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EXPERIENCE IN BUILDING CAPACITY OF HEALTH FACILITY MANAGERS IN UGANDA ON LEADERSHIP, MANAGEMENT, AND ACCOUNTABILITY:

A Missing Link in Routine Immunization Service Delivery

BACKGROUND

To help strengthen the routine immunization (RI) system in Uganda, JSI Research and Training Institute, Inc. (JSI) has supported the Ministry of Health and Uganda National Expanded Programme on Immunization (MOH/UNEPI) by working in 246 health facilities across ten districts. JSI's Stronger Systems for Routine Immunization (SS4RI) project introduced the Reaching Every Child using Quality Improvement (REC-QI) approach in these districts during the period of 2014-2019. The approach embeds quality improvement methodologies in essential management processes to strengthen the delivery, quality, and utilization of RI services.

The JSI team observed that despite providing basically uniform program inputs to all health facilities, the extent to which REC-QI practices were adopted varied widely – even across facilities very similar in terms of size, staffing, and context. Further examination revealed that a key determinant of the uptake of these practices (and, by extension, improved routine immunization) was the leadership, management, and accountability capability of managers at health facility level. In clinics where facility managers lacked this capacity, plans were poorly developed and budgeted, infrequently referred to and monitored, and incompletely implemented.

Traditionally, there has been limited investment in building the capacity of health facility managers to lead, manage, and account for RI. It is a missing link that falls between the training of district health teams and frontline vaccinators. Based on the observations noted above, JSI embarked on a program with district health teams to address this gap.

While Uganda's pre-service education equips health professionals with the knowledge and skills needed to provide high quality clinical care, limited attention is given to the critical day-to-day management skills required to lead and manage the provision of these services. However, health facility in-charges must be capable of identifying managerial challenges and devising innovative solutions to address them.

The success of immunization services requires that facility managers budget at an appropriate level for this public health service, which extends to all community members – not just those who come to health facilities. To support such services, each government-supported health facility receives an allocation of Primary Health Care (PHC) funds which the central government disburses quarterly to support all PHC services. As immunization is a core PHC service that facilities must provide, it is essential that facility managers recognize the need to allocate adequate PHC funds for immunization and leverage other potential funding sources as needed.

JSI'S APPROACH TO BUILDING LEADERSHIP MANAGEMENT AND ACCOUNTABILITY (LMA) CAPACITY AMONG HEALTH FACILITY MANAGERS

To address the gap in facility level leadership, management, and accountability (LMA), JSI developed the systematic approach shown in Table 1. It is comprised of first capturing experience from strong facility managers, designing and conducting a training approach for other facility managers, and reinforcing the learning through follow-up support and opportunities for skills application.

In Uganda, the district service commission and the district health office appoint managers for health facilities based on their professional training and staffing hierarchy rather than their leadership or management abilities. Medical doctors are assigned as managers at the district hospital and sub-district Health Center IV level; personnel with a diploma in clinical medicine are assigned to manage Health Center III facilities; and registered nurses or midwives are assigned to manage Health Center II facilities.

JSI'S APPROACH TO BUILDING THE LEADERSHIP, MANAGEMENT AND ACCOUNTABILITY CAPACITY OF HEALTH FACILITY IN-CHARGES

1. Sought input on essential LMA practices from managers of high-performing health facilities

In 2016, JSI convened a meeting of 43 in-charges and immunization focal persons from five districts to share the practices they view as key to high immunization performance. These staff were selected based on their leadership and management capability, as evidenced by the following practices:

- Conducted and attended monthly meetings of staff and quality work improvement teams (QWITs)
- Displayed information in their facility on the release of PHC funds
- Delegated the management of immunization funds to the Expanded Programme on Immunisation (EPI) focal person in their facility
- Linked with sub-county leaders by presenting monthly performance reports on immunization and attended Technical Planning Committee meetings
- Provided supportive supervision on immunization within their facilities and participated in the provision of immunization services

2. Developed key content for LMA training

Based on the above guidance, JSI developed an orientation package for strengthening the LMA capability of health facility managers. Key material was summarized in a presentation that also drew on leadership-related content from the World Health Organization Mid-Level Managers (MLM) course for immunization.

