



Zero-Dose
LEARNING HUB

EQUITY IN ACTION: Local Strategies for Reaching Zero-Dose Children & Communities

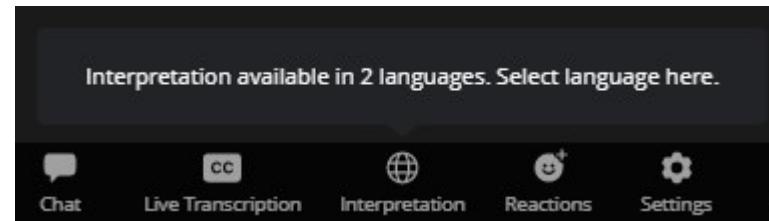




Zoom Translation

English: Click the Interpretation icon to have the option to hear the meeting in French.

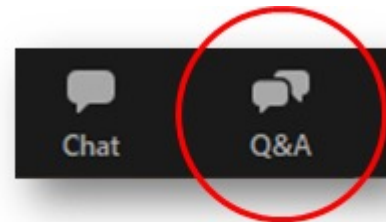
Français: Cliquez sur l'icône intitulée "interprétation" pour avoir la possibilité d'écouter le webinaire en français.



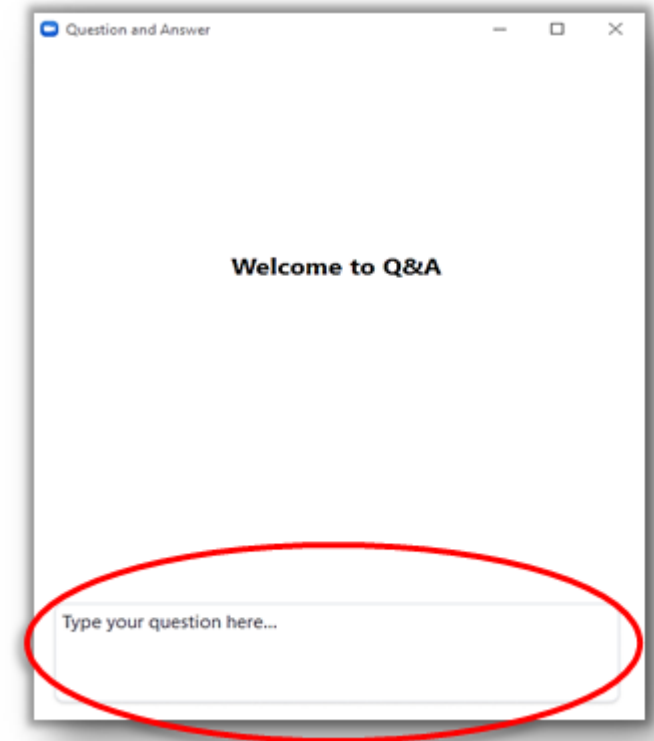


Question and Answer Box

Please submit your questions for the panelists in the Q&A box.



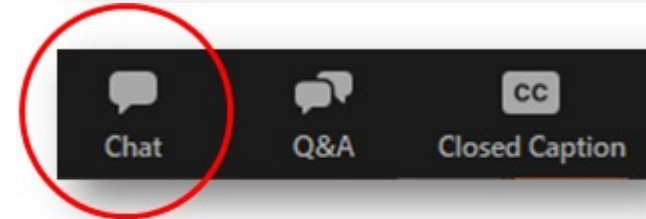
Panelists will either reply back to you via text in the Q&A box or will answer your question during the discussion portion of the webinar.



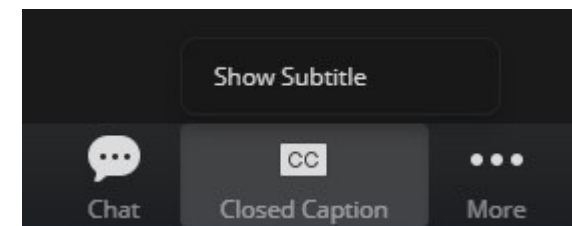


Zoom Reminders

- If at any point during today's webinar you are unable to hear the speakers, please make sure you've connected your audio by selecting the headphones icon.
- Please send a message to *Everyone* in the chat box to introduce yourself, send in your questions, or ask for support during today's webinar.
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- Please note that this meeting is being recorded.



To: **Everyone**
Type message here ...





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Welcome!

Speakers:

Reda Sadki, The Geneva Learning Foundation
Jenny Sequeira, The Geneva Learning Foundation
Charlotte Mbuh, The Geneva Learning Foundation

Facilitator:

Heidi Reynolds, Gavi, The Vaccine Alliance



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Learning about learning

A new learning-to-action pathway to identify and reach





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“Engagement with frontline staff through peer learning is powerful and can identify ‘what works’ and ‘how’ at the local levels and strengthen approaches for knowledge translation and evidence use.”

Gavi's Zero-Dose Learning Hub IRMMA Aligned Interventions: Semiannual Update (October 2023)



We grew a ZDLH community of zero-dose practitioners from 0 to >3,000 in 6 months

3458 registrants from 100 countries

2 ZDLH-X events | 31 May 2023 | 13 September 2023

- ▶ Afghanistan (11)
- ▶ Algeria (3)
- ▶ American Samoa (2)
- ▶ Angola (6)
- ▶ Argentina (1)
- ▶ Armenia (2)
- ▶ Australia (5)
- ▶ Bangladesh (32)
- ▶ Barbados (1)
- ▶ Belgium (3)
- ▶ Benin (60)
- ▶ Bhutan (1)
- ▶ Botswana (3)
- ▶ Brazil (1)
- ▶ Burkina Faso (79)
- ▶ Burundi (11)
- ▶ Cambodia (1)
- ▶ Cameroon (142)
- ▶ Canada (9)
- ▶ Central African Republic (15)
- ▶ Chad (59)
- ▶ Colombia (2)
- ▶ Comoros (4)
- ▶ Congo (23)
- ▶ Congo, Democratic Republic of the (368)
- ▶ Côte d'Ivoire (91)
- ▶ Croatia (1)
- ▶ Djibouti (11)
- ▶ Egypt (1)
- ▶ Equatorial Guinea (1)
- ▶ Eswatini (3)
- ▶ Ethiopia (72)
- ▶ France (6)
- ▶ Gabon (4)
- ▶ Gambia (15)
- ▶ Germany (3)
- ▶ Ghana (109)
- ▶ Guatemala (1)
- ▶ Guinea (59)
- ▶ Guinea-Bissau (9)
- ▶ Guyana (2)
- ▶ Haiti (11)
- ▶ India (63)
- ▶ Indonesia (10)
- ▶ Iraq (3)
- ▶ Ireland (1)
- ▶ Italy (1)
- ▶ Jordan (3)
- ▶ Kenya (67)
- ▶ Kosovo (1)
- ▶ Kuwait (1)
- ▶ Lao People's Democratic Republic (5)
- ▶ Lebanon (2)
- ▶ Lesotho (8)
- ▶ Liberia (14)
- ▶ Libya (1)
- ▶ Madagascar (38)
- ▶ Malawi (7)
- ▶ Maldives (2)
- ▶ Mali (79)
- ▶ Mauritania (9)
- ▶ Morocco (2)
- ▶ Mozambique (7)
- ▶ Myanmar (7)
- ▶ Namibia (1)
- ▶ Nepal (9)
- ▶ Netherlands (4)
- ▶ Niger (44)
- ▶ Nigeria (1138)
- ▶ Norway (2)
- ▶ Pakistan (44)
- ▶ Panama (1)
- ▶ Papua New Guinea (5)
- ▶ Philippines (5)
- ▶ Romania (1)
- ▶ Rwanda (4)
- ▶ Sao Tome and Principe (1)
- ▶ Saudi Arabia (2)
- ▶ Senegal (70)
- ▶ Sierra Leone (25)
- ▶ Solomon Islands (2)
- ▶ Somalia (29)
- ▶ South Africa (9)
- ▶ South Sudan (25)
- ▶ Spain (2)
- ▶ Sri Lanka (2)
- ▶ Sudan (6)
- ▶ Switzerland (22)
- ▶ Tanzania (22)
- ▶ Thailand (1)
- ▶ Togo (85)
- ▶ Tunisia (4)
- ▶ Turkey (1)
- ▶ Uganda (154)
- ▶ United Kingdom (12)
- ▶ United States (103)
- ▶ Vietnam (6)
- ▶ Yemen (11)
- ▶ Zambia (19)
- ▶ Zimbabwe (12)

