Reflections on Identifying and Reaching Zero-Dose Children

Zero-Dose
LEARNING HUB

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Zoom Translation

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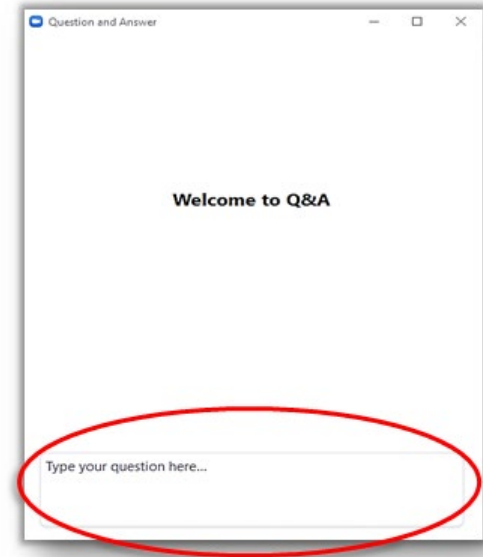
![Zero-Dose Learning Hub logo]
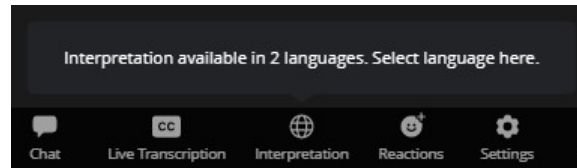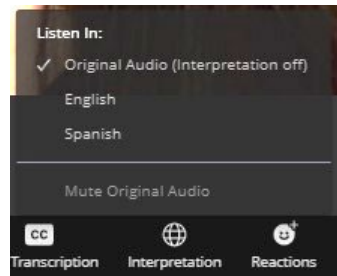
Question and Answer Box
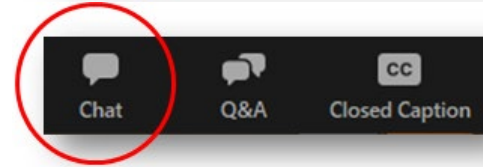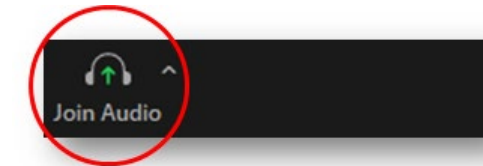
Please submit your questions for the panelists in the Q&A box.
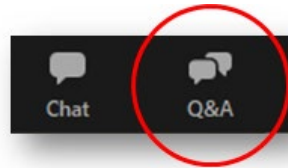
Panelists will either reply back to you via text in the Q&A box or will answer your question during the discussion portion of the webinar.

![Zero-Dose Learning Hub logo]

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Zero-Dose Learning: Background & Rationale

Lessons learned from Gavi 4.0 revealed a fragmented approach to evidence generation that resulted in missed opportunities to provide more timely and complete information and improve use of evidence and learning.

Gavi's Learning System Strategy outlines a Zero-Dose Learning Agenda (ZD LEARN) which learning priorities across Identify-Reach-Monitor-Measure-Advocate (IRMMA) and processes and tools generate and synthesize evidence.

Learning Hub (LH) initiative is an important key enabler to support IRMMA framework and zero-dose learning agenda, recommended by the Programme and Policy Committee and Gavi Board in 2020.

Country Learning Hubs (CLHs) designed to ensure more timely, prospective measurement of implementation and performance and to inform the 5.0 strategy.
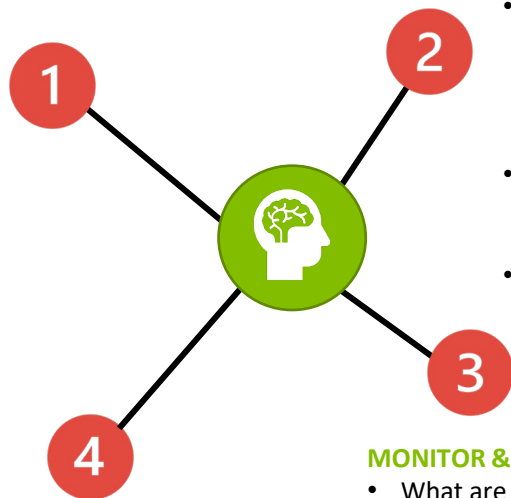
ZD Learning Priority Questions Identified Through Consultation

IDENTIFY

- **Where, who, and how many are zero-dose children (ZDC)** and missed communities? **Why** are they being missed and what are the root causes?
- What are the **most effective approaches and methods** used for **identifying zero-dose** communities? What works well, what does not work well, and why?
- What are the **key barriers and enabling factors** at each level (policy to community) **to identify zero-dose** communities?

REACH

- What **specific approaches are designed to reach ZDC** and missed communities and to bring them into the health system towards full immunization? What works well, what does not work well, and why?
- What are the **key barriers and enabling factors** at community level **to reach ZDC** and to bring them into the health system through full immunization?
- What are effective ways to **engage with other parts of the health sector** to reach the marginalised, missed communities and zero-dose children?

ADVOCATE

- What **strategies are effective in securing and sustaining political will** across different levels to identify and reach zero-dose populations?

MONITOR & MEASURE

- What are the most **effective approaches and methods to monitor and measure reaching ZDC**, under-immunised children UIC), and missed communities? What works well, what does not work well, and why?


Cross-cutting areas: Cost and sustainability; Gavi contribution and levers; Gavi country segments

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Learning Hub Initiative: Overview

- Augment monitoring, implementation research, and other learning activities to go deeper into the factors influencing the implementation and performance of programmatic approaches to rapidly understand what works, what does not, and what are the gaps to identify and reach zero-dose children.

- Learning priorities are **equity-focused** and answer questions about barriers and effective approaches to identifying, reaching, and monitoring zero-dose children and missed communities.

- Design informed through broad consultation and agreement with Alliance and other technical partners and other donors.

- Mali, Nigeria, Uganda, and Bangladesh implement and lead country learning hubs from 2022-2025.

- The global Zero-Dose Learning Hub (ZDLH) operates at the global level, and supports the country learning hubs and synthesizes learnings and translates their use across learning hubs and other countries (2022-2026).

Country Learning Hubs
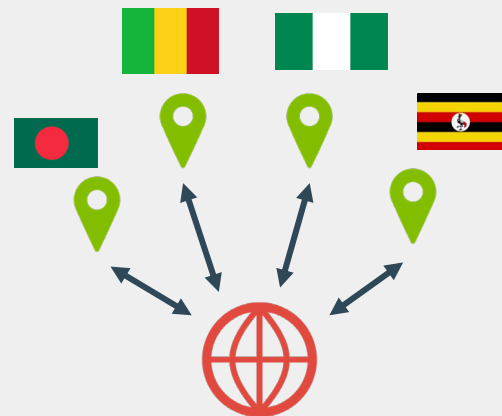
Zero-Dose Learning Hub (Global)
JSI with The Geneva Learning Foundation (TGLF) & the International Institute of Health Management Research (IIHMR)

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Country Learning Hubs (2022-2025)

Bangladesh, Mali, Nigeria, and Uganda

Objectives

- Generate and synthesize learning about the **barriers to reach ZDC** that can be used to influence programme planning and tailored approaches.

- Strengthen the evidence base of **effective approaches to identify and reach ZDC** by understanding what works, what should be scaled up, and what does not work and to do so in a timely, iterative manner.

- **Improve metrics, measures, and methods** to access and use data on a regular basis to improve reaching ZDC and missed communities.

Activities

- **Rapid assessment**

- Stakeholder engagement and mapping

- Improved timely monitoring

- Implementation research (including costing)

- Knowledge translation (KT)

- Project monitoring & learning (M&L)

Focus of Today's Webinar

Rapid Assessment Methods and Results

- **Triangulation** and **other methods to identify subnational areas** with the largest number and percent of zero-dose children.

- **Localized and contextualized barriers and drivers**, including demographics of zero-dose children through quantitative and qualitative data collection.

- **Service delivery and availability assessment** (including data systems and data availability).

To Answer "Identify" Learning Priorities

- **Where, who, and how many** are zero-dose children and missed communities? Why are they being missed and what are the **root causes**?

- What are the **most effective approaches and methods** used for identifying zero-dose communities? What works well, what does not work well, and why?

- What are the **key barriers** and **enabling factors** at each level (policy to community) to identify zero-dose communities?

Zero-Dose and Under-Immunized Children in Bangladesh: Experiences from a Rapid Assessment

Md. Jasim Uddin, PhD
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Objectives

- To identify the location of ZDC and UIC.

- To inform the context specific intervention(s) for the planned implementation research (IR).

- To understand the context-specific barriers and determinants in order to inform the interventions.

Methods

- A rapid assessment was conducted from December 2022 to May 2023.

- **Sites (ZD priority areas):** Haor (wetlands), Hilly (mountainous), Coastal, Char (sand or silt land surrounded by water), Plain land & Urban slum (City Corporations [CCs]).