3. Trained health facility managers on LMA

1. During 2017-2018, JSI convened a series of one-day orientations in eight districts to a total of 121 health facility managers. The Chief Administrative Officer (the head of district civil service) played a key role in facilitating these orientations, thereby underscoring the importance of the link between the work of health personnel and administrative officers.
2. The content focused on the specific roles, traits, qualities, and practices of a good health manager needed for immunization, including: planning and objective setting, delegation, organizing services, staffing, leadership, controlling human and financial resources, coordination, communication, and motivation.
3. Facility managers relayed their views and initial LMA commitments during group sessions, panel discussions, and individual presentations. They each received a copy of the presentation with core content on LMA for their further reference.

4. Provided follow-up on-job support on LMA to health facility managers

1. District health teams (DHTs) provided the trainees with further on-job mentorship and coaching on the LMA content during integrated supportive supervision visits at health facilities.
2. DHTs used the district supportive supervision checklist to assess health facility managers' progress in implementing LMA actions. They also identified existing gaps and discussed with the health manager possible solutions to address them.

5. Supported adaptive learning

Managers of high-performing facilities were given the opportunity to present and share the promising LMA practices that they found most useful during quarterly review meetings in their districts. This enabled learning by other facility managers and encouraged them to improve their own LMA practices.

Health facility managers discuss with all staff and community members to develop microplans to reach all communities in their catchment area

LESSONS LEARNED FROM THE LMA INTERVENTION

Following the introduction of the measures described above, JSI observed changes in the actions of health facility managers towards improving RI services. These centered on three cross-cutting themes:

1. **Microplanning to reach all children:** ensuring all villages are reached
2. **Budgeting PHC funds for routine immunization:** budgeting as a team effort so that sufficient PHC funds are allocated to support RI.
3. **Delegation of duties and resources:** empowered the EPI focal persons and motivating other staff to support RI services.

I. Microplanning to reach all children

Microplanning is a continuous process of identifying in detail the needs, resources, and actions required to deliver health services to communities. It is a key process for REC and REC-QI. Using microplans has proven to be an effective way for managers to identify and reach villages previously missed with immunization services.

- Before introduction of the REC-QI approach and the LMA intervention, facility managers said that they viewed the microplan as a formality that they developed on their own or just with the EPI focal person. They did not refer back to it or use it to guide decisions on RI. Instead, they relied on their personal knowledge on where they thought large populations resided as the basis for siting outreach posts for immunization.

"[Before SS4RI] we had no knowledge on RI microplan. But as I talk now it's a simple tool that everybody can make and update…it helped us improve RI performance"

- Health Facility Manager, Health Center III

- Facility managers reported that JSI's LMA support empowered them to work with all staff and community members to develop the microplan. They now use accurate information on each village's target population and input from communities to identify strategic locations for outreach.
- On a monthly and quarterly basis, these managers now work with their teams to review their target populations, assess existing barriers, devise innovations for the next period, and update the microplan accordingly. They also reported using the microplan's population targets and numbers of unimmunized children to forecast the quantities needed for vaccines and supplies.

"Before [LMA support], we were budgeting at 20% which was far too little to cater for all services in routine immunization. Now we have allocated 42% which we feel is adequate. We also lobby for other extra resources from sub county and other local funders."

Health Facility Manager, Health Center II

II. Budgeting PHC funds for routine immunization

PHC funds are intended to facilitate service delivery at community level. The level of allocation for RI services is made at the discretion of the health facility manager who also serves as the financial controller. UNEPI recommends that facilities (or districts) allocate 20% of PHC funds to immunization. However, PHC funds are usually insufficient to cover the costs required for health worker transport, mobilization of communities for services, and other operational costs for immunization.

