



# Zero Dose Learning Hub (Nigeria)

COUNTRY LEARNING HUB FOR IMMUNIZATION EQUITY

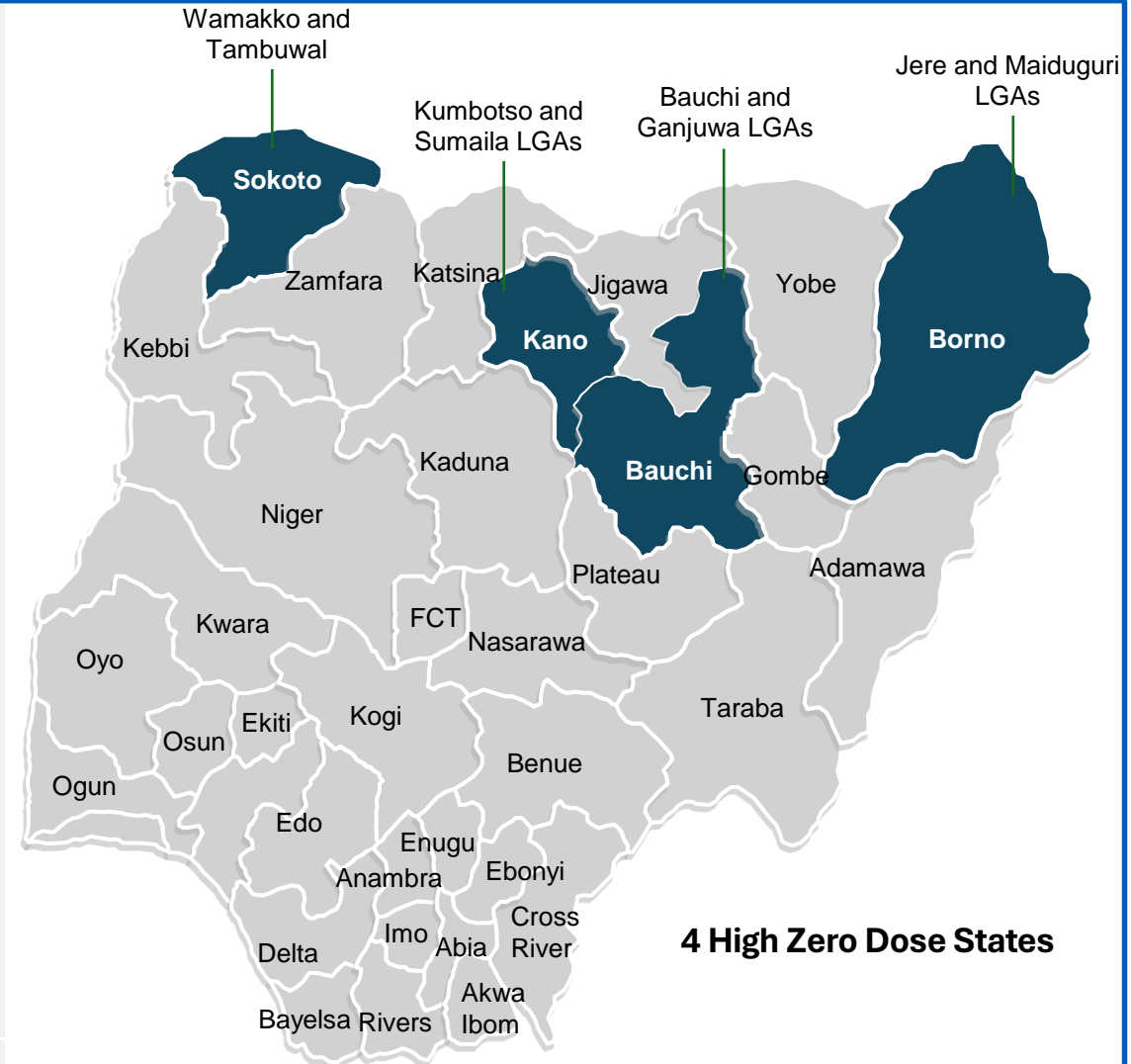
Successes & Opportunities from the Nigeria Zero Dose Learning Hub Project