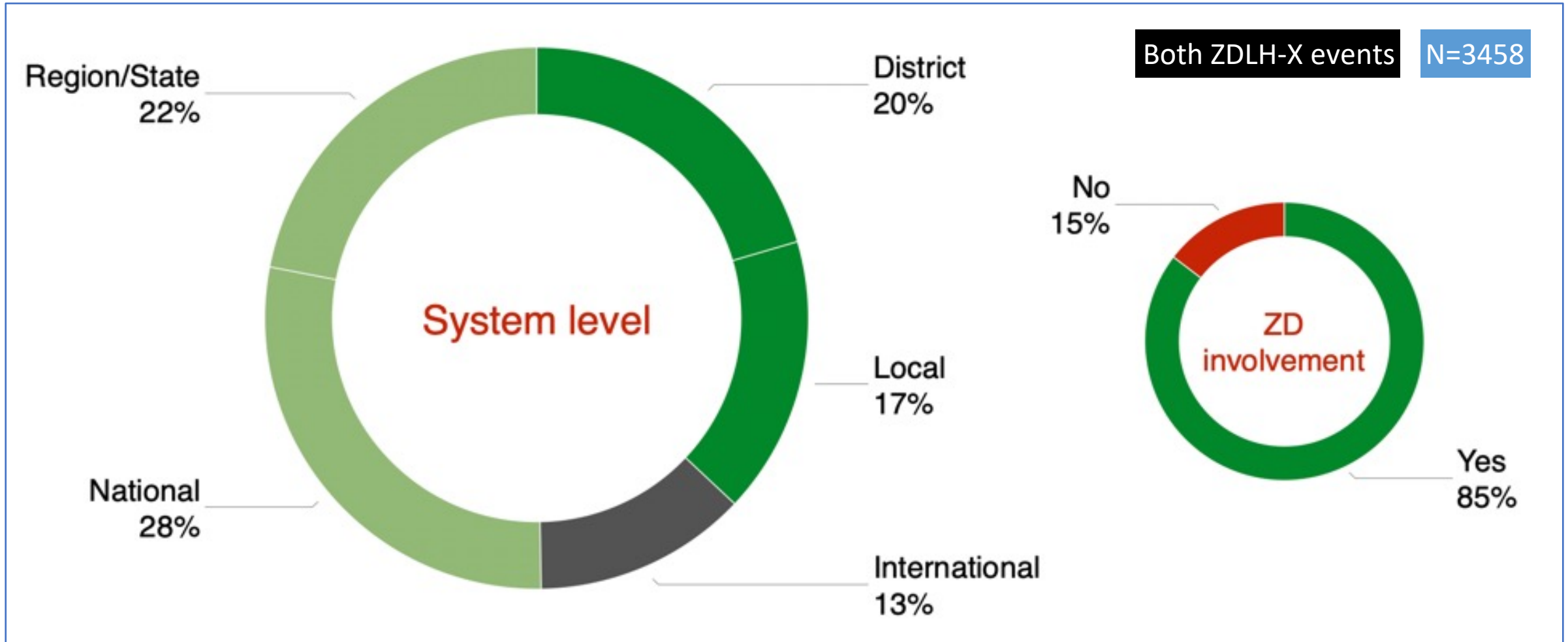
Table 3: Platform usage

ND = No data

Platform	No. of registrants					No. registered in past 3 months	No. active in last 6 months
	Total	BD	MA	NI	UG		
Movement IA2030	48,151	189	1099	10,902	451	4448	4158
CORE Group	15,000	ND	ND	ND	ND	ND	500
Teach to Reach	14,134	6	29	3642	116	2701	1240
IAPHL	7909	21	17	1864	201	148	ND
TechNet-21	5903	35	51	589	67	285	1000
Sabin Boost	3500 ¹	ND	ND	ND	ND	ND	ND
Vx Demand Hub	1899 ²	ND	ND	ND	ND	1938 ³	2011 ⁴
Gavi ZD CoP ⁵	1016	ND	ND	ND	ND	127	304
Social Norms, GL	725	2	ND	68	25	27	ND
Social Norms, NG	119	ND	ND	119	ND	3	60
Comm Init Netwk	ND	ND	ND	ND	ND	ND	ND
The Curve	ND	ND	ND	ND	ND	ND	ND
Social Norms, E.Af	ND	ND	ND	ND	ND	ND	ND

<https://doi.org/10.5281/zenodo.10204774>

Who did we reach?





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So how did we do it...?

We knew “continuous learning” is the Achilles heel of immunization

1. Relative lack of learning opportunities
2. Limited ability to experiment and to take risks
3. Low tolerance for failure
4. Focus on task completion at the expense of developing capacity for future performance
5. Lack of encouragement for learning tied to tangible organizational incentives

TGLF learning culture and performance global measurements (2020 and 2022)

Year	n	Continuous learning	Dialogue & Inquiry	Team learning	Embedded Systems	Empowered People	System Connection	Strategic Leadership
2020	3830	3.61	4.68	–	4.81	4.68	5.10	4.83
2022	6185	3.76	4.71	4.86	4.93	4.72	5.23	4.93



How can “continuous learning” be strengthened?

1. Motivate me to believe strongly in the importance of knowledge translation
2. Give me practice dealing with difficult situations I might face
3. Give me practice in being mentally resilient in the face of obstacles
4. Prompt me to enlist coworkers to support me
5. Help me enlist my boss to provide guidance, support, and resources
6. Help me identify and overcome workplace obstacles

1. Share

2. Experience

3. Reflect

4. Lead change

Knowledge translation

- Share your ZD experience

721 experiences

- Listen to shared experiences
- Give and receive feedback
- Share your own experience

1964 registered

378 joined live event

913 views on YouTube

- What value has this created for you?
- What did you learn?
- What will you do differently?

364 insights

- Stay connected with fellow practitioners
- Identify the best strategies for you
- Adapt these strategies to your local context

30 minutes

90 minutes

30 minutes

Self-sustaining

RESEARCH

Open Access

Accelerating problem-solving capacities of sub-national public health professionals: an evaluation of a digital immunization training intervention



Karen E. Watkins^{1*}, Lorilee R. Sandmann¹, Cody Aaron Dailey², Beixi Li³, Sung-Eun Yang¹, Robert S. Galen² and Reda Sadki⁴

Abstract

Background: This article reports an evaluation of the *Immunization Training Challenge Hackathons* (ITCH), invented by The Geneva Learning Foundation (TGLF) for national and sub-national immunization staff who strive to develop the knowledge and capacity of others to improve immunization program performance. ITCH, a fully-digital program focused on networked collaborative problem-solving between peers, provided an “opt-in” activity for learners in the Teach to Reach (T2R) Accelerator Program designed to improve training effectiveness in the immunization sphere.

Methods: Conducted by a team from the University of Georgia, this mixed method evaluation consisted of thematic analysis of recorded sessions and open-ended comments; and statistical analyses of application and follow-up survey data. The evaluation focused on what was learned and how ITCH participants implemented what they learned. Key stakeholder interviews provided supplemental data about program intent and results. ITCH consisted of 17 30-min sessions held in 2020, in English and French, with 581 participating at least once out of 1,454 enrolled in the overall program. Challenge owners and respondents came from 15 African and Asian countries and spanned different roles with differing scope.

Results: Over 85% [$n = 154$] of survey respondents [$n = 181$, a 31% response rate] indicated they were able to implement what they learned from the ITCH sessions. A majority [$n = 139$, 76.7%] reported finding the sessions useful. Issues with poor connectivity and the timing of the live meetings impeded some in their ability to participate, a problem compounded by consequences of the pandemic. **The ITCH process constituted of learning or coming to consciousness simultaneously of four types of learning — participants realizing how much they could learn from each other (peer learning), experiencing the power of defying distance to solve problems together (remote learning), and feeling a growing sense of belonging to a community (social learning), emergent across country borders and health system levels (networked learning).**

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Full list of author information is available at the end of the article



“The process constituted of learning or coming to consciousness simultaneously of four types of learning — participants realizing how much they could learn from each other (**peer learning**), experiencing the power of defying distance to solve problems together (**remote learning**), and feeling a growing sense of belonging to a community (**social learning**), emergent across country borders and health system levels (**networked learning**).”