Before the LMA intervention, health facility managers single-handedly budgeted and disbursed PHC funds without consulting other staff, resulting in wide variations in allocations. For example, the manager of one health facility allocated 20% of PHC funds for immunization while managers at two other facilities allocated only 10%. In another health center, PHC funds allocated for immunization in the amount of UGX 5000 (approximately US$1.50) were distributed uniformly to all staff regardless of whether they took part in immunization activities.

The LMA intervention emphasized the importance of budgeting as a team effort and the need to allocate sufficient PHC funds to support RI.

- One facility manager established a budget committee comprised of key facility staff and community members and delegated all budgeting duties to it. This committee has since allocated 50% of the PHC funds to RI services to enable immunization to reach its large, dispersed target population of 28,000 people.
- Other health facility managers said they too have adopted a team approach for budgeting and have doubled the PHC funds allocated for RI.
- To promote transparency and accountability, some health facility managers now display PHC fund allocations and disbursements on public notice boards. This has been particularly motivating to other staff in the health facility as they now know the level of funding available for immunization and how they PHC funds are actually used.

"SS4RI told us it's a good practice to delegate the portion of [PHC funds for] immunization to EPI focal persons to manage. [This] also empowered the EPI focal person: he can now decide who to go for outreaches… when he commands, they will respect him."

-Health Facility Manager, Health Center III

III. Delegation of duties and resources

At the health facility level, RI services are the responsibility of the EPI focal person, whose duties include planning and providing immunization services and reporting on performance.

- EPI focal persons said that prior to the LMA activities, they had been responsible for immunization services yet lacked control over the resources needed to provide them. As a result, some outreach sessions that they had planned could not be conducted and payment of outreach allowances to health workers and village health teams (VHTs) was irregular.
- Following LMA support, health facility managers delegated responsibility for managing the PHC funds allocated for immunization to the EPI focal persons, holding them accountable for reaching more children. This helped ensure that staff and VHTs involved in immunization outreach had their costs covered while holding them to task for achieving their immunization goals.
- Facility managers confirmed that this delegation empowered the EPI focal persons while also motivating other staff to support RI services – a new development. The EPI focal persons have used the funds to provide allowances for transport and meals to staff who go for outreach. Allowances have also been provided to community members such as VHT members and village chairpersons to mobilize and follow up children needing vaccination.
- At one health center, the health facility manager realized after the LMA training that they were using a Gavi-donated motorbike for other activities, instead relying on the less reliable and more expensive practice of hiring a taxi motorbike to transport health workers for outreach sessions. He immediately reassigned this motorbike to the EPI focal person, who now uses it to deliver, monitor, and mobilize for immunization services.

ENGAGEMENT OF NON-HEALTH STAKEHOLDERS AND RESOURCE MOBILIZATION

JSI has observed that engaging local actors from outside the health system is vital to building support for routine immunization.

"Non-health stakeholders" (NHS) are local political, administrative, civic, religious and cultural leaders and community resource persons who have direct contact with communities and are trusted by them. They also control both monetary and non-monetary resources. At sub-national level, these stakeholders include the village chairperson, VHT members, parish chiefs, sub-county chiefs, parish level councilors, clergy, and others.

- Before LMA training, health facility managers viewed RI as being the sole responsibility of health workers. This resulted in inadequately mobilized communities and low turnout for immunization both at clinics and outreach posts.
- The LMA support educated health facility managers on the benefits and "how-to" of engaging non-health stakeholders in immunization, particularly to build community demand for RI.
- After LMA training, some facility managers said they held meetings with non-health stakeholders and now educate them on the benefits of immunization and the current performance of the health unit, and inform them of their responsibilities to mobilize and follow up with communities for immunization.
- These managers noted that sharing their facility's immunization targets, as well as the constraints to reaching them, gave rise to solutions and commitments from these non-stakeholders to address the problems, e.g.: the identification of previously-missed villages and provision of outreach posts there, mobilization of households to come for immunization, and registration of all eligible children for immunization by VHTs.
- Health facility managers said they now participate in quarterly technical planning committee meetings at sub-county level. Sub-county chiefs ask them to discuss their immunization performance, existing gaps, and actions requiring financial and in-kind support of these stakeholders.
- The manager of one health facility secured a motorbike from the sub-county to support community mobilization. At another facility located in a predominantly Catholic community, the health facility manager engaged the priest to use church services, weddings, and local gatherings to encourage communities to immunize their children. Managers of other health facilities persuaded sub-county chiefs to purchase megaphones to publicize immunization and help defray the costs of transporting health workers for outreach services.