Gavi Zero Dose Learning Week | 11<sup>th</sup> September 2024



# Background

- Country Learning Hub (CLH) is an innovative approach to advance uptake of research & evidence to improve immunization policy & programming
- Funded by Gavi, CLH will compliment TWG RI & SPHCDA's effort towards ZD reduction by providing evidence towards improving immunization equity
- Implemented by AFENET & AHBN with support from JSI consortium under guidance of NPHCDA & Gavi
- The project has 2 phases: April - Dec 2023 & Jan 2024 - Dec 2025
- Implementation is structured into three (3) broad pillars to deliver prioritized strategies:
  - Promote country learning on IRMMA
  - Advocacy & Partner engagement
  - Capacity building



CLH = Country Learning Hub; TWG RI = Technical Working Group on Routine Immunization

SPHCDA = State Primary Health Care Development Agency; NPHCDA = National Primary Health Care Development Agency

# Rapid Assessment – Scoping Findings



To map & summarize existing literature on barriers & facilitators of immunization in Nigeria



Review approach conducted in alignment with updated scoping review guidelines from the Joanna Briggs Institute (JBI) and Arksey & O'Malley



Reporting guided by the PRISMA-ScR checklist for systematic reviews

# Findings: Regional Variations & Identified Barriers Vs Facilitators

## NORTH-WEST

### •Barriers

- Low trust in healthcare workers & poor vaccine confidence
- Gender inequality & economic barriers

### •Facilitators

- Engage community influencers (religious & traditional leaders as vaccine advocates)
- Empower women (education & economic)

## NORTH-EAST

### •Barriers

- Vaccine Stockout
- Low trust in healthcare workers & poor vaccine confidence

### •Facilitators

- Novel vaccine delivery methods
- Engage community influencers (religious & traditional leaders as vaccine advocates)

## NORTH-CENTRAL

### •Barriers

- Geographic & Economic disparities

### •Facilitators

- Improve Access & Financial incentives for immunization

## SOUTH-WEST

### •Barriers

- Long queues
- Poor access in rural areas

### •Facilitators

- Increased skilled work force
- Improved access in rural areas

## SOUTH-EAST

### •Barriers

- Concerns about Vaccine safety & benefits

### •Facilitators

- Leveraging existing communication channels (WhatsApp & SMS) for reminder systems & education campaigns

## SOUTH-SOUTH

### •Barriers

- Inconvenient timing of vaccination session

### •Facilitators

- Leveraging existing communication channels (WhatsApp & SMS) for reminder systems & education campaigns

# Decentralized Immunization Monitoring



**AIM:** To better assess RI performance at LGA & ward levels & to understand local drivers/barriers of vaccination as well as identify priority indicators at ward level for quick & effective intervention



To estimate average coverage proportions for priority immunization indicators at LGA level



To identify priority RI & BeSD indicators at the ward level



To identify priority wards that do not reach the LGA average coverage point estimates for each antigen

## METHODOLOGY

- **Study Design:** Cross-sectional design
- **Study population:** Caregivers of 0-11 & 12-23 months children
- **Eligibility criteria:** New residents, visitors & secondary caregivers
- **Sample size determination & technique:** 418 eligible caregivers sampled using multi-stage sampling.
  - 19 settlements selected using Population Proportionate to size (PPS) across all sub-districts
  - Two eligible Households (HH) were sampled using segmentation & parallel sampling approaches
- **Instruments:** Behavioural & Social Drivers of Vaccination (BeSD) & Lot Quality Assurance Sampling frameworks

# Decentralized Immunization Monitoring (Key Findings)

- **ZD prevalence was 39% (876) out of 2242 children sampled across 5 LGAs (3 states)**

- ✓ Sokoto; highest prevalence of 59%, Borno 29% & Kano 23%
- ✓ Prevalence was slightly higher amongst 0-11 months (40%) compared to 12-23 months (38%)
- ✓ Caregivers of ZD had no formal educational, Quintile Wealth Index between 1 – 3 & poor economic status were significant demographic characteristics
- ✓ 75% of ZD Caregivers had no history of antenatal while 54% delivered at home