Watkins, K.E. et al., 2022. Accelerating problem-solving capacities of sub-national public health professionals: an evaluation of a digital immunization training intervention. *BMC Health Serv Res* 22, 736. <https://doi.org/10.1186/s12913-022-08138-4>



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...and does it make a difference?

How do we measure the creation of value in learning interventions?

	Baseline (2022) n=10095	ZDLH-X	Δ
Value created			
Participation changed me as a professional	4.93	5.11	+0.18
Participation affected my social connections	4.57	4.30	-0.27
Participation helped my professional practice	4.96	4.99	+0.03
Participation changed my ability to influence my world as a professional	4.88	4.94	+0.06
Participation made me see my world differently	4.90	4.93	+0.03

Strongly disagree = 1

Strongly agree = 6

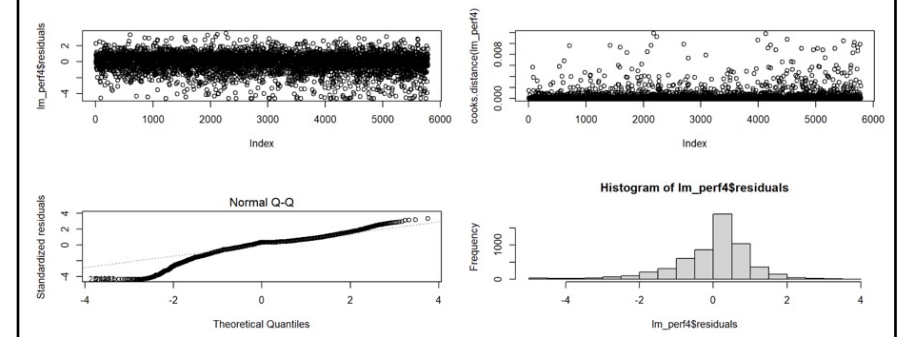
If we invest in effective learning, does that improve performance?

Knowledge performance (translation): The model is statistically significant, with moderate effect size. The learning dimensions account for 28% of the variability in knowledge performance scores.

Mission performance (coverage): The model is statistically significant, with moderate effect size. The learning dimensions account for 14% of the variability in mission performance scores.

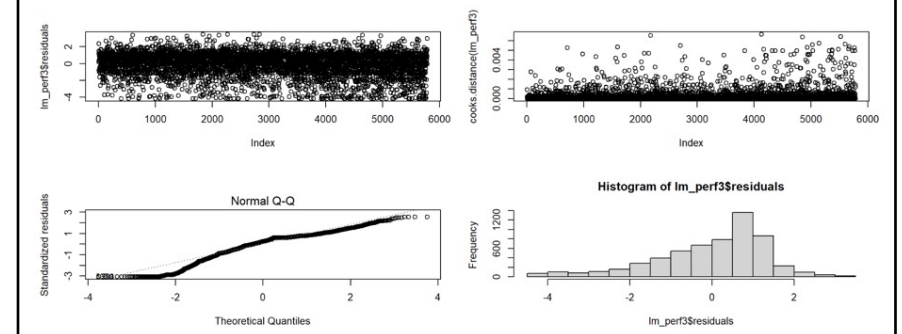
5.4 Predicting knowledge performance from DLOQ items

5.4.1 Assumptions



5.3 Predicting immunisation program performance from DLOQ items

5.3.1 Assumptions





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How can we measure change in relation to learning and performance? By analyzing...

Capacity for change (environment)

& Value created (for individuals and teams)

& Health indicators (attribution/contribution)



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“In response to the new strategies learnt from the Gavi Zero-Dose Learning Hub, we are adapting the practices on top of the existing ones in our district. One of them is tracking mothers at ANC. Also the missed opportunity and service integration strategy, screening eligible children at out patient departments and immunizing them immediately.”



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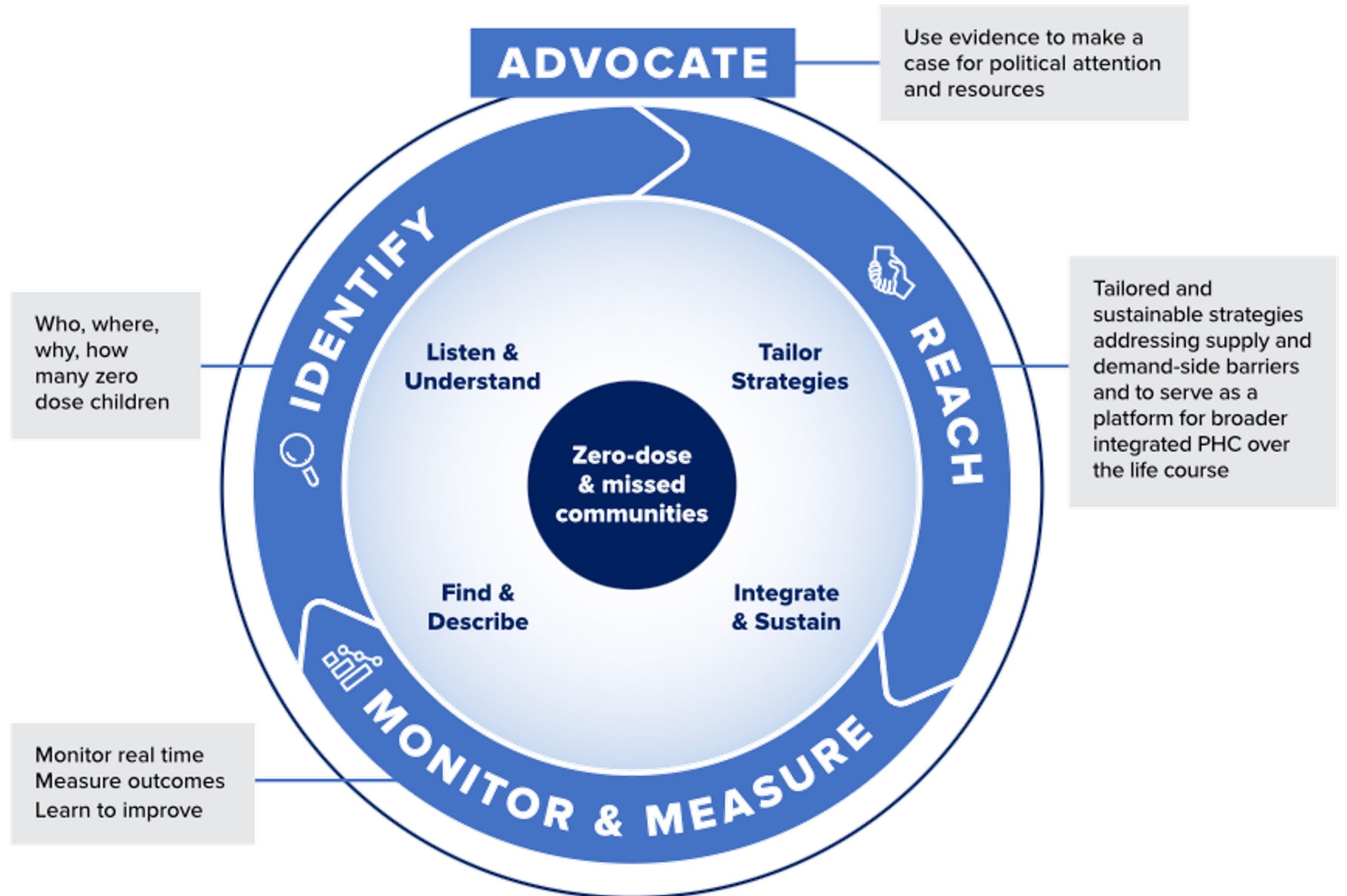
ZD Case Studies from Sub-National Practitioners in Bangladesh, Mali, Nigeria, and Uganda



ZDLH-X: peer-to-peer exchanges in 2023

- **May: Bangladesh & Mali**
 - Featured topics:
 1. Finding clusters of ZD children and communities missed by immunization services
 2. Community engagement to consistently find and vaccinate children in urban, rural remote, and conflict affected areas
- **September: Nigeria & Uganda**
 - Featured topics:
 1. Integration - maximizing opportunities to reach ZD children and missed communities
 2. Microplanning – revising microplans on a continuous basis to better address ZD challenges

ZDLH-X looked at case studies drawing on Gavi's IRMMA framework and its **continuous cycle focus**



Where does your experience fit?