"We have managed to get a lot of support from the sub county and the parish chief in terms of transport, allocating an extra motorbike for outreaches, buying megaphones, and allocating funds to the health facility in support of immunization."

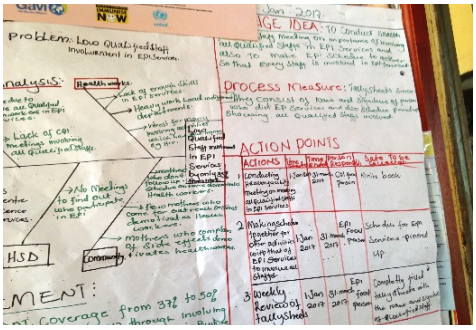
-Health Facility Manager, Health Center III

USING DATA AND TEAM EFFORT TO SOLVE PROBLEMS

Prior to the LMA intervention, health facility managers reported that when they received immunization data from the EPI focal person in their clinic, they simply forwarded it to the district level without reviewing it. The LMA intervention built their understanding of how to relate the immunization data to population targets, identify reason s for not meeting targets, and find solutions to resolve the problems.

Following the LMA support, facility managers reported greater functionality of Quality Work Improvement Teams which engage health workers from different departments and community members to meet each month. They noted that, unlike in the past, they themselves now review EPI data rather than viewing it is as the sole responsibility of the EPI focal person. Guided by quality improvement tools such as Plan-Do-Study-Act cycles, they lead the process of identifying and planning to reach those communities with large numbers of unvaccinated or under-vaccinated children.

These facility managers noted that they now realize how locally-generated data could be used for decision making. The increased value that they now place on having high quality data has, in turn, motivated them to review and analyze their own facility's RI data before submitting it to the district.



Immunization data and planning tools displayed at a health facility

INNOVATIONS FOR SUSTAINING ROUTINE IMMUNIZATION PERFORMANCE

The REC-QI concept was based on thinking outside the box and challenging the status quo. Following are examples of innovations that emerged from interviews with facility managers.

- Upon realizing the high number of unimmunized children in her catchment area, one health facility manager led her team to initiate an integrated quarterly immunization day—a one-stop shop where comprehensive health education is provided, mothers receive family planning services, and their infants and children are immunized, dewormed, and assessed for nutrition.
- A health facility manager came up with an innovation of incentivizing mothers to complete the vaccination schedule by stamping every child's immunization card after they receive their final dose of vaccine. This has generated interest and demand for immunization in the community.
- One facility in-charge, together with her team and their VHT, formed a savings group that meets monthly. They use this forum to request updates on whether children previously identified as defaulters are now vaccinated and identify newborns needing to start the vaccination schedule. These innovative practices promote teamwork and, as they require no additional budget, are likely to be sustained.

"These quarterly immunization days work as a mop up for the health facility. Even those children that you have missed in the past three months, you see them coming."

-Health Facility Manager, Health Facility II

CONCLUSION

JSI's approach to building the LMA capacity of health facility managers has strengthened the critical but under-recognized link between midlevel managers at district level and the front-line health workers who provide vaccination services.

The emerging learning from this work suggests that the facility managers who participated in these efforts are now more empowered, involved, and committed to RI than in the past. They are better able to utilize data, motivate their teams, budget responsibly, and engage non-health stakeholders to identify and contribute to meeting the immunization needs of underserved populations. Through these linkages, more local resources have been generated to close funding gaps. The benefits from investing in building health facility manager capacity in leadership, management, and accountability has the potential to extend to interventions beyond immunization in order to better meet the health needs of children and families.

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