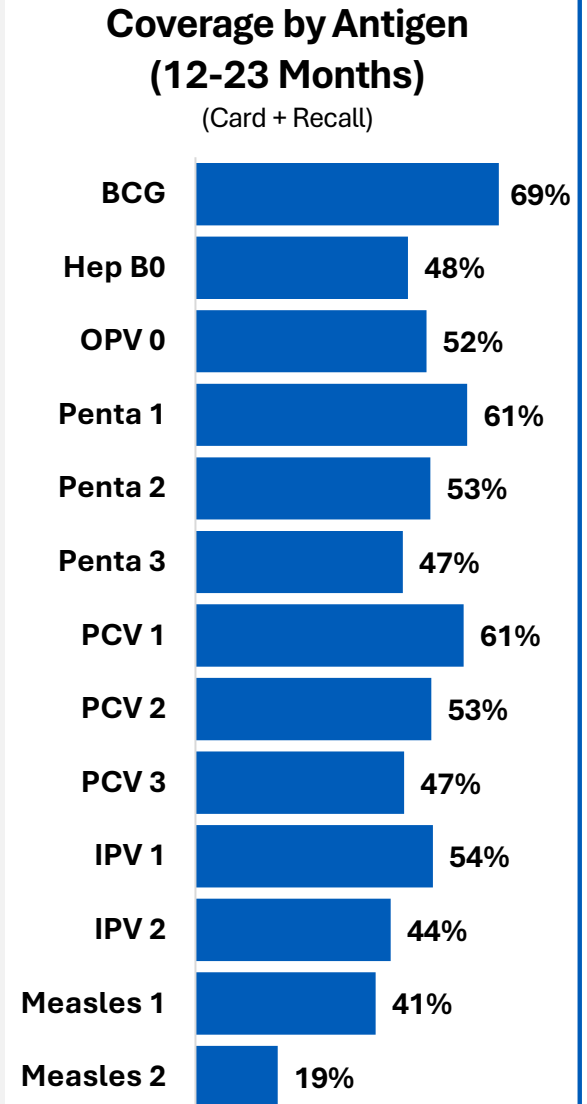
- **Behavioural & Social Drivers of Vaccination**

- ✓ **Thinking and Feeling**

- 42% of ZD Caregivers do NOT trust healthcare workers that vaccinate children
- 52% of ZD caregivers do NOT or Don't Know the belief of vaccination
- 50% of ZD Caregivers do NOT believe that the vaccines are safe