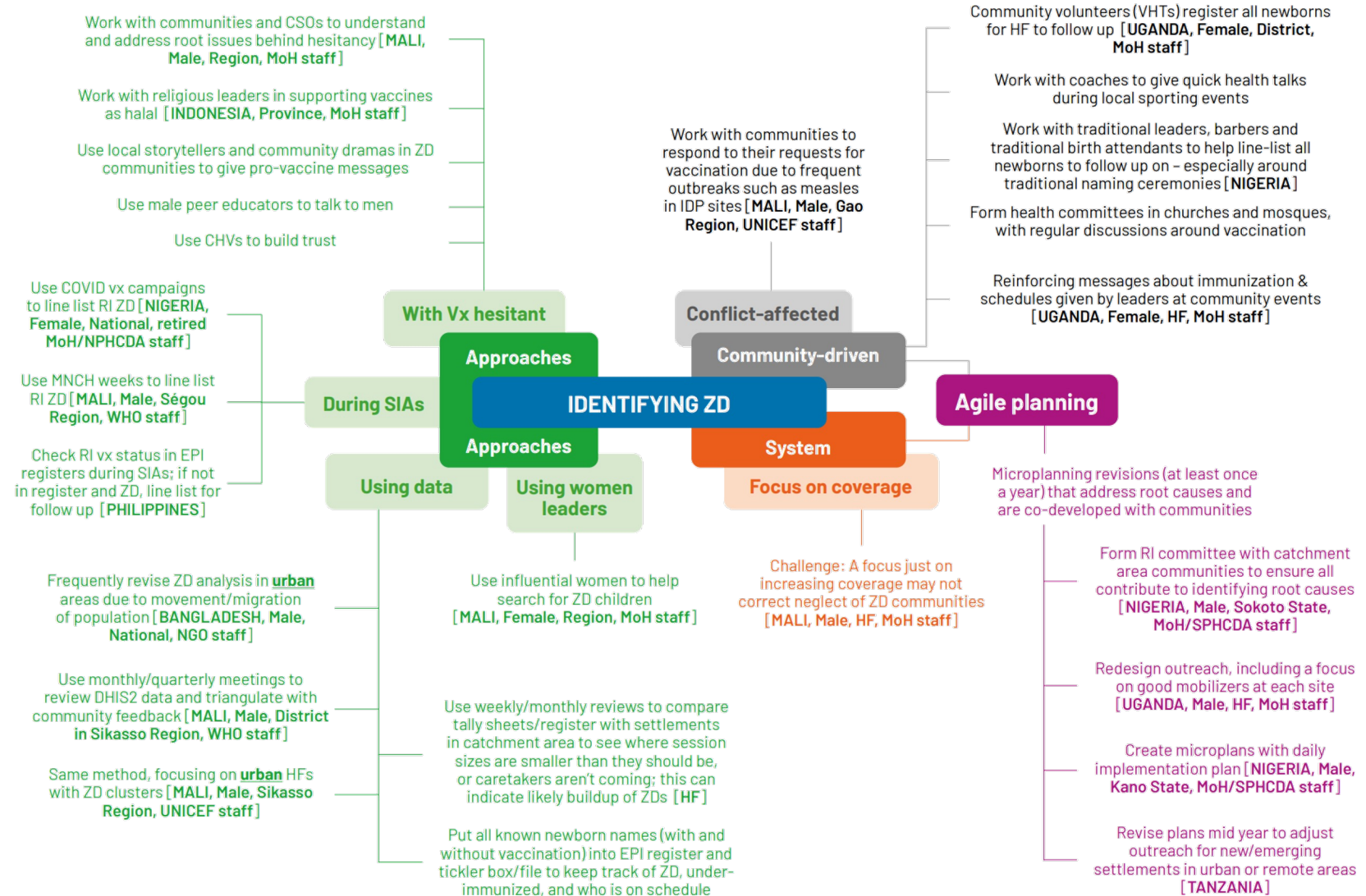
What are we doing to move from evidence to action?

Conceptual Framework insights that connect to IRMMA’s “Identify”

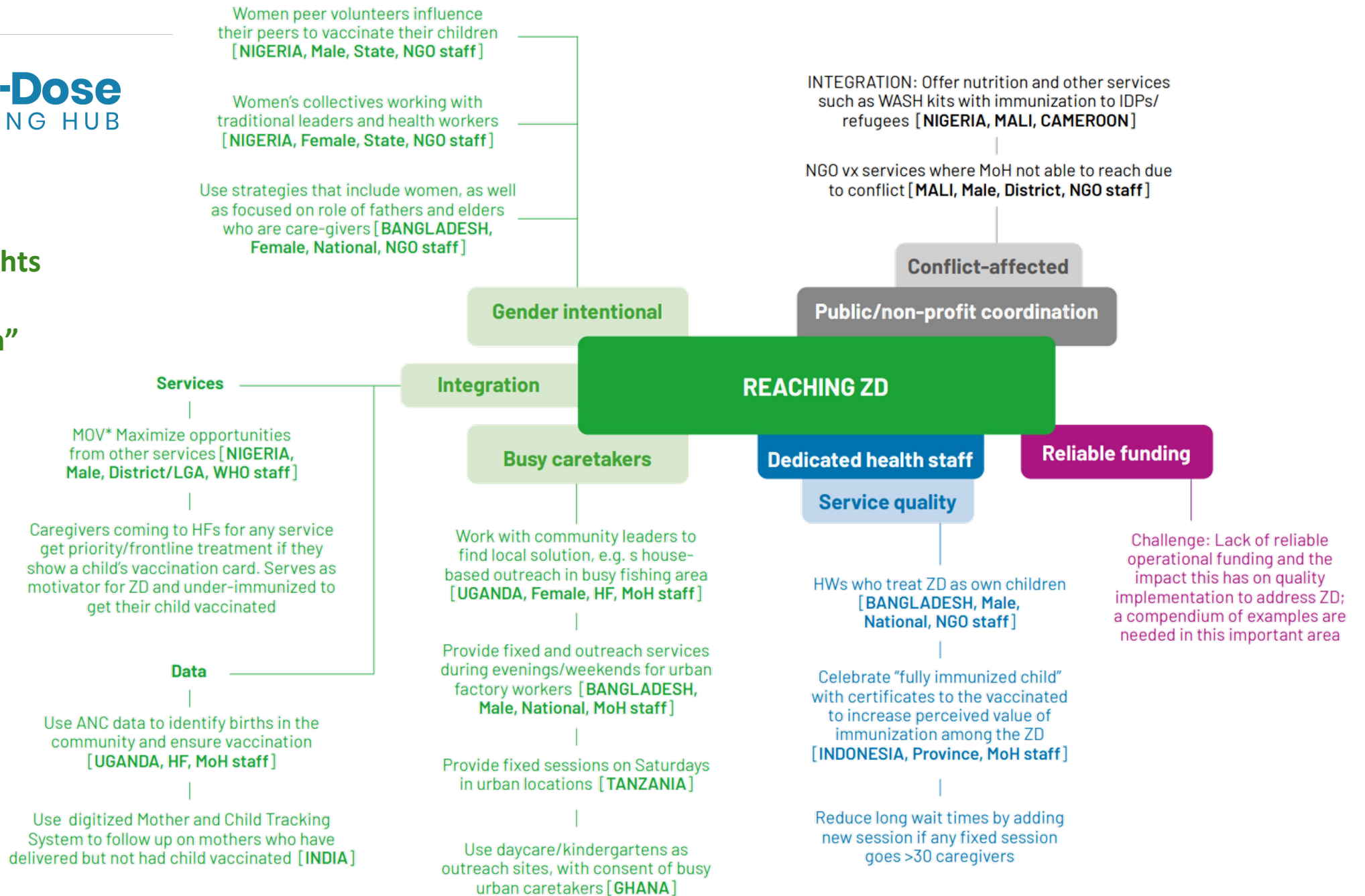
Conceptual Framework:

- A compendium of insights from case studies that emerged from ZLDH-X
- Helps illustrate components of IRMMA framework, starting with examples around “Identify” and “Reach”
- Does not illustrate how an intervention links continuously to other IRMMA components

ZDLH will continue building out illustrative examples around each IRMMA component