- **Study population:**
  - Caregivers of children aged 4.5 months (4 months 15 days) to 23 months
    - ✔ 4.5 months for ZD measurement was considered for provision of one month extended time if the child missed scheduled third dose of pentavalent vaccine.

  - Policymakers, program managers, and service providers.

Data Sources
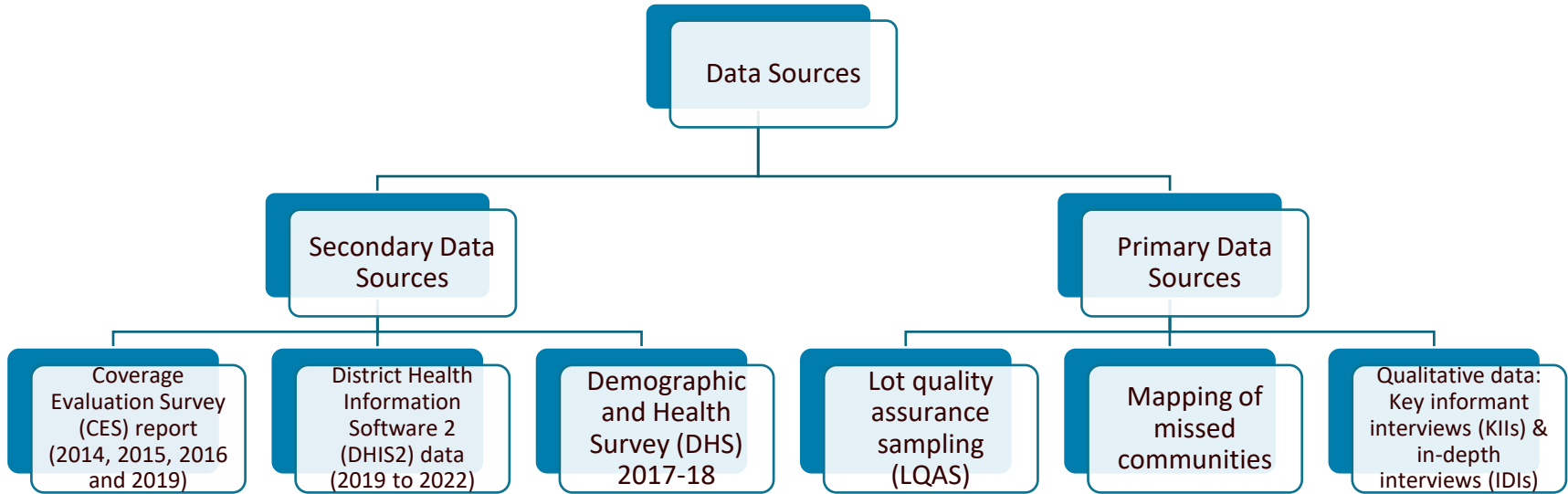
Process Followed for ZD Identification

Initial identification of ZD	• Consultation with Expanded Programme on Immunization (EPI) stakeholders through meetings (briefing session, inception meeting, monitoring committee meeting) • Secondary data analysis (CES 2019; DHIS2 2022)
Verification of DHIS2 data	• Field visit to collect monthly EPI report (hardcopy)
Re-analysis for ZD area identification	• Ranking of ZD sub-district by geo-locations from DHIS2 (2022) • Identification of districts with two high ZD sub-district and identification of CCs with two high ZD wards for LQAS
Confirmation of missed communities	• Collection and analysis of LQAS data
Identification of socio-economic determinants for ZD and UI	• Use of Bangladesh Demographic and Health Survey (BDHS) 2017-18 data
Identification of demand and supply side factors	• Qualitative data collection: KIIs and IDIs

LQAS: Household Selection Process

District / CC
- Secondary data analysis [CES and DHIS2]

Sub-district/ Zone
- Secondary data analysis [DHIS2]

Union and Ward
- Consultation with service providers and review of monthly EPI report

Cluster
- Identified two clusters with high ZDC and UIC from selected ward in each sub-district for LQAS

Household
- Interviewed 28 caregivers from each cluster
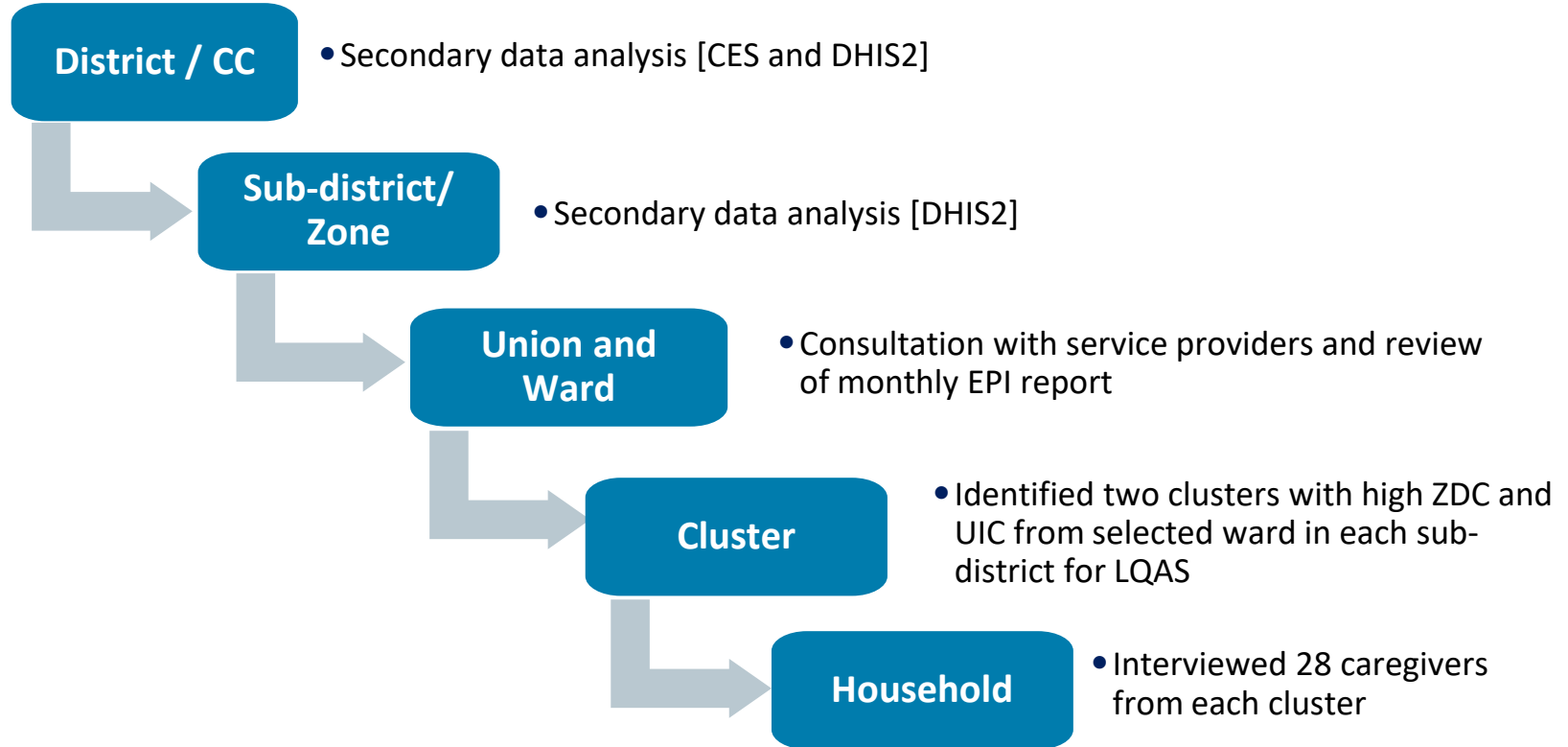
Qualitative Data

Level	Method	Participants	Number
National	KII	Policymakers / EPI Specialists / Stakeholders	6
Sub-national (Rural)	KII	District, sub-district, and union-level Govt. Officials and providers	28
Sub-national (Urban)	KII	Managers / Service providers from Government of Bangladesh (GOB) and Non-Governmental Organizations (NGOs)	4
Community	IDI	Mothers having a living child under 2 years	10
Total			48

Analysis

Quantitative data
Analytical approach for identification of ZDC

| Initial identification of ZDC	Verification of initial findings	Updating data	LQAS
• Information of first dose of pentavalent (Penta-1 vaccine coverage used from CES. • DHIS2 EPI Penta-1 data used for sub-district and CC level information.	• A study team was sent to collect EPI monthly reports. • Monthly reports data were matched with DHIS2.	• Analyzed the updated data of DHIS2 (2022). • Sorted sub-district according to the ZD percentage.	• ZD calculated according to the definition of Gavi. • If we found 5 or more households with ZDC or UIC in a cluster, the cluster was considered a missed community.

Analysis (cont.)

Qualitative

- Framework approach.

- Verbatim transcription.

- Incorporation of field notes and interviewers' observations.

- Data were systematically coded, synthesized, and interpreted.

