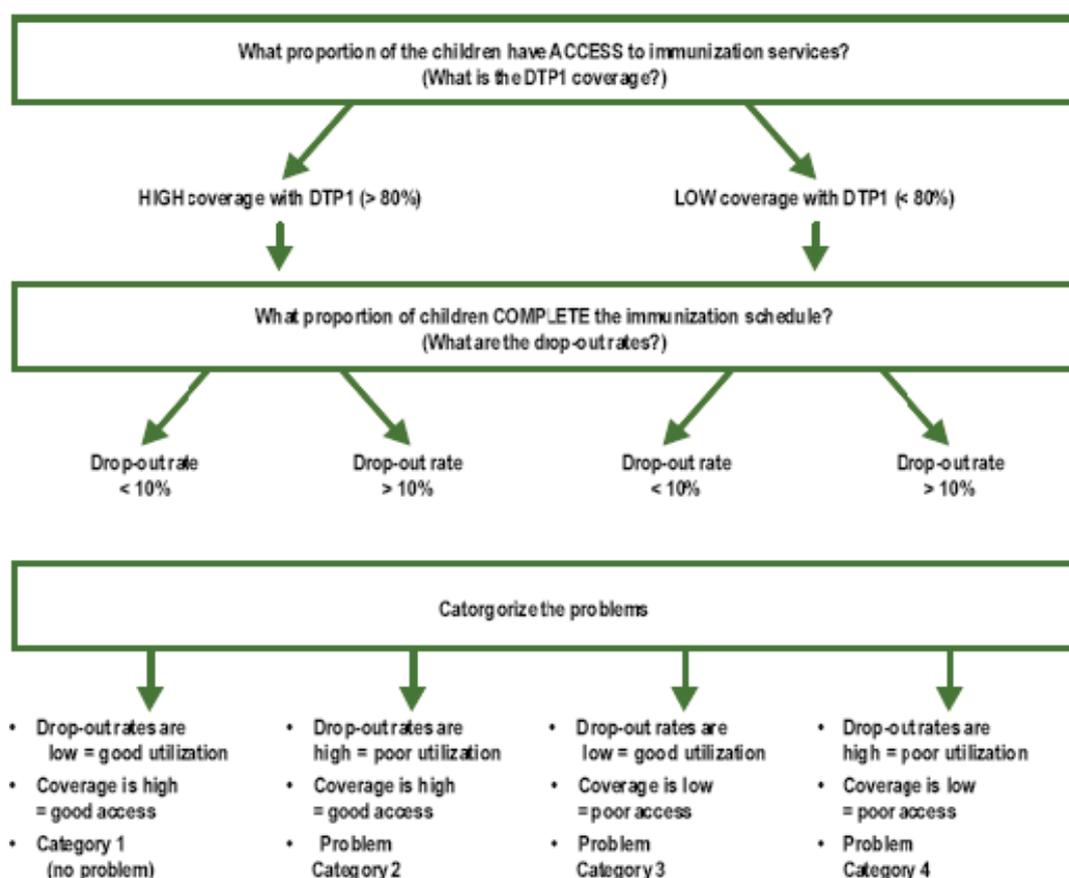
Name(s) and position of health provider(s):

Name of supervisor:

Date of supervision:

| Practice(s) that need improvement (parts 1 to 3) | What the provider(s) will do | What the supervisor will do to support the provider(s) | What others need to do: write who will do what |
|---|---|---|---|
| | | | |
| | | | |

ANNEX 4: ANALYSIS OF ACCESS AND DROP-OUTS⁷



Category 1: No problem

High DTP1 coverage = **good access**

Low drop-out rates = **good utilization and a consistent supply of good quality services**

Category 2: Problem

High DTP1 coverage = **good access**

High drop-out rates = **poor utilization and/or an inconsistent supply of services or services of low quality.**

Category 3: Problem

Low DTP1 coverage = **poor access**

Low drop-out rates = **good utilization and a consistent supply of good quality services, at least in those areas with access**

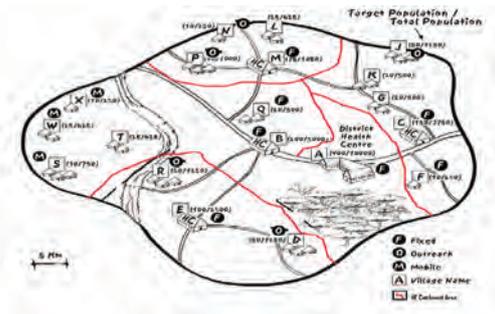
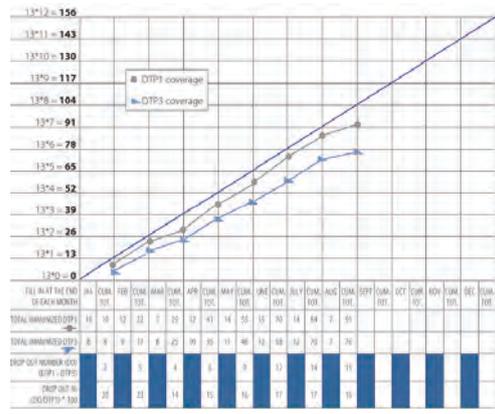
Category 4: Problem