Conceptual Framework insights that connect to IRMMA's "Reach"



The importance of connecting different types of evidence:

- ZDLH-X showcases stories directly from immunization practitioners, in real time & unfiltered, focusing on 4 country learning hub locations
- Gavi's **pro-equity evidence mapping** by FHI360 gives global examples, using rapid reviews, conducted by researchers
- Many other data sources, with differing types of evidence

Methods: Rapid reviews

- Rapid reviews: relatively narrow, well-defined scope
- Developed general methodology and topic-specific methodologies
 - Topic-specific methodologies developed in two iterative phases (exploratory and execution)
- Focused on evidence for effectiveness and implementation
- Differentiated data extraction approaches
- Evidence synthesized into Evidence Briefs and made available online on evidence map
- Need for some degree of standardization to facilitate interpretation

Evidence Briefs	Relevance	Effectiveness	Implementation in ESG settings				
			Urban poor	Remote rural	Conflict	Gender barriers	Other (not specific to ESG settings)
Identify							
Using surveillance data to identify ID ID	•	•	•	•	•		•
GIS Mapping ID		•	•	•	•		•
Reach							
Campaign integration ID	•	•	•	•	•	•	•
Financial provider incentives ID	•	•					
Nonfinancial Provider Incentives ID	•	•					•
Incentives for users ID	•	•	•	•	•	•	•
Learning Women's Groups ID	•	•	•	•		•	•
Community groups paid via CHWs ID	•	•	•	•	•	•	•
Measure & Monitor							
Community-based monitoring ID	•	•	•	•	•	•	•
Supervise supervisor ID	•	•	•	•	•	•	•
Targeted analysis ID	•	•	•	•	•		•
Advocate							
Score accountability ID	•	•	•	•	•	•	•
Co-creating							
Monitoring ID		•	•	•		•	•

Online Evidence Map:
<https://www.equityevidencemap.org/>



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“I learned that zero-dose children are not just in rural underserved settlements but also found in urban and peri urban settings.”

Health worker’s quote from ZDLH-X event exit survey

ZDLH-X Featured Case Studies

(detailed slides in Annex & in ZDLH-X reports)

1. MICROPLANNING: Revising microplans to better address ZD challenges (Uganda)
2. INTEGRATION: Maximizing integration opportunities to reach ZD and missed communities (Nigeria or Uganda)
3. COMMUNITY ENGAGEMENT: to consistently find and vaccinate children in urban, rural remote, and conflicted affected areas (Mali)
4. FINDING CLUSTERS OF ZD & MISSED COMMUNITIES: Using rapid convenience monitoring (Bangladesh)



Microplanning

Highlighted case studies from ZDLH-X2 event featuring Nigeria & Uganda
Revising microplans as a continuous process to better address ZD challenges

Nigeria/Sokoto State, Sokoto North & Kware LGAs (LGA = district): Aminu Yahaya, State Primary Health Care Development Agency
Reorienting microplanning to better address local ZD challenges

Uganda/Isingiro District, Health Facility: Muhangi Ambrose, Ministry of Health
Redesigning static/fixed & outreach services to reach more ZD children, linked to community mobilizers

Uganda/Kasese District, Health Facility: Edwin Mbusa, Ministry of Health
Revising microplans around specific needs of individual communities, especially where there are clusters of ZD children

Nigeria/Bauchi State: Halima Buba, Solina Centre for International Development and Research (NGO)
Revising microplans to focus more on ZD and under-immunized children by leveraging women's collectives and traditional leaders



Today we remember Vaccination Hero **AMINU IBRAHIM YAHAYA** Nigeria, Sokoto State

*Aminu passed away on Sunday,
14 January following a short illness.
MAY HIS SOUL REST IN PEACE*

Aminu was a public health specialist with over 24 years of experience in family planning, MNCH, and immunization. He worked for UNICEF, WHO, and other organizations, and dedicated his career to building closer collaboration between communities and health services.

Aminu's ZDLH case study: Reorienting microplanning to better address local ZD challenges



DeeNee

Case Study: Uganda/Isingiro District, Health Facility; Muhangi Ambrose, Ministry of Health; *Microplanning - redesigning static/fixed and outreach services to reach more ZD, linked to community mobilizers*

CHALLENGE: Immunization coverage was lagging despite all planned immunization sessions taking place. We didn't know where the problem was.

APPROACH TAKEN: Using Uganda's "Reach Every Child" microplanning tools, we refined our service delivery plan with community health volunteer mobilizers (Village Health Teams/VHTs) to better reach ZD and under-immunized children living both near and far from the HF

INTERVENTION DETAILS:

- ▶ Worked with VHTs to line-list all the under-ones in all of the catchment area
- ▶ Based on the line-listing data, increased static/fixed services from 1 to 3 times a week and outreach from 2 to 4 times a month (using "5 Why's process to understand root issues)
- ▶ Mapped all the villages and assigned outreaches to specific VHT mobilizers
- ▶ Mobilizers agreed to help with a follow-up list after every session to track missed appointments for subsequent visits
- ▶ Team agreed to conduct quick weekly reviews and more in-depth monthly reviews to validate data and interventions
- ▶ Microplan is revised each quarter as needed, including using tools such as the "5 Why's"



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“I now think that health care interventions should include microplanning with community leaders, religious and other stakeholders in the community to ensure that real issues or barriers are identified and the interventions are community supported. This ensures sustainability and this is what I will now do differently in my work.”

Health worker’s quote from a ZDLH-X event exit survey



Integration

Highlighting case studies from ZDLH-X2 event featuring Uganda or Nigeria

Maximizing integration opportunities to reach ZD and missed communities

Nigeria/Sokoto State: Abubakar Muhammad Amali, Male, WHO

Using service integration strategies to reduce missed opportunities for vaccination (MOV) in larger health facilities and secondary hospitals

Uganda/Kotido District, Health Facility: Scovia Okello, Ministry of Health

Using Antenatal Care (ANC) data to follow up on births & vaccination

Uganda/Kumi District, Health Facility: Akello Rebecca, Ministry of Health

Integration of services & special outreaches at community events to reach ZD children

Case Study: Nigeria, Sokoto State; Abubakar Muhammad Amali, Male, WHO
integration strategies to reduce Missed Opportunities for Vaccination (MOV) in larger health facilities and secondary hospitals (1)

CHALLENGE: Sokoto State has many ZD children and we are missing opportunities to vaccinate them when they or their caretaker come for other PHC services (e.g., for treatment of malaria or other illnesses, antenatal care, family planning or nutrition [Community-Based Management of Acute Malnutrition/CMAM]).

APPROACH TAKEN: The national level (NPHCDA) encouraged states to adapt and test the global MOV strategy. Our adaptation is called “Missed Opportunity and Service Integration Strategy” (MOSIT) to ensure all children who attend any other PHC service get vaccinated during that visit. We also want to be sure clients receive adequate information about all services when they receive any service.

INTERVENTION DETAILS: Most large health facilities and hospitals offer immunization at the same time as outpatient services, ANC, FP, and CMAM services

- ▶ When clients come to the HF/hospital, the front desk officer screens them to identify other services they may be eligible for; this includes children accompanying the client
- ▶ The front desk officer registers the client and puts any other service they are eligible for into the *Service Integration Register*, then gives them a referral slip detailing the different services they can get, which include immunization
- ▶ The health worker who provides the service the client came for asks if they have any referral slip, and if they do, then the health worker refers them where to go for the other services, including immunization

Case Study: Uganda/Kotido District, Health Facility; Scovia Okello, Female, MOH; *Integration: using ANC data to follow up on births & vaccination*

CHALLENGE: Some of our ZD children come from mothers who attended antenatal care (ANC) but deliver at home; how can we ensure that all women who visit ANC at least once are followed up when they give birth so that their child is vaccinated?

APPROACH TAKEN: Midwives realized that the facility could use ANC registration data to track expected delivery dates (EDD) of mothers and worked with the immunization unit and community volunteers to develop an intervention for following up with ZD children who were delivered at home.

INTERVENTION DETAILS

- ▶ We document the EDD of pregnant women during ANC attendance
- ▶ If the woman doesn't return for ANC for a month after her EDD, we expect she would have delivered from somewhere
- ▶ We use Village Health Teams (VHTs – community health volunteers) and community leaders to understand the mother's situation; if delivery is from home, VHTs identify if any are ZD children
- ▶ During immunization sessions (static/fixed or outreach), VHTs and other leaders make sure that these ZD children come to get immunized

MAIN ISSUES WITH IMPLEMENTING ANC-EDD APPROACH: most mothers don't know their EDD, so we have to estimate.