Key Findings

- Prevalence of ZD and UI were 7.7% and 24.0% respectively.

- ZD found in every 12 selected sub-districts and identified those areas for IR.

- ZD and UI were more in coastal areas and urban slums.

Key Findings: Identified Areas for IR
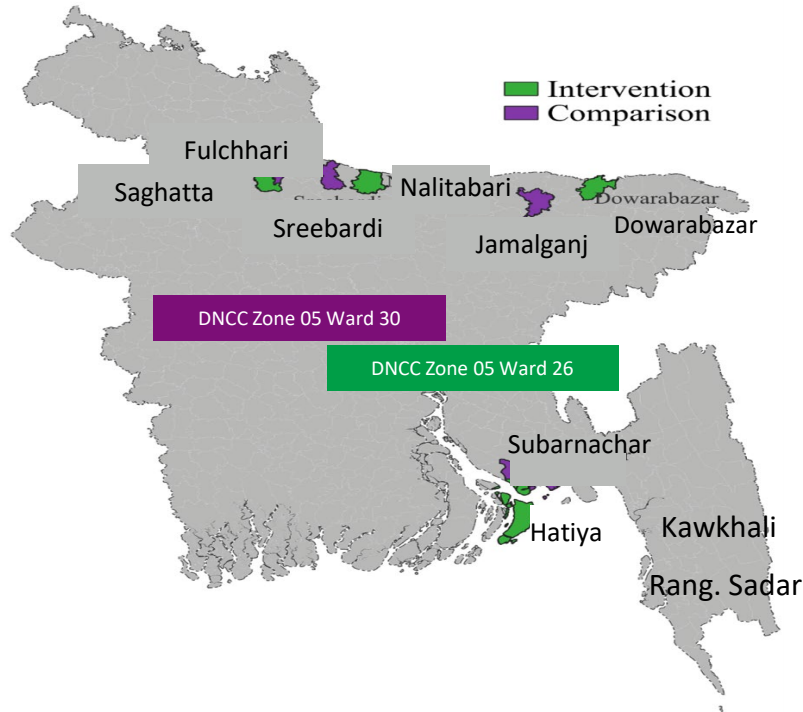
Reasons for ZDC (demand-side):

- Migration
- Side-effects of vaccines
- Business of caregivers
- Misconceptions and hesitation

Reasons for ZDC (supply-side):

- Shortage of vaccinators
- Lack of interpersonal communication (IPC)
- Distance to EPI centers
- Unavailability of transport in hard to reach areas
- Inaccurate denominator

Designed Area Specific Interventions for IR

All Areas
- Training of service providers
- EPI e-tracker (e-registration, e-messaging, e-monitoring)
- Use of e-screening checklist (except urban slum and street dwellers)
- Distribution of behavior change communication (BCC) materials
- Modified EPI session schedule (evening / mobile / crash program / weekend sessions) - if needed

Hard-to-reach char areas
- Advocacy with community leaders

Hard-to-reach haor areas
- Strengthen EPI support groups (Traditional Birth Attendants [TBAs], Imams, Students, Union Parishad [UP] members, etc.)

Hard-to-reach hilly areas
- Advocacy with community leaders
- Involvement of existing NGO community worker

Hard-to-reach coastal areas
- Health education through Community Health Care Provider (CHCP)
- e-supervision checklist

Plain land
- Conduct courtyard meeting

Urban slum and street dwellers
- Community engagement (landlord, club/committee member, Imam, etc.)
- Health education through NGO counsellors

Challenges

- Denominator issue in DHIS2.
- Shortage of human resources / vaccinators.
- ZD definition differs from the definition of existing EPI.

Recommendations for Identifying ZD & Designing IR Interventions

- Use of DHIS2 data is useful for initial identification of ZD areas – measures should be taken to improve quality of administrative data.
- Denominator issue needs to be solved for obtaining exact performance.
- National surveys (e.g. CES, DHS) should provide micro-level, such as sub-district / zone level information.
- LQAS survey can be widely used for identification and verification of missed communities.
- Area (sub-district / ward) specific interventions are recommended for reducing ZDC and UIC.

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Thank You

This project has been funded

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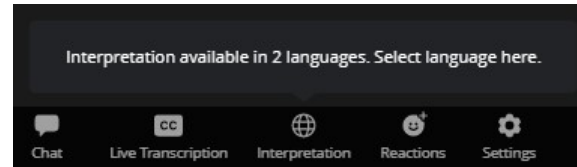
Comprendre les obstacles à la vaccination au Mali

Analyse des obstacles et déterminants par contexte de districts

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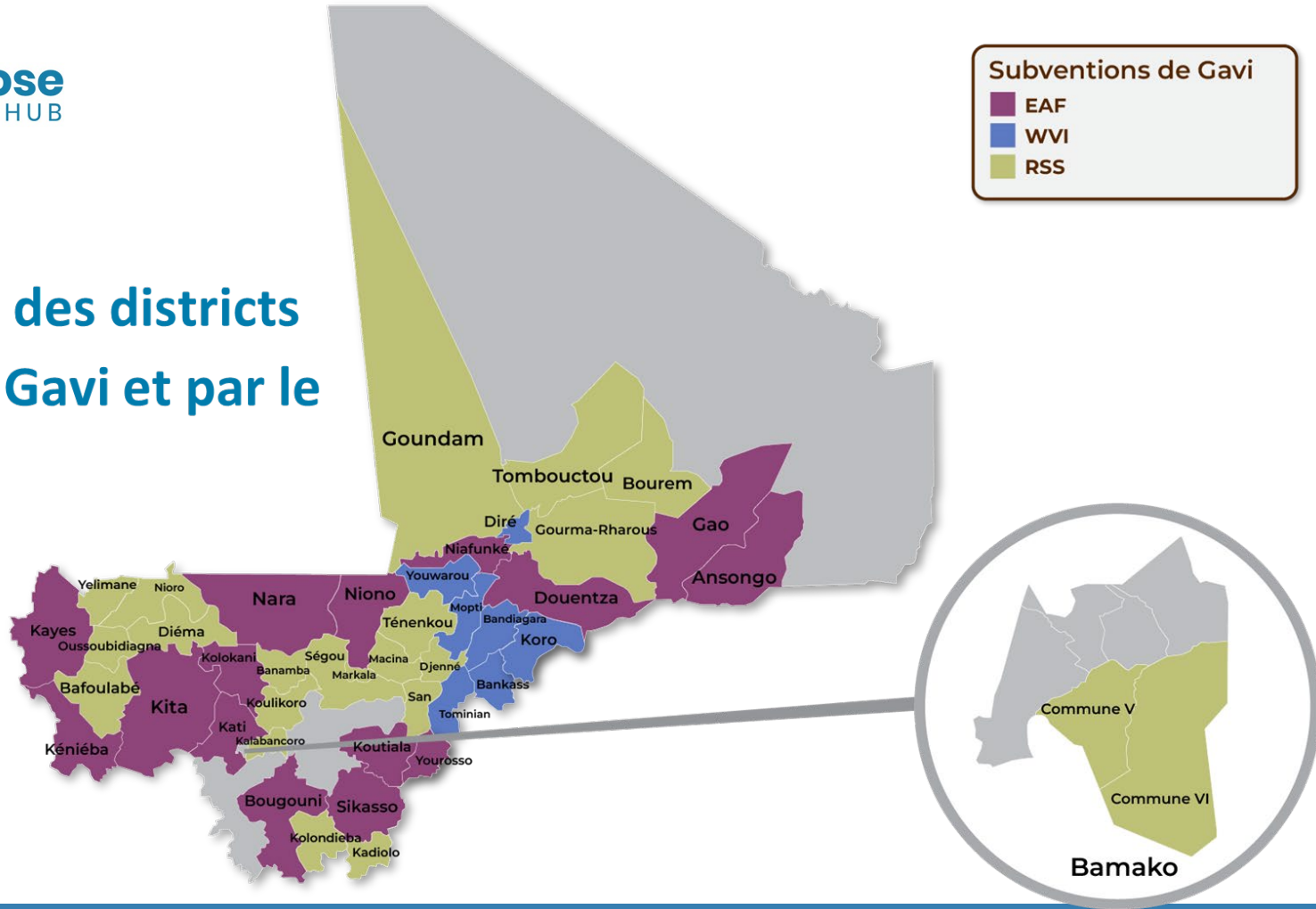GaneshAID

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Identification des districts soutenus par Gavi et par le LH

Objectifs et Méthodologie

Objectif principal

Mettre à jour la situation des EZD, ESV, communautés manquée et le niveau de performance des interventions du Mali pour surmonter les obstacles à l'équité vaccinale et à la couverture en 2023.