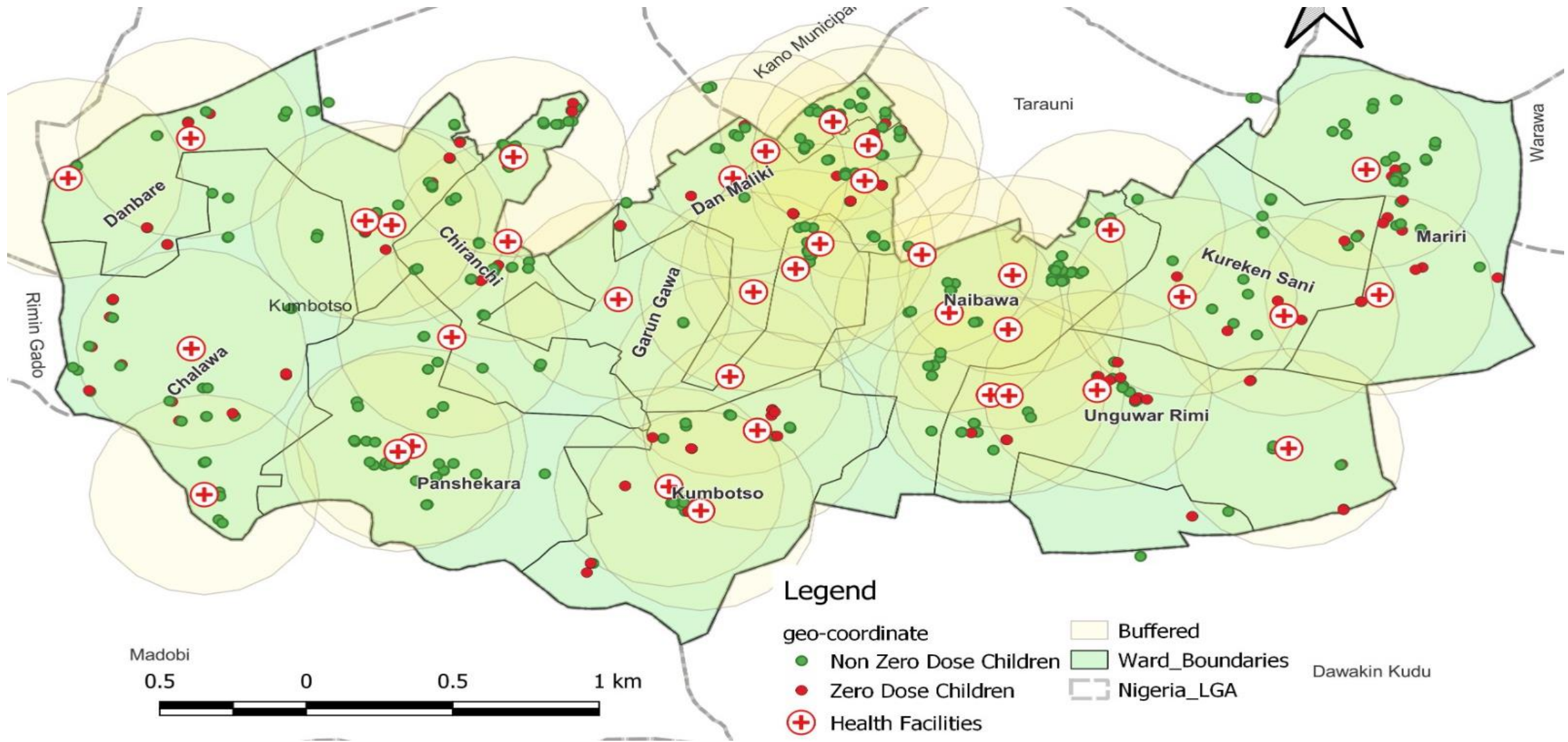
- ✓ **Social Processes**

- About 85% of ZD Caregivers require Permission (84% from Husbands, 2% from Grand Parents) to vaccinate
- HCW recommended vaccination for 82% of ZD Caregivers





# Key Findings - Geospatial Analysis



# Implementation Research (Bauchi & Sokoto)



**AIM:** To generate evidence-based insight on current strategies and new strategies to identify ZD children in different settings

1

To explore the barriers & facilitators in access, uptake & delivery of routine immunization in different settings in the study areas

2

Assess the effectiveness & efficiency of Z-Drop & IEV in identifying & reaching zero-dose children & missed communities in different settings

3

Examine the incremental cost of reaching zero-dose children and examine the cost-effectiveness of Z-Drop & IEV in identifying & reaching zero-dose children & missed communities

## Assessment of Zero Dose Reduction Operational Plan (Z-DROP)

### METHODOLOGY

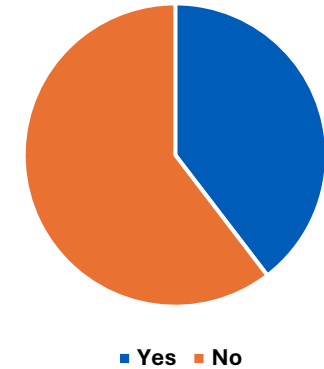
- **Data:** Quantitative
- **Sample size:** 484
- **Target population:** caregivers of children aged 0-11 & 12-23 months