LESSONS LEARNED SO FAR: Reviewing data weekly helps you know if you are on the right track or not. We aim to analyze our data weekly, especially the data for delivery and BCG vaccine.



Community Engagement

Highlighting case studies from ZDLH-X1 event featuring Mali

Maximizing opportunities to consistently find & vaccinate children in urban, rural remote & conflicted affected areas

Mali/Region: Dr. Fantamady Camara, UNICEF

Community engagement in 11 urban areas of Sikasso city in collaboration with women's groups & home visits to talk to fathers and mothers

Mali/Bamako District/ Valentine de Pablo Health Center Bamako: Fane Moussa, Ministry of Health

Addressing ZD challenges among conflict-affected populations with limited or unreliable access to health services

Mali/Health Facility: Adama Traore, Ministry of Health

Working with community relays and village chiefs in rural remote areas to identify live births & support follow-up vaccination

Case Study: Mali, Sikasso Region): Dr Fantamady Camara, Male, UNICEF; *Finding zero-dose and missed communities - community engagement in urban areas*

CHALLENGE: In the health district of Sikasso, which has 45 health areas, we found that the majority of ZD and under-immunized children came from 11 community health centers in the city of Sikasso

APPROACH TAKEN: We proposed to adapt and test the urban immunization strategy tool in Sikasso, with a strong focus on including feedback from mothers and fathers in our design

INTERVENTION DETAILS:

- ▶ Established an urban strategy team, who conducted a situational analysis that included health facility data and focus group discussions with mothers and fathers of young children
- ▶ Based on results, worked with community to form and train women's groups to do home visits and identify ZD
- ▶ Also used immunization register to line list under-immunized children
- ▶ Process involved multiple levels and actors; this included strong support from the Regional Health Directorate, District and health areas
- ▶ Funding was provided by GAVI
- ▶ Follow-up has just started and a data review was planned in 2023

Case Study: Mali/Valentie de Pablo Health Center Bamako; Fane Moussa, Male, CSO;
Finding zero-dose and missed communities - community engagement in rural remote areas

CONTEXT: Remote or physically hard-to-reach rural populations, conflict-affected internally displaced populations & refugees with limited access to health services, including access to health services only during working hours, lack of immunization awareness

CHALLENGE: During malnutrition sessions, when we ask mothers for their children's vaccination records, we realize that they are not up to date, due to lack of knowledge of the vaccination schedule, low importance given to child health and poverty.

APPROACHES TAKEN: Catch-up immunization campaigns for missed age groups, Community engagement approaches, including with religious/traditional/other leaders or community health groups/councils, Community outreach and mobilization.



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“*What I think differently about health care is that the focus is gradually moving from health facilities to communities and families.*”

Health worker's quote from an exit survey after a ZDLH-X event



Finding Clusters of ZD & Missed Communities

Highlighting a case study from ZDLH-X1 event featuring Bangladesh

Using Rapid Convenience Monitoring

Bangladesh/District, Chattogram City Corporation: Md Sorwer Alam, WHO

Using data to find and vaccinate zero-dose and missed communities in an urban area



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Summary of discussion with case study speakers

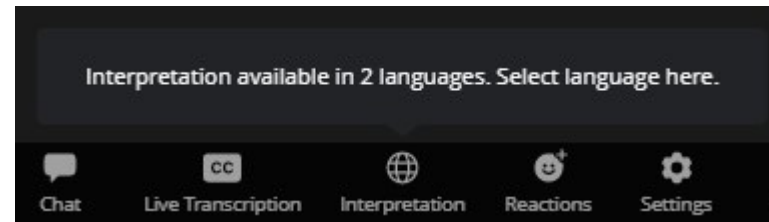
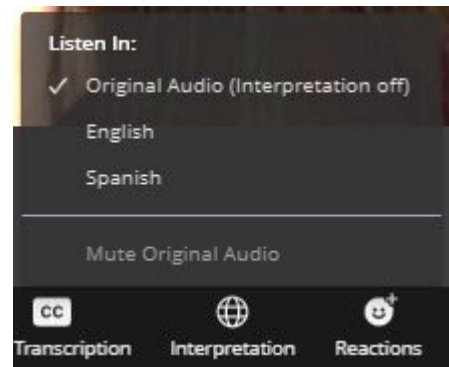




Zoom Translation

English: Click the Interpretation icon to have the option to hear the meeting in French.

Français: Cliquez sur l'icône intitulée "interprétation" pour avoir la possibilité d'écouter le webinaire en français.





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**Please share your questions
in the Q&A box**



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Save the Date

Mark your calendars for ZDLH's next webinar discussing pro-equity interventions and case studies from FHI 360

Thursday, February 29, 2024 | 9 a.m. ET / 3 p.m. CET



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Thank you!

For more information, contact
zero_dose@jsi.com





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ANNEX: Case studies featured in ZDLH-X events

For ZDLH-X details, see:

[ZDLH-X1 recording & report](#) and [slides](#) (featuring Bangladesh & Mali)

[ZDLH-X2 recording & report](#) and [slides](#) (featuring Nigeria & Uganda & summary of findings from both events)



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ZDLH-X Case Studies: **MICROPLANNING**

Planning, implementing, revising as a continuous process

Case Study: Aminu Yahaya, Male, SPHCDA, Sokoto North & Kware LGAs (Sokoto State), Nigeria, Reorienting Microplanning to better address local challenges (1)

What is the challenge that you are trying to solve? Our past plans have not worked well in finding and vaccinating the large numbers of zero-dose children (ZDC) in our area. We wanted to reorient how we develop our plans so that our interventions focus better on local challenges.

Why did you use that approach? Our past plans have not worked well in finding and vaccinating the large numbers of zero-dose children in our area. We wanted to reorient how we develop our plans so that our interventions focus better on local challenges.

What is your intervention? Microplanning in depth with communities to develop a better plan that will help us continuously find and follow up on ZDC. We call the approach in our microplan “Project Radiance”. Below is an example of using the Project Radiance approach in one of our health facilities:

Amina, an immunization officer at Kware town PHC HF (in Kware LGA) worked with community mobilizers, local leaders, and data analysts to develop a comprehensive microplan. Steps we used are:

- ▶ Form a Routine Immunization Committee with the communities in the health facility catchment area
- ▶ Map out remote settlements with the RI Committee
- ▶ Look at service delivery utilization patterns at fixed and each outreach point
- ▶ Conduct a series of community dialogues & focus group discussions to understand caretaker decision dynamics and hidden issues
- ▶ Do a community mapping of key barriers to accessing immunization services; the data from this exercise showed where many of the ZDC lived, their demographics, and the reasons behind their lack of immunization
- ▶ Compile a list of ZDC and missed communities, starting with the EPI Register to understand the under-immunized; develop a ZDC list using Every Opportunity Strategy (EOS; described on next slide)
- ▶ Support community leaders to hold meetings with caregivers to discuss barriers, misconceptions, and parents’ concerns, and gather their ideas on how the health facility can improve its services
- ▶ Use all of the gathered information to develop an immunization plan that addresses each key issue raised during community discussions, mapping, etc.

Case Study: Aminu Yahaya, Male, SPHCDA, Sokoto North & Kware LGAs (Sokoto State), Nigeria, Reorienting Microplanning to better address local challenges (1)

EOS: We use Every Opportunity Strategy (EOS) to identify ZDC by using traditional birth attendant (TBAs) and traditional barbers (TBBs) who feed us with information about caregivers who attend naming ceremonies with their child; we line list the naming ceremonies and plan an outreach session during each naming ceremony, issue an immunization card, and refer to the nearest health facility to continue with remaining doses. We also identify new settlers who have migrated due to security challenges in their area and with help of community and religious leaders we line list these new settlers with eligible children and refer them to the health center for RI and other PHC services

What are your main challenges with implementing this community-based strategy?