Objectifs spécifiques

1. Mettre à jour les **indicateurs clés de quantification des EZD et ESV** (#EZD& #ESV par régions, districts et aires de santé, #DTC 1 & 3, taux de couverture et le taux d'abandon).
2. Mettre à jour les **indicateurs de performance des services de vaccination** (nombre de sessions de vaccination, rupture de stock, équipement PQS fonctionnel, etc.).
3. **Actualiser la cartographie des EZD et sous immunisés** (distribution géographique ; profil sociodémographique des communautés ZD).
4. **Analyser le système administratif et sa capacité à générer des données de qualité.**
5. Mettre à jour les **données sur les barrières et déterminants à l'identification et à l'atteinte des enfants zéros doses selon les contextes**.
6. Documenter les i**nterventions chiffrées et planifiées pour atteindre les EZD** ainsi que les politiques et directives y afférentes.

Données secondaires :
- Revue documentaire (politiques et stratégies, rapports d'étude, rapports de supervision, rapports de réunions, etc.);
- Données de population, recensement, DHIS2);
- Base de données de l'IHME

Revue documentaire de 62 documents stratégiques et techniques

Données primaires :
- 4 districts avec 8 centres de santé dans 4 contextes.
- 176 informateurs

- **32 entretiens individuel:** Directeur Technique CSCOM (DTC), Agent de santé communautaire (ASC), Chargé PEV, Femme leader (stratégie urbaine)
- **24 focus groupes**: Homme, Femme et Prestataire de santé (144 informants)
- **DQA dans 8 CSCOMs**

Zones infranationales ciblées pour l'Évaluation rapide

La sélection des zones de l'étude a été faite par choix raisonné :

- Forte concentration en Enfants zéro dose.
- 4 types de district
- L'accessibilité sécuritaire pour les enquêteurs.

CSCOMs Ciblés pour l'évaluation rapide CAPEV

Districts	Contexte	Health Areas
Ségou	Rurale/éloignée	Katièna, Banankoro
Tominian	Conflit	Tominian central, Yasso
Kayes	Populations spéciales	Khasso, Gouthioubé,
Commune VI de Bamako	Urbaine/ périurbaine	Senou, Yirimadio
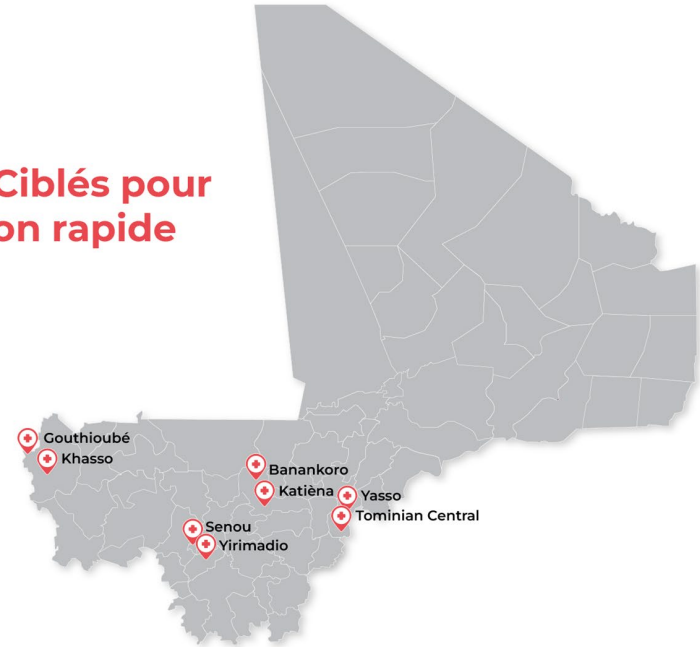
Profil des communautés d'EZD par type de district au Mali

Communautés des EZD par type de district au Mali (2023)			
	Urbains - périurbain	**Populations spéciales difficiles d'accès**	**Rural**	**Conflit - Fragile**
Zones géographiques	• Quartiers spontanés aux environs des grandes villes • Collines et milieu périurbain	• Lit des fleuves • Zones Champêtres • sites d'orpaillage	• 77% de la population vivent en zone rurale au Mali	• Régions du Centre et du Nord • Obstacles naturels: désert de sable ou rocheux, relief accidenté. • Centre de santé >15 km
Profils des communautés zéro dose	• Population périurbaine pauvre • Communautés sans domicile fixe: mendiants • Camps de réfugiés	• Nomades, insulaires et désertiques • Agriculteurs • Migrants • Groupes religieux extrémistes	• Populations spéciales difficiles d'accès • Population dispersée, enclavée et mobile • Nomadisme	

Obstacles liés à l'offre de service au Mali par type de district

Synthèse des obstacles liés à l'offre par contexte de district au Mali (2023)			
Urbains - périurbain	**Populations spéciales**	**Rural**	**Conflit - Fragile**
• Insuffisances des activités d'éducation et de partage des connaissances pour les parents et les membres de la famille sur l'importance et les avantages de la vaccination • Insuffisance d'engagement des personnes influentes dans la communauté • Absence de stratégie de communication ciblée pour lutter contre les informations erronées et désinformation • Ruptures de stock • Insuffisance dans la gestion des MAPI, communication de risque	• Stratégie inadaptée et insuffisante pour les populations spéciales • Faiblesse de la chaîne d'approvisionnement avec insuffisance en chaîne du froid et ruptures de stock • Distance des centres de santé fournissant la vaccination • Faible intégration de la vaccination à d'autres services de soins de santé primaire et santé animale	• Insuffisance des points de prestation de vaccination avec personnel compétent et équipement • stratégies fixes, avancées et mobiles insuffisantes • Insuffisance de stratégie de suivi des abandons et absents • Faible intégration de la vaccination à d'autres services de soins de santé primaire	*INSECURITE* • indisponibilité des services de vaccination • Stratégie inadaptée et insuffisante • Stratégie mobile insuffisante • Appui partenaires insuffisant • Faiblesse de la chaîne d'approvisionnement avec rupture de stock • Irrégularité des services • Personnel compétent insuffisant • Faible coordination avec les partenaires et OSC intervenant dans ces zones de conflit
• *"c'est la longue file d'attente qui décourage les mamans"* • *Mauvaises expériences aux séances* • *'manque de suivi des normes par les équipes'* • *'Ruptures de stock de vaccin qui découragent les gardes d'enfants de revenir au centre de santé'.*	• *"Rupture des doses de vaccins, avec une absence de BCG depuis plus de six mois, souvent appelé ''Mali tampons'' par les femmes".* • *"en raison de l'absence de réfrigérateur pour stocker les vaccins, l'ASACO dépense chaque jour 500 francs CFA en glace pour les conserver dans des boîtes isothermes"*	• *"...On a vu beaucoup de parents se prononcer sur le fait qu'ils ont fait plusieurs allers et retour sans succès".* • *"Il faut augmenter le nombre du personnel pour faciliter la participation de tous un chacun et leur motiver dans le cadre de la vaccination"*	*"Bon souvent les femmes viennent en nombre alors que le nombre de vaccin est limité c'est-à-dire la demande est supérieure à l'offre surtout nous rencontrons ce problème généralement avec le vaccin BCG"* *"découragement par la file d'attente trop longue"*

Obstacles liés à la demande de service au Mali
par type de district

Synthèse des obstacles liés à la demande par contexte de district au Mali (2023)			
Urbains - périurbain	**Populations spéciales**	**Rural**	**Conflit - Fragile**
• Cas d'isolement social et de résistance "sunnites" • Manque d'intérêt et motivation vis-à-vis de la vaccination malgré la connaissance des avantages de la vaccination • Peur des effets secondaires et rumeurs	• Aspects pratiques : éloignement. • Processus sociaux : rejet de la vaccination comme ne faisant pas partie de la culture et tradition. • Motivation : peu d'intérêt, manque de connaissance. • Conditions climatiques, comme l'hivernage, détériorent les routes, rendant difficile l'accès aux centres de santé.	• Faible connaissance des moyens de communication les plus utilisés par ceux qui prennent des décisions sur la santé des enfants • Insuffisante utilisation des canaux de communication pour atteindre les femmes. • Insuffisance de stratégies pour amener les services aux ménages ou aux endroits où se trouvent les communautés manquées (stratégie mobile)	• Peur de la situation sécuritaire • Nouveaux déplacements de population à chaque conflit: forte augmentation des personnes déplacées internes (PDI) • Peur des effets secondaires et MAPI +++ • Méconnaissance des bénéfices de la vaccination par certains +++, Incompréhension de la vaccination
• " paresse des mamans », et "négligence des mamans", "absence de motivation à cause de l'attente" • "les sunnites, parents sunnites refusent" • "après la vaccination les enfants tombent malade, fièvre" • Croyance que la vaccination créée d'autres maladies, "Impact négatif des réseaux sociaux sur la motivation des mamans"	• "Certains parents refusent la vaccination si l'enfant a de la fièvre après." • "À mon avis les enfants zéro dose ne pourraient parvenir que dans le milieu des sunnites, car ce sont eux qui ne veulent pas la vaccination des enfants"	• "C'est dans leur comportement et attitude qu'on peut constater leur volonté de refus. Si c'est comme ça je fais appel au relais et au griot"	• "Le niveau de connaissance des parents sur l'importance de la vaccination est un frein à la vaccination des enfants" • "Toi-même tu verras que la grand-mère prend l'enfant et le cache" • "En ce qui concerne les enfants zéro dose nous les rencontrons chez les peulhs"

