



TARGETED ASSESSMENTS TO IDENTIFY, REACH, AND MONITOR ZERO-DOSE AND UNDER-IMMUNIZED CHILDREN

Webinar Q&A

Questions extracted from the webinar Q&A box edited for clarity, with responses added by speakers after the webinar.

Webinar Speakers and Panelists

- **Dr. Chilunga Puta**, Senior Immunization Data Advisor, MOMENTUM Routine Immunization Transformation and Equity.
- **Dr. Jessica Shearer**, Monitoring, Evaluation, Learning Lead, MOMENTUM Routine Immunization Transformation and Equity.
- **Dr. Sarah Wanyoike**, Vaccine Preventable Diseases Team Lead, WHO-IST-Eastern and Southern Africa.
- **Dr. Ana Morice Trejos**, Medical Epidemiologist and Pediatrician.
- **Dr. Shehu Sambo**, Director PHC, Jigawa State Primary Health Care Development Agency.
- **Dr. Carolina Danavaro**, Medical Epidemiologist, World Health Organization.

What is the difference between rapid convenience monitoring and rapid coverage monitoring?

Dr. Ana Morice Trejos: It's the same tool. Rapid Coverage Monitoring has been used with different names. Some countries use Rapid Coverage Monitoring, Rapid Coverage Assessment, Rapid Convenience Monitoring, among others.

There are a significant number of zero-dose and unimmunized children among nomadic populations between Nigeria, Chad, Cameroon, and Niger. Could you please share specific and tailored strategies to vaccinate them? Is there any collaboration between countries?

Dr. Shehu Sambo: Answered live.

Dr. Jessica Shearer: You might reach out to partners working on the Gavi ZIP project, which is a cross-border collaboration aiming to reach zero-dose children in the Sahel and Horn of Africa:

<https://www.gavi.org/vaccineswork/zip-new-way-get-vaccines-zero-dose-children-some-worlds-toughest-regions>

Based on the zero-dose children toolkit work to date, what type(s) of data collection would you recommend for more deeply understanding why children are zero-dose or underimmunized in local contexts? Will such data collection guidance be included in the zero-dose children toolkit?

Dr. Jessica Shearer: The toolkit will link to existing data collection tools for understanding 'why' such as the [Behavioral and Social Drivers qualitative interview questionnaires](#) and the WHO Harmonized Health Facility Assessment to assess health systems readiness. The toolkit will also include tools to help analyze data using root cause analysis, and co-create context-tailored solutions. Feel free to reach out if you would like more resources or data collection and analysis tools to inform your work.

Do you have anything to say on how commodities and services are triangulated?

Dr. Ana Morice Trejos: Triangulating commodity data (e.g., vaccine stock data) and service data (e.g. vaccine administration data) can potentially help fill gaps in either data source and be used to identify zero-dose children or missed communities. The toolkit will include links to existing data triangulation guidance. You can find more information about it in the guidance modules available from: [Triangulation for improved decision making in immunization](#)

What criteria was used by Jigawa State to arrive at the number of zero-dose children in the state?

Dr. Shehu Sambo: Jigawa State uses multiple data sources to identify the number of zero-dose children, such as:

- The National Immunization Coverage Survey, which was last conducted in 2021.
- The Multiple Indicator Cluster Survey, which also takes place every 5 years and the last was released in 2021.
- The National data platform, DHIS2, which is based on data submitted by various hospitals and Immunization service units in the country.
- Lot quality assurance sampling conducted every quarter, which also tells us the numbers and the location of the zero-dose children. The advantage of this is that it's more frequent than major surveys.
- Routine immunization supportive supervision. During our routine supervision we also identify a number of zero-dose children and where they live for subsequent immunization.

Knowing the state target for penta 1, the above-mentioned sources help identify the number of children not immunized with the penta 1 vaccine and are presumed zero-dose.

What is the cut off week or month to determine if a child is zero-dose or under-vaccinated after missing a schedule? For example, missing DPT1 at 6 weeks.

Dr. Jessica Shearer: Assuming you are referring to using routine administrative data, this often depends on country. Many countries use a four-week grace period after a child is age-eligible for a dose, after which time the child is considered 'late' or a 'defaulter' for that dose.

Dr. Carolina Danavaro: For monitoring purposes, most information systems only capture doses as among <12 months or >12 months. Data aggregation then allows to estimate DTP1 coverage for surviving infants, or among children aged 12-23 months in most surveys. Therefore, the estimated number of zero-dose children, calculated as denominator-

number vaccinated with DTP1 is often for children who missed the dose in their first year of life. At the individual level, delayed vaccination is after four weeks of the scheduled time for a dose (or four weeks after an earlier dose).