- ▶ Some communities were harder to reach than others
- ▶ Based on the challenges, the HF revised strategies, strengthened partnerships, and found innovative ways to navigate the intricacies of each catchment area (innovations in our updated plan include Baby Friendly Shows, Majalisa Meeting (Men's Forum Meeting point), Child adoption strategy, Every opportunity strategy (described above), Naming Ceremonies Vaccination
- ▶ Unexpected barriers emerged such as political differences and security challenges

How do you know Project Radiance is a promising or successful approach? We reached 10% **(Penta1) more** of our ZDC compared to the last four months, based on our monthly DHIS data (tally sheets and monthly summary reports); we also know that many missed children are tracked in batches from line lists, reached, and vaccinated.

What lessons have you learned so far, including any contextual considerations? We learned how important it is to work very closely with community leaders and to keep asking questions to try and find out issues that have long remained hidden. The ripple effect of this micro-planning approach reached beyond healthcare, fostering community empowerment.

Case Study: Muhangi Ambrose, Male, MoH, Health Facility (Isingiro District), Uganda, Microplanning – redesigning outreaches to reach more ZD, linked to mobilizers

What is the challenge that you are trying to solve? Our health facility's immunization coverage was lagging, yet we were holding immunization sessions and we didn't know where the problem was.

Why did you choose this approach? With the adoption of "Reach Every Child" microplanning, we refined our plan so that we now schedule outreaches to the distant villages with good mobilizers. This means we are finding and reaching more children with our services.

What is your intervention?

- ▶ As a team we put up a strategy to line list all the under one year children in all villages to help us follow-up
- ▶ Based on the line-listing and locations of children, we increased the number of sessions in a week from 1 to 4 in order to have all children mopped out and take their antigen
- ▶ We mapped out the villages and then assigned outreaches to specific mobilizers
- ▶ Mobilizers help with a follow up list after every session to help track those missed appointments in subsequent visits
- ▶ As a team we agreed to have monthly performance reviews to validate our data and plans
- ▶ Our microplanning has put our activities in order, and all targets can be reviewed depending on monthly and quarterly analysis

Additional questions: what **main** challenges did you face with the redesigned outreaches? **What data do you use to monitor if the redesigned outreaches are working?** What lessons have you learned ?

Case Study: Halima Buba, Woman, Solina (NGO), Bauchi State, Nigeria, Revising microplans to focus more on ZD and under-immunized children by leveraging women's collectives and Traditional Leaders

What is the challenge that you are trying to solve? Find and vaccinate ZDCs and under-immunized children by leveraging women's collectives and Traditional Leaders

Why did you use this approach? Existing approaches have not been able to fully address our ZDC challenges. The concept was informed from (a) successes from leveraging traditional leaders to identify and track un/under immunized children (including newborns) as well as resolve reported ZD cases using a name-based strategy); (b) demonstrable impact identified in using women collectives/networks to drive peer knowledge sharing and nudges to facilitate caregiver uptake of services and; (c) an opportunity to leverage the ubiquitous polio resources to drive household identification and referral of vaccination.

What is your intervention? The strategy leveraged traditional leaders to identify resident women volunteers (including polio resources) who were passionate about supporting community development initiatives

- ▶ The volunteers conducted a house-to-house microcensus to identify under-2 children and their immunisation status.
- ▶ The microcensus data was compared with health facility registers and used to track and refer all identified ZD children (children not found in the registers);
- ▶ This resulted in an increased demand and uptake of RI services which necessitated the revision of health facility microplans with regards to target population and vaccine consumption;
- ▶ Following the success of this strategy in identifying and tracking zero-dose children, the Bauchi SPHCDA has rolled out this strategy to identify and locate un/under immunised children in its 20 Zero Dose targeted wards and is tracking progress

Other questions for this case study: what **main** challenges did you face with these interventions, **and with sustaining them?** How do you know that the community engagement approach is working? What lessons have you learned ?



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ZDLH-X Case Studies: **COMMUNITY ENGAGEMENT (Mali)**

Maximizing opportunities to reach zero-dose children and missed communities

Case Study: Dr Fantamady Camara (Male, Region, UNICEF Mali) - 1

Finding zero-dose and missed communities

Community engagement in urban areas

Reduce the number of zero-dose and under-immunized children in the 11 urban CSComs of the city of Sikasso by communicating with the children's fathers

The identification of these children is done with support from women's platforms and groups during home visits in the households of the 11 urban communities of the city of Sikasso. It is also done through the compilation of names in the vaccination registers. To date, 1703 under-immunized children and 6 zero-dose children have been recovered and 652 under-immunized children have been caught up with the support of the women. The process involves all actors (Regional Health Directorate, District and health areas) and is financially supported by GAVI.

It began with a situation analysis that consisted of data collection in health facilities and households, as well as focus group discussions with mothers and fathers of children. The groups were then trained to search for zero-dose children and dropouts. It is important to note the strong involvement of the Regional Director of Health and the Chief Medical Officer of Sikasso with our support as a UNICEF and WHO partner.

Case Study: Dr Fantamady Camara (Male, Region, UNICEF Mali) - 2

Finding zero-dose and missed communities

Community engagement in urban areas

Lesson learned

Since 2018 I have been supporting the health districts in the implementation of monthly EPI and epidemiological surveillance data review sessions. Thus, in the health district of Sikasso, which has 45 health areas, we found that the majority of under-immunized children came from the 11 community health centers in the city of Sikasso. Thus, in order to improve immunization in these health areas, the district, with our support, proposed to test the urban immunization strategy tool. This implementation began with the establishment of the urban strategy team and the analysis of the situation which identified the bottlenecks followed by the analysis and adoption of a strategy to seek and catch-up either zero-dose children or dropouts. The women's groups have been formed and have already reached 652 children and recovered 6 zero-dose children. Follow-up has just started and data review is planned.

Case Study: Adama Traore (Male, Health Facility, MOH Mali)

Finding zero-dose and missed communities

Community engagement in rural remote areas

Identifying all the live births with the help of the relays accompanied by the parents' contacts and to convince the village chiefs to ensure the movement of the vaccinators

I arrived at the post at the end of 2021 and the vaccine coverage target was not reached according to the data extracted from Dhis (District health information system). The team decided to set up a mobile strategy that lasted 6 days with the identification of many zero-dose children whose age was between 3 months and 7 years.

Challenge: The zero-dose population in the Biladjimi health area is composed exclusively of nomadic populations and there are insufficient resources to reach them. There is especially the insufficiency of means of transport to travel tens of kilometers and community relays are not sufficiently trained to follow-up this nomadic population. For the outreach strategies, motorcycles are frequently borrowed from staff or even individuals.

Strategy: Registration of all births by community relays trained for this purpose. Once the birth is registered in this book in the form of a vaccination register, it is placed under the responsibility of the chief who will have chosen a relay and each session in the same way as the vaccinator fills in his register, the relay does the same with his.

Community involvement: One village contributed fifteen thousand CFA francs and another five thousand CFA francs to support the volunteers.

Case study: FANE Moussa (Homme, Etablissement de santé, Mali)

Finding zero-dose and missed communities

Community engagement in rural remote areas

Who are they? Isolated due to geographic constraints; remote or physically hard-to-reach rural populations, Poverty, Conflict situations/ internally displaced populations, refugees, Limited or unstable access to health care services (public or private/NGO), including access to health services only during working hours, lack of immunization awareness

Challenge: During the malnutrition sessions, when we ask mothers for their children's vaccination records, we realize that they are not up to date, due to lack of knowledge of the vaccination schedule, low importance given to child health and poverty.

Strategies: Catch-up immunization campaigns for missed age groups, Community engagement approaches, including with religious/traditional/other leaders or community health groups/councils, Community outreach and mobilization.



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ZDLH-X Case Studies: **INTEGRATION**

Maximizing opportunities to reach zero-dose children and missed communities

Case Study 1: Scovia Okello, Female, Health Facility (Kotido district), Uganda

Integration: using ANC data to follow up on births & vaccination

What is the ZD challenge that you are trying to solve? Some of our zero-dose children come from mothers who attended antenatal care (ANC) but deliver at home; how can we ensure that all women who visit ANC are followed up when they give birth so that their child is vaccinated?

Why did you choose this intervention? We are missing a chance to vaccinate more children if we don't use our ANC registration data to track expected delivery dates (EDD) of mothers and follow up to vaccinate their children.

What is your intervention?