Obstacles liés au genre au Mali
par type de district

| Synthèse des obstacles liés au genre par contexte de district au Mali (2023)			
Urbains - périurbain	**Populations spéciales**	**Rural**	**Conflit - Fragile**
• Faible representation des femmes dans les ASACO: 50-77% au moins 1 femme est membre du comité de gestion (2022) • Horaire : les femmes qui travaillent ou étudient ont des difficultés de respecter les horaires de vaccination. • Contraintes financières: la carte de vaccination est vendue à 100 FCFA, les autres documents fournis à la première visite de l'enfant coûtent jusqu'à 900 FCFA en plus des coûts de transport et perte de revenu pour la journée de travail. • Charges ménagères et des enfants à la femme: une surchage de travail des femmes	• Faible pouvoir de décision des femmes dans les communautés • Charge de la femme • Manque de moyen de transport • Choix de la médecine traditionnelle	• **Difficultés financières**, crainte de devoir payer des frais de consultation prénatale à payer pour les femmes qui ont accouché à la maison • **Distance entre la maison et les aires de santé:** faible moyen de déplacement, travaux champêtre, travaux de la maison, manque de moyen financiers, dépendance de la mère • **Stigmatisation des femmes** qui ont accouché à la maison. • La **maman ne décide pas** de la vaccination : décision de vaccination par l'homme, la belle mère	
• *"vaccination peut être sources de divorce"* • *état de la route durant l'hivernage*	• *"le manque de moyens peut les retenir chez eux là-bas"* • *"l'occupation des mamans à la cuisine"* • *"C'est l'homme qui prend la décision concernant la vaccination de l'enfant"* • *"les médicaments traditionnels coûtent moins chers que ceux de la médecine moderne"*	• *"l'homme a la décision", "non seulement le mari n'accompagne pas la femme, mais l'interdit de se déplacer avec l'enfant pour une quelconque question de vaccination"* • *"Même pour transporter la femme et l'amener au centre de santé pour la vaccination, ils ne le font pas"* • *"manque de frais pour acheter la carte de vaccination (500 FCA)"*	

# Evaluation de la qualité des données (DQA) de vaccination

Surestimation des données du DHIS2 par rapport aux supports primaires dans les 8 CSCOMs

Les causes plausibles de cette surévaluation sont:

- Insuffisance dans le **remplissage** des différents supports causée par un déficit de supervision formative des agents;
- **Multiplicité** des supports à renseigner;
- **Non rapportage** des données des séances de vaccination en stratégie avancée;
- Non prise en compte des données de certaines **structures privées et confessionnelles** qui font la vaccination, dans les supports primaires de collecte des CSCom, en particulier à Bamako.
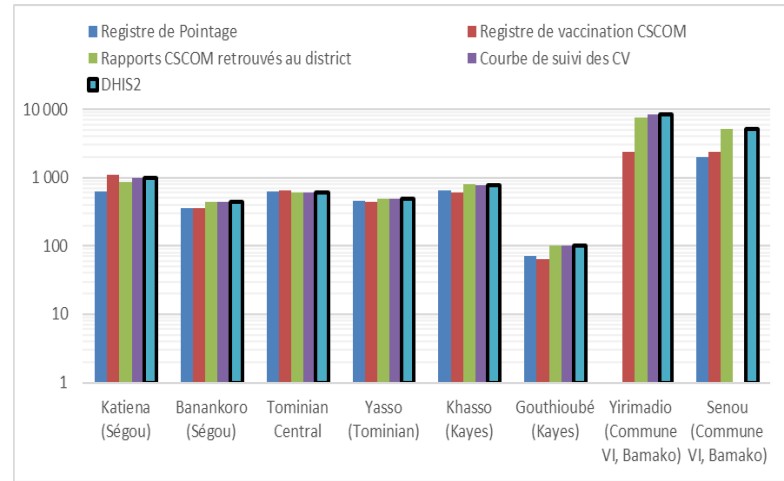
Concordance entre les données de DTC1 rapportées dans le DHIS2 et les supports de collecte primaire
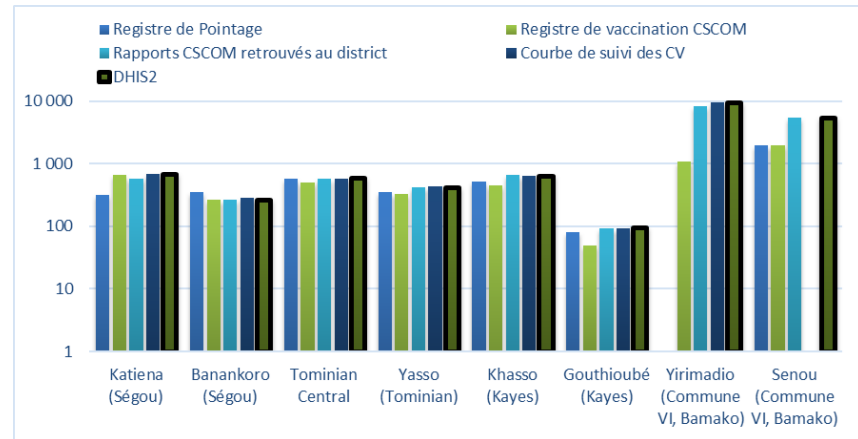
Concordance entre les données de DTC3 rapportées dans le DHIS2 et les supports de collecte primaire

Produits d'apprentissage

→ Infographie avec les principales conclusions sur les tendances et les obstacles des EZD pour les identifier et les atteindre au Mali

→ Un webinaire "faire correspondre obstacles et interventions pour atteindre les EZD au Mali"

→ Notes techniques
- Cartographie des obstacles à la vaccination et leurs causes dans les 4 typologies de districts maliens.
- Monitorage des obstacles à la vaccination: mécanismes et sources d'information.
- Gestion de l'apprentissage et de la performance C2P: modalités de renforcement des compétences des personnels
- eLMIS - Medixis: visibilité des stocks de vaccination de bout en bout → réduire les ruptures de stock et surstocks

→ Notes d'orientation stratégique/politique
- Surmonter les obstacles des districts urbains et périurbains : la stratégie urbaine de vaccination.
- Surmonter les obstacles des districts en zone de conflit : la stratégie de renforcement de la vaccination en zone de conflit.
- Surmonter les obstacles des populations spéciales et zones rurales : co-concevoir des interventions pro-équité avec la communauté.

→ Une infographie "Qui, Combien, Où et pourquoi les EZD au Mali en 2023"

→ Un article sur les résultats de l'évaluation rapide.

→ Ateliers de validation des apprentissages

Conclusions

→ Forces
- ◆ 1ère évaluation rapide permettant d'analyser les obstacles selon les contextes des districts → information cruciale pour le Mali et les interventions pro-équité financées par Gavi
- ◆ Résultats de l'évaluation rapide servira de données de base pour la recherche d'implémentation

→ Limitations
- ◆ Nombre de centres de santé de l'étude et méthode de sélection pouvant engendrer des biais de représentativité
- ◆ Défis sécuritaires redirigeant la collecte vers des zones potentiellement ayant moins de défis
- ◆ Estimation des enfants zéro dose (estimation CAPEV) qui combine 2 sources, elles mêmes perfectibles
- ◆ Non quantification de la force de chacune des barrières identifiées par type de district; ce qui réduit la possibilité de procéder formellement à leur priorisation

→ Leçons apprises
- ◆ L'identification et l'atteinte des EZD au Mali nécessite une approche différenciée et un ciblage de haute précision; ce qui renforce le besoin de disposer de données hautement désagrégées et diversifiées
- ◆ Le rôle du CAPEV aux cotés du CNI est crucial pour optimiser les interventions et devra s'inscrire dans le moyen terme pour renforcer la culture de l'utilisation routinière et systématique des données pour informer et optimiser les interventions

Ensemble pour l'équité vaccinale au Mali !

Website: ganeshaid.com
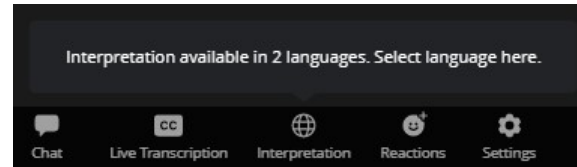**Facebook** : facebook.com/GaneshAID.Nonprofit.Consultancy
Twitter : https://twitter.com/Ganeshaid_/
LinkedIn : linkedin.com/company/ganeshaid-a-nonprofit-consultancy-company

Zoom Translation

Click the Interpretation icon to have the option to hear the meeting in French. If you would like to hear the entire webinar in English, select English at the beginning of the presentation.

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

Introduction

- Global immunization coverage remains a persistent challenge, despite substantial efforts.

- Two-thirds of unvaccinated children in Gavi-implementing countries are concentrated in just five middle and low-income nations, including Nigeria.