Low DTP1 coverage = **poor access**

High drop-out rates = **poor utilization and/or an inconsistent supply of services or services of low quality at least in those areas with access**

⁷ Increasing immunization coverage at the health facility level, WHO/V&B/02.27
http://www.who.int/immunization_delivery/systems_policy/www721.pdf

ANNEX 5: RED QUICK REFERENCE

| <p style="text-align: center;">1. Planning and Management of Resources (Human, material and financial)</p> <p>At the district and facility levels, planning should identify what resources are needed to reach all target populations in a way that can be managed well and thus maintained. Good planning involves: (a) understanding the district/health facility catchment area (situational analysis); (b) prioritizing problems and designing microplans that address key gaps; (c) as part of microplanning, developing a budget that realistically reflects the human, material and financial resources available; and (d) regularly revising, updating and costing microplans to address changing needs.</p> | <p style="text-align: center;">2. Reaching the Target Populations</p> <p>“Reaching the target populations” is a process to improve access and use of immunisation and other health services in a cost-effective manner through a mix of service delivery strategies that meet the needs of target populations.</p>  <p>The map displays a geographical area with various service delivery points marked by letters A through S. A central point is labeled 'District Health Centre (DHC)'. Red lines radiate from the DHC to various points, representing service delivery routes. A legend indicates: A) Floor, B) Outreach, C) Mobile, D) Village Name, and E) Delimit Area. A scale bar shows 5 Km. The title of the map is 'Target Population / Total Population'.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---------------|---------------|-----|----|----|-----|----|----|-----|----|----|-----|----|----|-----|----|----|-----|----|----|-----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|---|
| <p style="text-align: center;">3. Linking Services with Communities</p> <p>This RED component encourages health staff to partner with communities in managing and implementing immunization and other health services. Through regular meetings, district health teams and health facility staff engage with communities to make sure that immunization and other health services are meeting their needs.</p> | <p style="text-align: center;">4. Supportive Supervision (Regular on-site teaching, feedback, and follow-up with health staff)</p> <p>Supportive supervision focuses on promoting quality services by periodically assessing and strengthening service providers' skills, attitudes and working conditions. It includes regular on-site teaching, feedback and follow-up with health staff.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>5. Monitoring for Action (Self-monitoring, feedback and tools)</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  <p>The chart displays DTP1 coverage (blue line with square markers) and DTP3 coverage (red line with triangle markers) from January to December. The Y-axis represents the number of children, ranging from 0 to 156. The X-axis represents months. A legend indicates DTP1 coverage (blue line) and DTP3 coverage (red line). Below the chart is a table with monthly data for DTP1 and DTP3 coverage.</p> <table border="1"> <thead> <tr> <th>Month</th> <th>DTP1 Coverage</th> <th>DTP3 Coverage</th> </tr> </thead> <tbody> <tr><td>JAN</td><td>13</td><td>13</td></tr> <tr><td>FEB</td><td>26</td><td>26</td></tr> <tr><td>MAR</td><td>39</td><td>39</td></tr> <tr><td>APR</td><td>52</td><td>52</td></tr> <tr><td>MAY</td><td>65</td><td>65</td></tr> <tr><td>JUN</td><td>78</td><td>78</td></tr> <tr><td>JUL</td><td>91</td><td>91</td></tr> <tr><td>AUG</td><td>104</td><td>104</td></tr> <tr><td>SEP</td><td>117</td><td>117</td></tr> <tr><td>OCT</td><td>130</td><td>130</td></tr> <tr><td>NOV</td><td>143</td><td>143</td></tr> <tr><td>DEC</td><td>156</td><td>156</td></tr> </tbody> </table> | Month | DTP1 Coverage | DTP3 Coverage | JAN | 13 | 13 | FEB | 26 | 26 | MAR | 39 | 39 | APR | 52 | 52 | MAY | 65 | 65 | JUN | 78 | 78 | JUL | 91 | 91 | AUG | 104 | 104 | SEP | 117 | 117 | OCT | 130 | 130 | NOV | 143 | 143 | DEC | 156 | 156 | <p>District health teams and health facility staff need a continuous flow of information that tells them whether health services are of high quality and accessible to the target population, who is and is not being reached, whether resources are being used efficiently and whether strategies are meeting objectives. Monitoring health information involves observing, collecting, and examining programme data. “Monitoring for Action” takes this one step further, by not only analyzing data but by using the data at all levels to direct the programme in measuring progress, identifying areas needing specific interventions and making practical revisions to plans.</p> |
| Month | DTP1 Coverage | DTP3 Coverage | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JAN | 13 | 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEB | 26 | 26 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MAR | 39 | 39 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| APR | 52 | 52 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MAY | 65 | 65 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JUN | 78 | 78 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JUL | 91 | 91 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AUG | 104 | 104 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SEP | 117 | 117 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OCT | 130 | 130 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOV | 143 | 143 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DEC | 156 | 156 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