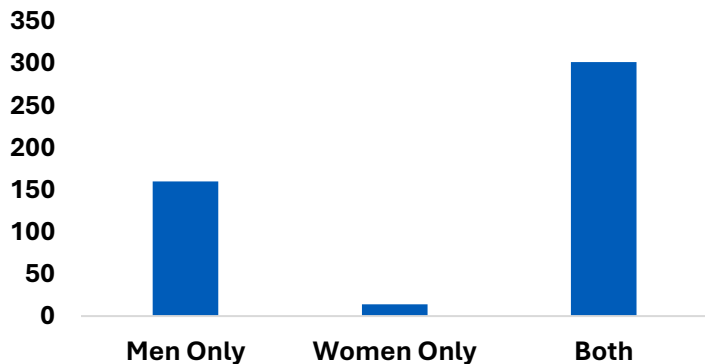
# Key Findings

- Females are primary caregivers (92%)
- Female caregivers have weak capacity because:
  - Limited participation in joint household decision around critical resources such as finances needed to facilitate uptake of RI (73%):
  - Require husband's permission to vaccinate children (88%)
- **Conclusion:**
  - Lack of decision-making power & control over use of family finances are barriers to uptake of RI
- **Recommendations:**
  - increase women participation in Joint household decision on finances & right to vaccinate children through dialogue to increase uptake of RI

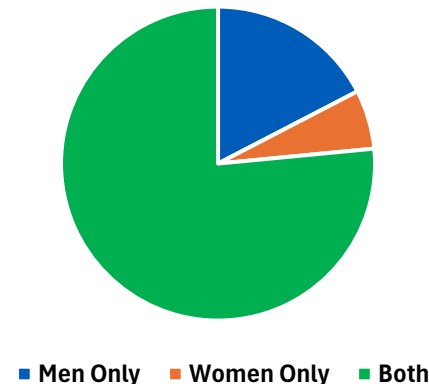
Does sex of Health care worker determines decision to or not to vaccinate children



Resource Control needed for Immunization



Person Responsible to seek Immunization




Those who believe that male caregivers are discriminated/ridiculed when they visit health facilities to vaccinate their children



# Learning Agenda

## OBJECTIVES OF THE LEARNING AGENDA



**To improve ZD program design & implementation through ongoing analysis & reflection on key questions, which NPHCDA can use to align what partners are working on**

**To organize & lead a ZD Learning Agenda prioritization with national-level immunization stakeholders**

**To develop & disseminate a ZD Learning Agenda, including recommendations for meetings/processes to facilitate evidence-use**

## LEARNING QUESTIONS

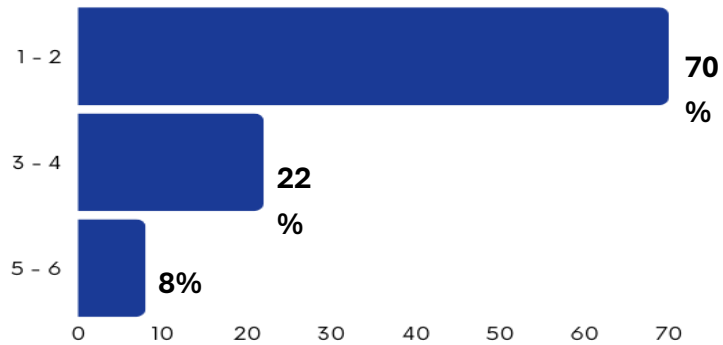
Rank	Learning Questions	Priority	Average Percentage of 3 ranking
1	3. What are the most effective approaches and methods for identifying zero-dose and under-immunised children and for monitoring and measuring their coverage through to full vaccination?	Most critical	100%
2	7. What community engagement strategies are most effective at reducing the number of ZD children?		97%
3	2. What are the key enablers and barriers at each level of the health system (policy to community) to identifying, monitoring, and measuring zero dose children and missed communities?		95.5%
4	1. Where and who are zero-dose children, and missed communities? Why are they being missed?		93.9%
5	6. What are the evidence gaps at national/sub-national levels related to the identification, monitoring and measurement of zero-dose and missed communities?		93.6%
6	5. How has integration of campaigns with other PHC services been used to reach zero-dose children and missed communities? What has worked well, or not, and why?	Somewhat critical	91.2%
7	9. What approaches are been used to harmonize parallel systems for data collection to identify, reach, and measure ZD?		83.8%
8	8. What capacity-building strategies/interventions (or combination of strategies) are effective in strengthening capacity of data managers at the health facility level		74.9%
9	4. How have partnerships contributed to strengthening immunization programs to date, and what is the potential of strategic partnerships for improving equitable immunization coverage, including zero-dose?		63.9%
10	10. What can we learn from the introduction of other vaccinations as an opportunity to identify and reach ZD children?	Least critical	60.7%