- ▶ We document the EDD of pregnant women during ANC attendance
- ▶ If the woman doesn't return for ANC for a month from her EDD, we expect she would have delivered from somewhere
- ▶ We use Village Health Teams (VHTs – community health volunteers) and community leaders to link to the mother's situation; if delivery is from home the problem may be that the child misses immunization; VHTs identify these children and give us the information
- ▶ During immunization sessions (static or outreach), VHTs and other leaders make sure that these children from home delivery come to get immunized

What are your main issues with implementing your ANC-EDD approach? The challenge is that most mothers don't know their EDD, so we have to estimate.

What lessons have you learned so far, including any contextual considerations that others should be aware of? What I have learnt is that reviewing data weekly helps you to know whether you are on the right track or not. We aim to analyze our data weekly, especially the data for delivery and BCG vaccine.

Additional questions: Did you have any prior evidence of the potential benefit of your approach? Do you know about how many of your ZD children come from mothers who have attended at least one ANC? Have other HFs adopted your EDD approach?

Case Study: Abubakar Muhammad Amali, Male, WHO, District/LGA (Sokoto State), Nigeria, Using service integration strategies to reduce missed opportunities for Vaccination in larger health facilities and secondary hospitals (1)

What is the challenge? We are missing opportunities to vaccinate ZD children when they or their caretaker come for other PHC services such as out-patient department (OPD for malaria treatment, etc.), antenatal care (ANC), family planning (FP) and nutrition (Community-Based Management of Acute Malnutrition or CMAM).

How did you develop or come up with this intervention?

The national level NPHCDA deploys innovative strategies and this was encouraged for states to adapt and test

Why does your intervention matter? We have many ZD children and don't want to miss an opportunity to vaccinate. We use an approach called "missed opportunity and service integration strategy" (MOSIT) to ensure all children who attend any other PHC service are able to get vaccinated during that visit. We also want to be sure there is adequate information sharing at health facilities between health workers and clients.

What is your intervention? We are practicing integrated PHC service delivery. In most of our large health facilities and hospitals immunization is offered at the same time as outpatient services, ANC, CMAM and FP services, and this approach has contributed significantly in tracking and vaccinating missed children.

The steps we follow are:

- ▶ When clients come to our hospital, the front desk officer who registers all clients screens them to identify other services they may be eligible for
- ▶ The front desk officer registers the client and puts any other service they are eligible for into the Service Integration Register; the desk officer then gives the client a referral slip that details the different services they can get, which include immunization
- ▶ The health worker who provides the service the client came for asks if they have any referral slip, and if they do, then the health worker refers them where to go for the other services, including immunization

Case Study continued: **Abubakar Muhammad Amali, Male, WHO, District/LGA (Sokoto State), Nigeria,** Integration using Missed Opportunities in Vaccination in larger health facilities and secondary hospitals (2)

How do you know it is a promising or successful intervention?

1. HWs have understood the concept of MOSIT and know how to enter data for MOSIT
2. There is adequate information sharing at health facilities between HWs and clients/caregivers
3. Though a newly launched intervention still under pilot, but has contributed significantly in improving RI performance from the data so far generated and presented by the State M&E technical working group

What lessons have you learned so far, including any contextual considerations that others should be aware of?

1. Our MOSIT approach is recommended only for HFs that have multiple HWs and where more than one PHC service is provided at the same time as immunization (e.g., OPD, ANC, FP, Nutrition, etc.). We agree this approach works best in larger PHC facilities and secondary hospitals (e.g., urban or referral location).
2. We need to review the contribution of MOSIT strategy towards improvement of RI activities in the state
3. We need to develop a guide for the scale up of the strategies to cover more of our larger HFs in the state

Additional questions: What evidence do you have on the number of missed opportunities for reaching ZD and UI?

Is the absence of documented evidence (immunization cards/record) at the time of visit to the HF or Hospital an issue? How do make sure doses recorded are added to that child's permanent record (wherever that might be)? Have you thought about adding a tetanus vaccination component for women of child-bearing age?

Other resources for Missed Opportunities in Vaccination/MOV. For global guidance, case studies, and training materials, do a web-search for “WHO Missed Opportunities in Vaccination” or see: [https://www.who.int/teams/immunization-vaccines-and-biologicals/essential-programme-on-immunization/implementation/reducing-missed-opportunities-for-vaccination-\(mov\)](https://www.who.int/teams/immunization-vaccines-and-biologicals/essential-programme-on-immunization/implementation/reducing-missed-opportunities-for-vaccination-(mov))

Case Study: Akello Rebecca, Female, MoH, Health Facility (Kumi District), Uganda, Integration of services & special outreaches at community events

What is the challenge that you are trying to solve? Ensure we are not missing any children of target age group if they come to any other services or at community events.

Why did you choose the approach you did? We don't want to miss any children if they connect with any PHC service.

What is your intervention? At our health facility, we have a community system to identify all children of the age group for vaccination, and connect them to immunization services. We do this in our large health facility at the out-patient department, inpatient wards and sometimes churches and burial ceremonies for community outreaches.

For identification we use the Village Health Teams (VHTs – community health volunteers) and also send messages to the church leaders informing them when the outreach is scheduled and the target age group so that they can announce during prayer time. We emphasize parents or caregiver to bring the immunization child cards along with them. The same to the burial places VHTs go on mics and do the same as a means of mobilisation for the scheduled outreach

What are your main challenges with implementing this approach? Many times we are not facilitated during this activity so it becomes difficult to engage all stakeholders since they would require transport and an allowance for their work. We end up using a few VHTs and community leaders who are within reach and they accept to volunteer

How do you know your approach is successful? Through improved performance when we chart on the vaccine monitoring charts which shows the trends in the graph whether increasing or decreasing. In our case all other antigens are on increase apart from BCG.

Lessons learned

- ▶ One needs to motivate one's self in all situations and also motivate others to achieve
- ▶ Sharing feedback with stakeholders is a good practice & good motivation; it also creates a sense of program ownership



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ZDLH-X Case Studies:

TOPIC: FINDING CLUSTERS OF ZD AND MISSED COMMUNITIES -

Using rapid convenience monitoring (Bangladesh)

Case Study: Md Sorwer Alam (Male, District level, Bangladesh) (1)

Using data to find and vaccinate zero-dose and missed communities in an urban area

Who are they? Slum dwellers, Snake charmer communities, fishermen, indigenous minorities, hilly settlement dwellers, garments workers, isolated communities like “Biharies” (Pakistani citizens stranded in Bangladesh) and Migrant populations in bordering areas (borders with city and district upazillas)

How are they identified? Through desk review, triangulation of disease surveillance data and EPI coverage, experience from outbreak lessons learned from nearby districts, rapid convenience monitoring, hospital records with the support of community and religious leaders.

How many? Since 2018, the number of un or under vaccinated population **was around 25,000** (most were partially immunized).

Why are they missed?

- Migration (bordering areas)
- Religious misbelief and language barriers (indigenous communities)
- Not included in micro planning (fishermen, snake charmers)
- Inconvenient session timing (garments workers)
- Low socioeconomic condition & lack of awareness (slums)
- Water logging (some parts of city during monsoon)
- Isolated communities (Bihari)

Case Study: Md Sorwer Alam (Male, District level, Bangladesh) (2)

Using data to find and vaccinate zero-dose and missed communities in an urban area

How has this been addressed?

- Following the IRMMA framework to identify, quantify, reach and do a root cause analysis for Zero dose, continuous monitoring for further zero dose identification, use special immunization activities for catch up, use child registers to call defaulter parents, triangulation of surveillance data and coverage data to identify high risk areas.
- Missed opportunities for vaccination (using any contact with health-care services to vaccinate what that individual is eligible for)
- Strengthening routine immunization services

Lesson learned:

Since 2017, there was a couple of Measles outbreaks every year in neighboring districts leading to the deaths of a couple of children. The common scenarios in these outbreaks were: affected communities were indigenous community that had language barriers and religious misbeliefs, kept out of micro planning, negligence from health workers and hard to reach areas. The lesson we learned from these outbreaks were to find out isolated communities, the communities that are indigenous, have socio cultural barriers, that may have issues like left out of microplanning, problems with accessibilities and migration. So during microplanning, these lessons were shared with local government, health workers and NGO partners to identify these communities in our areas. Since then, every year during micro planning, certain communities and areas are identified and they are being included in microplanning. Through these, we were able to reduce zero dose and zero dose communities greatly and it is a continuous process which must go on.