- Nigeria accounts for 2.2M estimated ZDC with 70% Penta-1 coverage and 57% Penta-3 coverage.[1]

- Several factors such as insecurity, poor access to health services, vaccine hesitancy, demand generation and lack of trust in vaccine efficacy, safety, behavioral and gender-related factors have significantly contributed to high number of ZDC hence poor immunization coverage.

- NPHCDA[1] in line with Immunization Agenda 2030 and Gavi 5.0 has developed different strategies

- Developed NSIPSS[2] 2.0 aimed at reducing the number of ZD children to less than 10% of the target cohort by 2024[2]

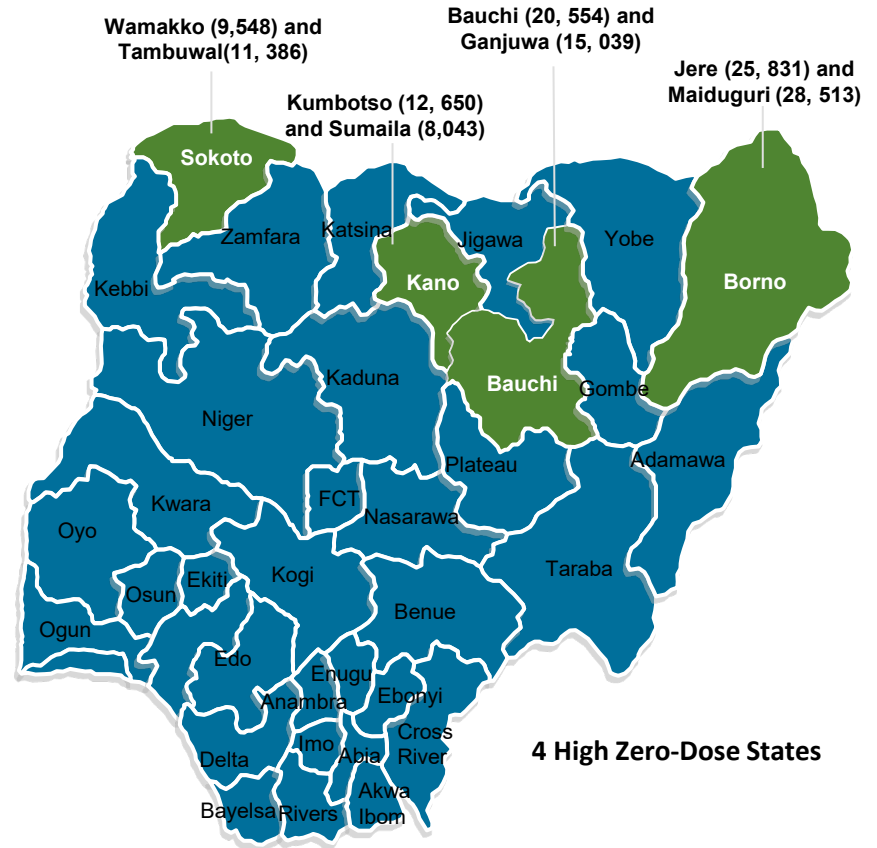# Identification for Targeted Subnational Areas

State Selection:
The 4 States selected were Borno, Bauchi, Kano, and Sokoto.

States with the highest number of ZD estimation were selected based on National Emergency Routine Immunization Coordination Centre (NERICC) Zero Dose Estimation and Prioritization analysis.

LGA (District) Selection:
Across selected states, Local Government Areas (LGAs) prioritized by NERICC were stratified into urban and rural settings (8 selected).

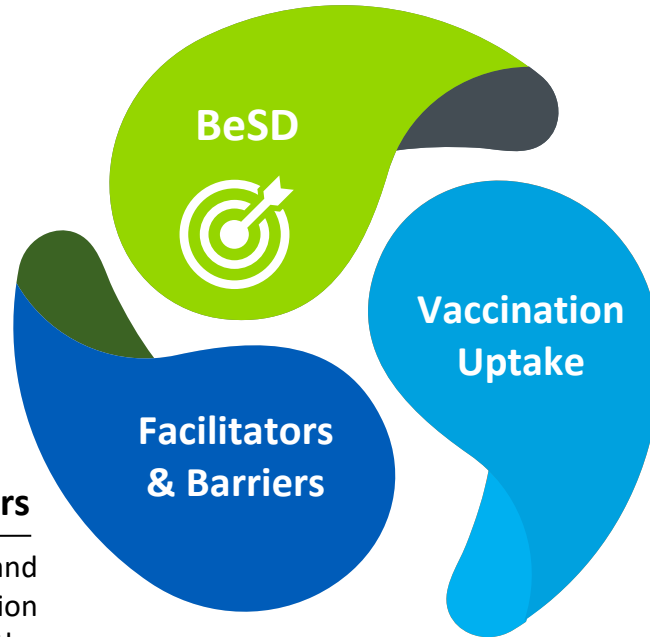LGAs with the highest number of ZD children were selected from each of the strata.

Wamakko (9,548) and Tambuwal(11, 386)

Bauchi (20, 554) and Ganjuwa (15, 039)

Kumbotso (12, 650) and Sumaila (8,043)

Jere (25, 831) and Maiduguri (28, 513)

4 High Zero-Dose States

Rapid Assessment Methods

Health Facility & Settlement Selection

- Health facilities with high Penta-1 drop out rate (2022 annual data), report of cVDPV2 and report of measles/diphtheria were randomly selected.

- Settlements ranked one (1) were selected.

- Health facilities designated as catchment for ZD were selected using the Z-Drop plan.

- Households with children less than two (2) years were selected.

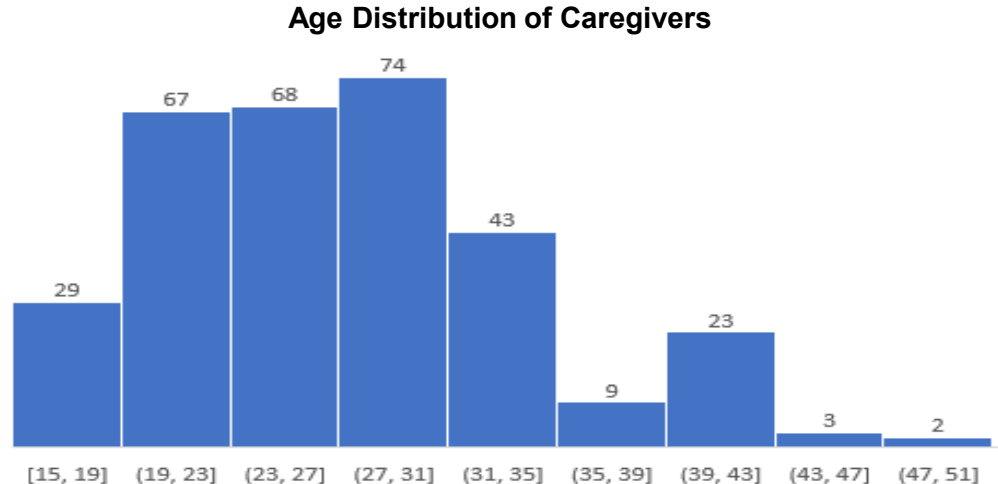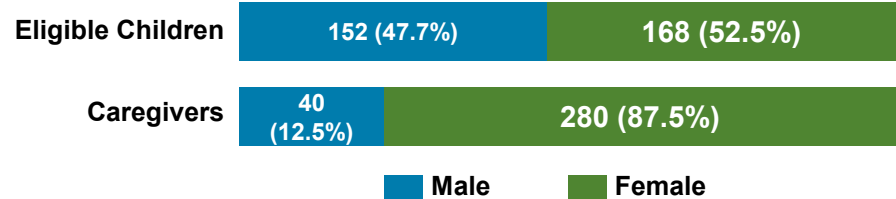| Data collection method	Approach
KII (92)	A face-to-face interview of selected stakeholders (PM Subnational Routine Immunization Coordination Center [SERICC], State Immunisation Officer [SIO], M&E Officer and 1 partner, LQA Immunisation Officer [LIO], LGA M&E Officer and 1 partner, Facility in-charge/ Routine Immunization [RI] Focal Person) conducted by trained research assistants.
Health Facility (HF) Assessment (32)	Assessment of health care workers using Open Data Kit (ODK) Traditional Leaders / Religious leaders (32)
Childhood Vaccination Survey (320)	Abstraction of vaccination history from eligible child (0-11 months, 12-23 months) using ODK tool
KII for Caregivers and BeSD Survey	Community assessment of caregivers of eligible child (0-11 months, 12-23 months) using BeSD Tools

Demographics - Sex and Age Distribution

- A total of 320 eligible children and caregivers sampled across the four states.

- 192 (60%) of eligible children sampled were 0-11 months old with mean of five (5) months while 128 (40%) were 12-23 months mean of 16 months.

- Mean age of caregivers was 28 (SD+8 years).

- 87.2% of caregivers have one (1) child.