# Capacity Building (Needs Assessment)

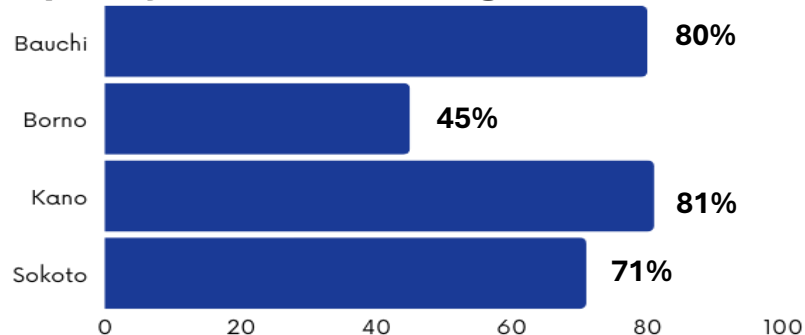
- 437 HCWs completed & submitted self-assessment checklist across the 4 intervention states; Bauchi, Borno, Kano & Sokoto
- Averagely, only 27% of respondents have good knowledge on how to address ZD (Bauchi=29%, Borno=15%, Kano=30% & Sokoto=33%)
- Averagely 46% of respondents have good practices towards addressing ZD

## Average Number of Thematic Areas

### Trained on Immunization

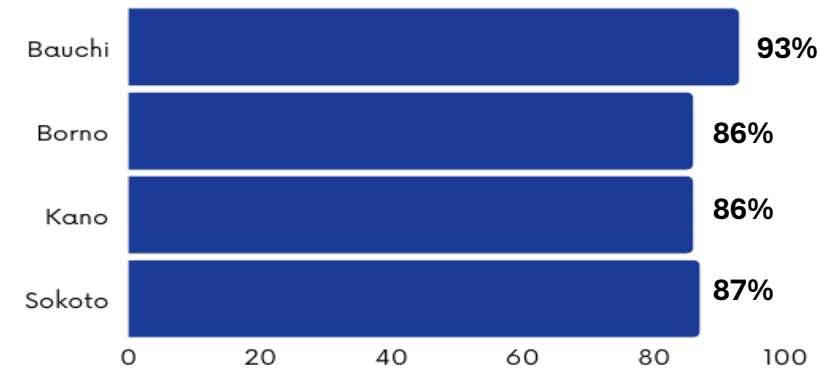


### Capacity to Draw RI Budget

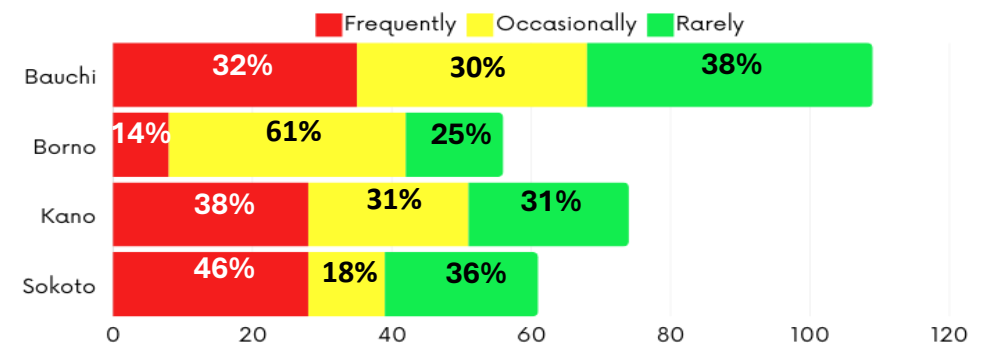


## Capacity to Identify Zero-dose Communities

- 89% of respondents claim to have capacity to identify zero dose communities
- 79% have the capacity to draw a budget for RI that includes zero dose