- Caregiver relationship with the child:

  - ✔ Father – 9 %
  - ✔ Mother – 87.2%
  - ✔ Grand Father – 2.2%
  - ✔ Others - 1.6%

	Male	Female
Eligible Children	152 (47.7%)	168 (52.5%)
Caregivers	40 (12.5%)	280 (87.5%)

Age Distribution of Caregivers

[15, 19]	(19, 23]	(23, 27]	(27, 31]	(31, 35]	(35, 39]	(39, 43]	(43, 47]	(47, 51]
29	67	68	74	43	9	23	3	2

Priority Indicators

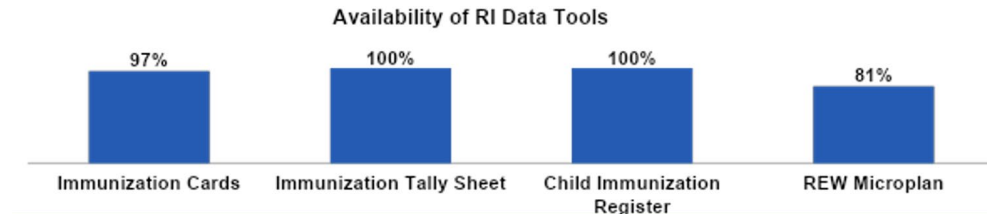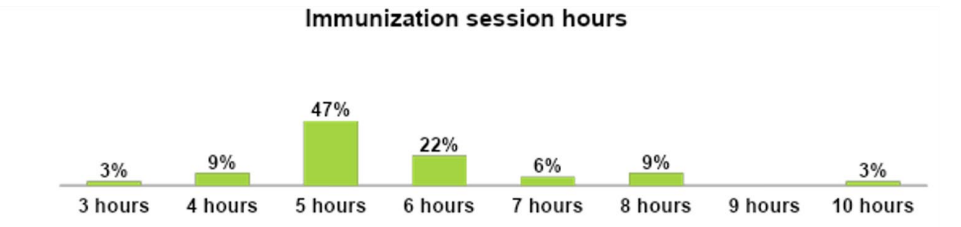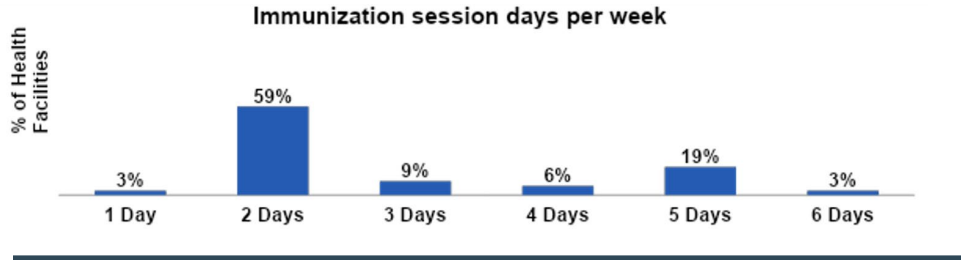| Summary of findings	% of caregivers	Urban	Rural	Discussion
Thinking and feeling — Parents/ caregivers who say vaccines are moderately or very important for their child's health	90	85	95	• *Negative rumors can influence caregivers' perceptions. In Kano, a caregiver mentioned,* ==**"Some women claim that vaccination prevents childbirth or something"**== **~Caregiver Gaida Fulani Charanci Kumbotso Kano**
Parents/ caregivers who say vaccines are moderately or very safe for their child	91	88	91	
Parents/ caregivers who say they trust the health workers who give children vaccines "moderately" or "very" much	95	96	95	
Social Processes — Parents/ caregivers who say most of their close family and friends want their child to be vaccinated	90	93	88	• Five critical motivators identified include; Father's approval, Desire to reduce child's morbidity and mortality, Caregivers' knowledge on importance of vaccination , Social influences from social circles and financial influence
Parents/ caregivers who say their community leaders want their child to be vaccinated	94	99	91	
Parents/ caregivers who say they do not need to take permission for child vaccination	88	95	76	
Motivation — Parents/ caregivers who say they want their child to get all the recommended vaccines	90	93	90	• Perceived economic challenges related to the cost of services can hinder access to immunization. A gatekeeper explained; ==**"In this harshness of life? Even if your wife is sick, not to talk of your child, he won't dare to take them to the hospital; even the transport fee is something else"**== **~Borno MMC-Kanuri-KII**
Practical Issues — Parents/ caregivers who say they know where to get their child vaccinated	90	90	90	
Parents/ caregivers who say vaccination is "moderately" or "very" easy to pay for	67	62	70	
Parents/ caregivers who say they want they are "satisfied" or "very satisfied" with vaccination services	88	90	83	

Zero-Dose LEARNING HUB

Health Facility Assessment

Immunization session days per week

- 1 Day: 3%
- 2 Days: 59%
- 3 Days: 9%
- 4 Days: 6%
- 5 Days: 19%
- 6 Days: 3%

Immunization session hours

- 3 hours: 3%
- 4 hours: 9%
- 5 hours: 47%
- 6 hours: 22%
- 7 hours: 6%
- 8 hours: 9%
- 9 hours:
- 10 hours: 3%

Availability of RI Data Tools

- Immunization Cards: 97%
- Immunization Tally Sheet: 100%
- Child Immunization Register: 100%
- REW Microplan: 81%

Limited work hours for service providers

✔ Pose a potential barrier to accessibility for individuals with weekday commitments.

✔ Poses gender barrier for mothers with chores and alternative sources of income.

About 19% of health facilities were reported not to have or whose microplan were unavailable for verification.

Recommendation:

- Need for **gender-sensitive** vaccination scheduling.

- Review of the Optimised Integrated Routine Immunization Session (OIRIS) strategies to emphasize on **rural** health facilities.

- Mandatory for updated Reaching Every Ward (REW) **microplan** to be pasted onsite to inform immunization service delivery.

- Allocation of a **budget line** for printing and distribution of data tool to health facilities.

COMMUNITY RAPID ASSESSMENT
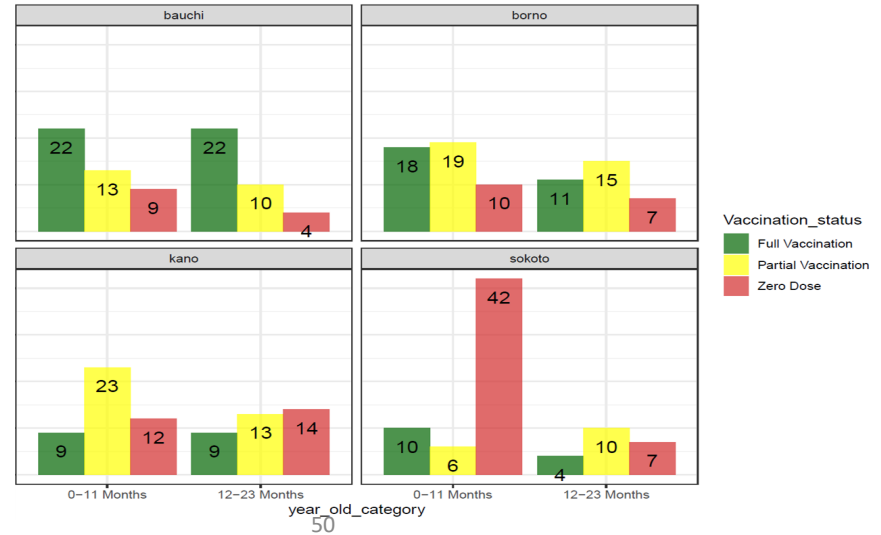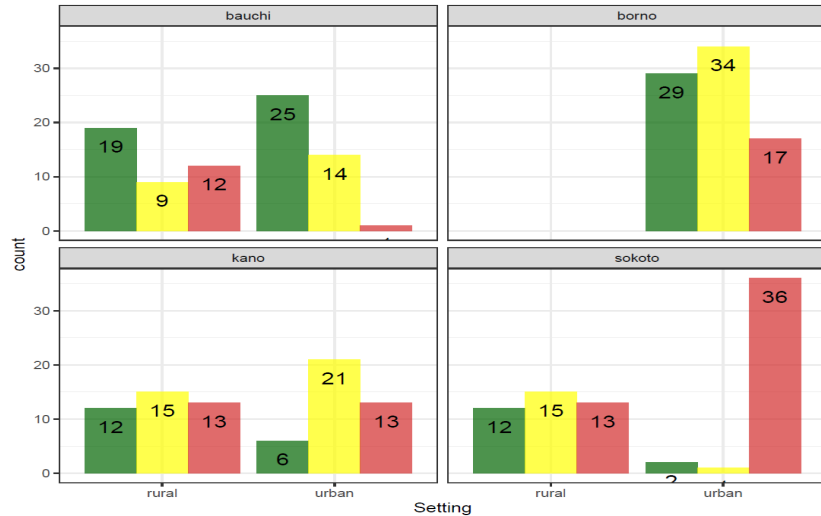
- **Sokoto** State has the highest number of zero-dose children followed by **Kano** state.
- There are higher zero-dose children in urban settings in **Sokoto** and **Borno** state while in **Bauchi** state, there are higher numbers of full vaccination in urban settings compared to rural settings.
- The age group **0-11 months** has the highest number of zero dose children from Sokoto state followed by 12-23 months from Kano state
- Across the eight LGAs, **Wamakko** has the highest number of zero dose in the 0-11 months age category followed by **Tambuwal** in the 0-11 months category.

AFRICAN HEALTH BUDGET NETWORK: Sub-national Budget Analysis Landscape on Immunization

OBJECTIVES

To analyze the co-financing model on health budget in the four selected ZDLH states focusing on immunization covering 2021, 2022, 2023 allocations and disbursement.

To review coordination and partnership at the state level that promotes immunization and equity to reach ZD children and missed communities.

To proffer recommendations for advocacy that will ensure reaching ZD children and missed communities.

Methodology

Desk Review

- Data review and collation of the approved budgets of the four states of focus, Health MoUs with Donors, Annual Operating Plans of the State Primary Health Care Boards, and other relevant documents.

Data Analysis

- Budget analysis of approved state budget, available co-financing documents from development partners, and other documents, such as Operational Plan MoU.

Key Informant Interviews (KII)

- KIIs were conducted to get a clearer picture and get more information to back the findings.

Focal State	Proportion of Budget Allocated to Health 2021	Proportion of Budget Allocated to Health 2022	Proportion of Budget Allocated to Health 2023
Bauchi	11.2%	11.4%	15.0%
Borno	15.8%	9.1%	7.4%
Kano	17.3%	15.4%	14.7%
Sokoto	11.8%	15.7%	13.5%

Proportion of total health budget allocated by state to SPHCMB

Year	Bauchi	Borno	Kano	Sokoto
2021	20.5	3.3%	3.3%	4.5%
2022	22.2	5.1%	5.1%	3.0%
2023	28.3	15.3%	15.3%	3.0%

Conclusion/Recommendations

Gender Considerations: Scheduling of vaccination days/times should consider gender-related practical issues which can affect the caregiver availability to visit the hospital.

Practical Issues: High knowledge of vaccine importance & motivation doesn't translate to high vaccination rates, especially in Sokoto. Practical issues hinder caregivers.

Budget/Accountability: Lack of overall allocation /disbursement of funds likely contributing to high number of ZD in Sokoto, Budget tracking/advocacy is paramount.

Community Engagement: Increase government support for community engagement. Ensure caregivers are aware of free/affordable services and importance of completing all vaccine doses.

Global/National: Gavi Full Portfolio Planning; Implementation Research; Advocacy (Executive and Legislative).

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Introduction

- The **Uganda National Expanded Program on Immunisation (UNEPI)** has made great strides in improving immunisation coverage over the last 20 years.

- **Challenges remain** to reaching every child:
  - Increased numbers of ZDC by 40% from 77,992 in 2020 to 109,338 in 2023.
  - Conversely, a decrease in the number of UI children (UIC) by 27% from 267,859 in 2020 to 195,684 in 2023.

- There's a need for **deeper understanding** of the unreached children, i.e. Who are they? Where are they? How many are they? Why are they not reached with DPT vaccine?

Selection of Study Districts

Focus districts

Selection criteria

- Districts selected by UNEPI:
  - Have high numbers of ZDC based on triangulation of DHIS2 and the Institute of Health Metrics and Evaluation (IHME) data.
  - Are targeted for interventions to address the ZD challenge under Gavi's Equity Accelerator Funding (EAF).
 - Have communities that are considered to have immunisation inequities.

Selection of Study Communities in Selected Districts

Based on:

- Reaching Every District/Reaching Every Child (RED/REC) categorisation of sub-counties and health facilities.

- Available equity reference groups (ERGs).

- Consultation with district stakeholders (district health teams (DHTs), health workers, village health teams [VHTs]).

- VHTs identified the caregivers.

Selected critical geographies:

Urban settlements, mountainous areas, islands, underserved areas, communities at national border, mining areas.
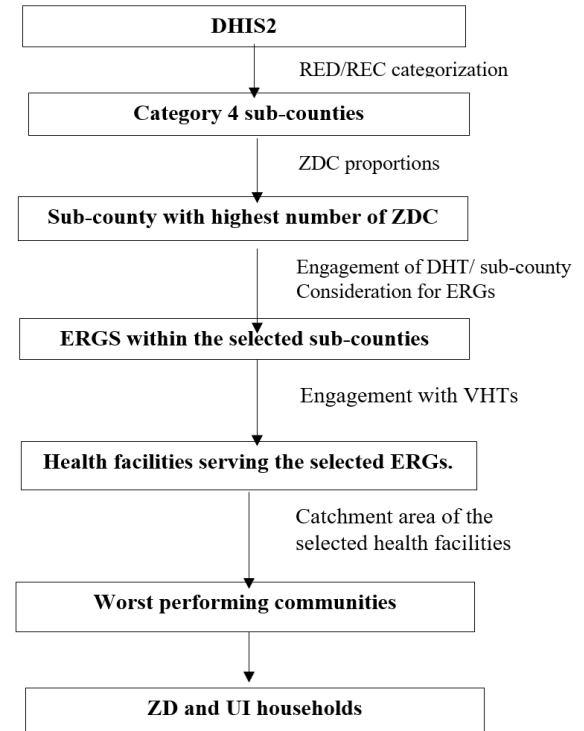
Rapid Assessment Objectives and Methods

Objective:

To characterise the ZDC, UIC, and missed communities in Uganda, and to understand the barriers and challenges of reaching them.

Methods

Method	Data source
Document review	EPI planning documents, national strategies / frameworks, reports from previous EPI coverage surveys, performance assessments (e.g., facility assessments and annual progress reports), DHS reports, UNICEF consultant reports and research reports
Secondary data analysis	DHIS2, house-to-house registration data from VHTs under UNICEF support
IDIs (37)	Caregivers of ZDC and UIC
KIIs (24)	VHTs (9), health workers (9), local community leaders (6)
Stakeholder engagement	Discussions during meetings at national, district, health facility, and community levels.

Cross-cutting Barriers to Immunisation Uptake

1. **Limited physical access to immunisation services**
   - Long distances to health facilities (10-15 km away)
   - Few / irregular outreaches
   - Geographical challenges

2. **Inadequate client-centered services**
   - Long waiting time at health facilities
   - Poor health worker attitude (rude, take bribes, open health facilities late and close early)
   - Hidden immunisation costs

3. **Vaccine stock-outs at health facilities**

4. **Fear of adverse events following immunisation**
   - Lack of knowledge on management of events (e.g. pain, crying, temperature, swelling, lameness)

Cross-Cutting Barriers to Immunisation Uptake

5. **Limited spousal support for immunisation**
    - Refusal by husbands to provide money for transport, physical assault.

6. **Myths and misconceptions**
    - Religious beliefs, rumoured adverse events, vaccine mistrust, cultural beliefs, misleading statements.

7. **Childbirth under TBAs**
    - Limited linkage to immunisation services.

8. **Competing priorities among caregivers**
    - Household chores, gardening, day-to-day jobs, community events.

Learnings

Identify

1. VHTs are key players in the identification of ZDC and UIC at community level.
2. Identifying ZDC/UIC and missed communities requires a data capture system that collects data at the community level and facilitates real-time data use at all levels.
3. Some households that had ZDC also had other children that were ZD and/or UI, suggesting clustering of ZDC or UIC.
4. The ZD burden is a moving target that requires routine assessments to align interventions as the situation changes. The health system must be adaptable to changing situations to reach ZDC.

Reach

1. Several definitions of ZDC exist in-country.
2. Barriers to uptake of immunisation services differ by context and therefore require tailored approaches to address them.
3. Despite the government ban on TBAs, they still offer delivery services in some communities. TBAs often don't refer the mothers to immunisation services for fear of being reprimanded.
4. There are emerging critical geographies that are not documented by UNEPI. These include communities at national & district borders, mining areas, underserved areas and those that have immigrants.

![Zero-Dose Learning Hub logo]

Potential Use of Findings

UNEPI

1. Can inform the design and implementation of EAF-supported activities.

2. Spur discussion on several issues:

   o Who is a ZDC?

   o How to ensure that children born under TBAs are linked to immunisation services.

   o How to improve data capture systems for immunization.

   o Use of existing community structures to identify ZDC and UIC.

Learning Hub

1. Understand the ZD context at baseline (before implementation of EAF-supported activities).

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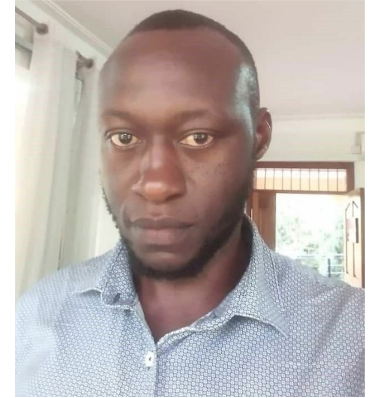Hub Coordinator, IDRC

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