## Frequency of Stockout



# Advocacy & Engagement (Subnational Budget Analysis)

- **Objectives**

- To assess the effectiveness of current immunization financing strategies in addressing funding gaps across Nigeria

- **Methods**

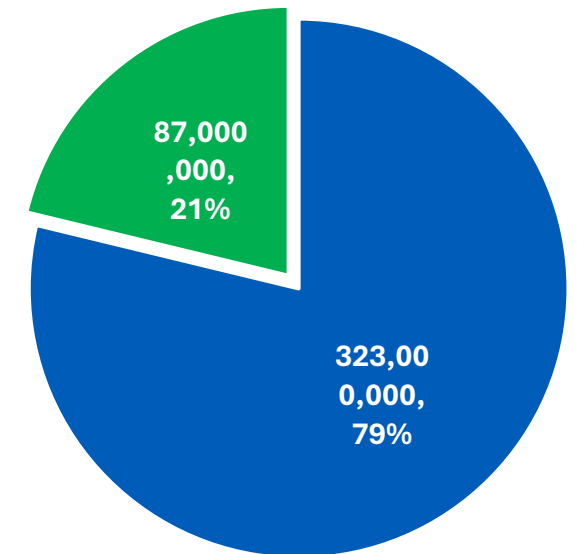
- **Quantitative Analysis:**

- Compared health budgets & assessed budget performance across four states (Bauchi, Borno, Kano, & Sokoto), selected as part of the ZD Learning Hub initiative

- **Qualitative Analysis:**

- Conducted a desk review of state budgets, health policies, & reports, & carried out 20 key informant interviews
- Examined implementation performance of state budgets & MoUs

**Bauchi State PHC MOU  
Contribution FY 2024**



■ Amount Released in Naira  
■ Remaining Balance in Naira

# Excerpt from the Analysis

## Proportion Of Annual Health Budget

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



# Advocacy & Engagement

## Established State-led Community of Practice on Immunization Budget tracking, Accountability & Sustainability Targeting ZDC & Missed Communities across the 4 states

- Budget line created to immunization for 2025 budget proposal in Bauchi
- Oversight function on supervisions to strengthen immunization & reaching zero dose children in Kano state



## Advocacy & Engagement

- National Assembly – House Committee Chairman on Immunization (10<sup>th</sup> National Assembly)
- Senate Committee Chairman on Health
- Governor Forum
- House of Representative
- National and State Religious and Cultural Council (CAN, MURIC etc.)



# Recommendations

**1** ZD prevalence is driven by caregivers' low education, socio-economic issues, & need for HH-head permission to vaccinate

**2** Only 2% vaccinated via outreach service while 80% of ZD exist with 5KM radius of a HF

**3** Limited knowledge of vaccine benefits & low trust in healthcare workers contribute to significant drop-out rates

**4** DIM provided baseline for RI KPIs for tracking & insight into caregiver behavioural & social characteristics to inform iterative learning & evidence-based decisions by stakeholders

**5** Clear link between low education, unemployment, & lower income with ZD children. Targeted outreach & strengthened collaboration with partners recommended

**6** Adopt & Scale-up DIM implementation across prioritized districts to establish baseline, track KPIs & generate prompt evidence

**7** Conduct process performance evaluation of Outreach services to understand contextual factors driving sub-optimal implementation

**8** Building capacity of HCW on effective communication skills, cultural sensitivity & community engagement techniques to improve service quality to reinforce trust

**9** Strengthen social mobilization & engagement activities towards Household Heads through community/religious & other community systems

# THANK YOU

