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MOMENTUM ROUTINE IMMUNIZATION TRANSFORMATION
AND EQUITY



WEBINAR: MAINTAINING FOCUS ON ROUTINE IMMUNIZATION THROUGH COVID-19 VACCINATION

April 27, 2021

Questions and answers extracted from the Q&A box

**Edited for clarity, with additional responses added by speakers after the webinar*

HOW CAN THE COVID-19 RESPONSE SUPPORT EFFORTS TO RECOVER ROUTINE IMMUNIZATION PROGRAMS?

Dr. Folake Olayinka - We discussed this during the last two presentations of the webinar and suggestions are included in the slides. There are several ways that the COVID-19 response can support the recovery of routine immunization (RI). COVID-19 vaccine microplanning can include details on where RIs have been missed, and plan for service delivery alongside vaccinations. Another example is in the use of digital COVID-19 vaccine appointment reminders could be expanded for RI follow up of those that have missed vaccinations. Integrated communication messaging for COVID-19 could be used to remind families about other vaccinations and answer questions they may have. We can build on community engagement for COVID-19 vaccine introduction to include RI services promotion.

IN UGANDA, THERE SEEMS TO BE A GENERAL DECLINE/STAGNATION IN IMMUNIZATION COVERAGE RATES FOR SOME VACCINES EVEN BEFORE COVID-19 DISRUPTIONS...WHY WOULD THIS BE? WHAT NEEDS TO BE DONE TO RESOLVE THIS?

Alex de Jonquières - Based on WHO and UNICEF data, Uganda's coverage has been flat for the past few years. This is partly a function of population growth; the country actually immunized ~10% more children in 2019 than 2015, but this was only enough to keep up with the growth of their birth cohort. It's also a reflection of how challenging it is to reach the last few missed children; Uganda's coverage is nearly 95% and the missed children are likely those living in urban slums; displaced, mobile, and marginalized communities; remote areas, or conflict-affected settings. Traditional strategies may not be adequate to reach those children.

Rebecca Fields - Increasing coverage to improve equity in Uganda requires tailoring strategies to the needs of different populations. It is also important to analyze and reduce drop-out rates, which are traditionally high in Uganda. The 2016 DHS survey indicated that they were considerably higher for OPV1-3 and PCV1-3 than for DTP1-DTP3. Facility-based microplanning with community participation has helped identify missed populations, and actively reaching out to local non-health stakeholders at district level, such as chief administrative officers, has mobilized local resources and promoted use of immunization services. These

methods are described in this report: <https://www.isi.com/resource/innovating-to-vaccinate-every-child-in-uganda-through-strengthening-subnational-management/>

THE KEY AREAS FOR INVESTMENT ARE INTEGRATED HEALTH SERVICE DELIVERY, HEALTH SYSTEM STRENGTHENING EFFORTS, CROSS-SECTORAL COLLABORATIONS, AND COUNTRY OWNERSHIP. HOW ARE THESE TIED WITHIN ONE PROJECT SUPPORTED BY USAID?

Dr. Folake Olayinka - USAID works globally through multiple bilateral and multilateral partners and project mechanisms across reproductive, maternal, newborn, and child health and primary health care, fostering cross-sector collaborations. Investments in health systems strengthening, education, and governance portfolios are also examples.

WE NOW KNOW THAT FOR EVERY \$1 INVESTED IN THE PURCHASE OF THE VACCINES ABOUT \$4–5 IS REQUIRED TO PREPARE AND IMPLEMENT THEM. BUT USAID’S \$ NUMBERS DO NOT CURRENTLY ALIGN THAT WAY. IS THERE AN OPPORTUNITY FOR COURSE CORRECTION?

Dr. Folake Olayinka - USAID gave 4 billion dollars to COVAX to support vaccines. USAID also provides technical assistance in over 60 countries for readiness and delivery. Several other bilateral donors, development banks, etc. are contributing to and collaborating on this global effort.

A LOT OF COUNTRIES FOCUS ON FULL IMMUNIZATION (I.E., VACCINATION COVERAGE UNDER 1 YEAR OF AGE), IT IS HIGH TIME THAT WE SWITCH FROM FULL TO COMPLETE IMMUNIZATION (ALL VACCINE DOSES RECEIVED UNDER 2 YEARS OF AGE INCLUDING MCV 2). COMPLETE IMMUNIZATION SHOULD BE A GLOBAL DEFINITION/INDICATOR THAT ALL DONORS AND PROGRAM MANAGERS URGE COUNTRIES TO FOLLOW. WHAT ARE PANELISTS’ VIEW ON THIS?

This is an excellent point. The new global vision and strategy—IA2030—does make this shift in the monitoring framework to completeness and vaccination along the life-course, such as incorporating metrics of MCV2 and even human papilloma virus.

IN TERMS OF NEW TOOLS AND APPROACHES, WHAT WOULD YOU SUGGEST EPI PROGRAMS START WITH?

Rebecca Fields - The starting point is to diagnose challenges facing the immunization program to tailor programs to the local context. Here is a compendium of tools and resources in a user-friendly, searchable

Excel file: (<https://www.technet-21.org/en/library/main/7095-technical-resources-for-improving-immunization-coverage-and-equity>)

Alex de Jonquières: Partners within the ACT-Accelerator have prioritized a set of areas where we see the greatest need and potential for introducing innovations and new ways of working. These include:

- Infodemic management: Novel social listening and engagement tools and platform analytics
- Micro planning: GIS-based digital mapping
- Counterfeit detection: Barcode-enabled track and trace and Global Trust Repository for authenticity verification
- Vaccination status: Smart vaccine certificates
- Vaccination monitoring: Community-level digital monitoring of doses given
- Safety monitoring: Digital track & trace and community-level digital communication tools for safety monitoring
- Learning & supervision: Digitally-enabled approaches to support capacity-building and performance of health workers
- Waste management: New approaches to managing biomedical waste

The decision on which to prioritize will need to be country and context-specific as each country will be in a different place in terms of their current systems and have different needs.

THANKS FOR THE INTERESTING PRESENTATIONS! ALEX - ARE THERE NEW MODALITIES THAT GAVI WILL EXPLORE TO HAVE LONGER-TERM IN-COUNTRY PARTNERSHIPS THAT ENGAGE COMMUNITY SERVICE ORGANIZATIONS (CSOS) AND EPI PROGRAMS MORE PROACTIVELY AND DIRECTLY (SUCH AS 2–3 YEAR FINANCING MECHANISMS THAT COULD INCLUDE MOUS WITH MOHS)?

Alex de Jonquières - Strengthening partnerships with CSOs and others is a priority as we move into Gavi 5.0. We are taking a new approach to CSO and community engagement to our board in June to lay the foundation for this. We are also looking at more dedicated efforts in cross-border fragile settings where we need new models and funding mechanisms to reach missed communities.

THANKS FOR THE GREAT PRESENTATION, ALEX. COULD YOU TALK ABOUT THE STRATEGIES THAT ARE BEING USED/CONSIDERED TO REACH ZERO-DOSE CHILDREN? ALSO, ARE THERE ANY STRATEGIES IN PLACE TO LINK ZERO-DOSE CHILDREN TO RI SYSTEM?

Alex de Jonquières - This is a big question! It is clear that strategies will need to be locally tailored to the specific contexts in which zero-dose children are living. This will include differentiated approaches targeting

the different settings where most zero-dose children live including in remote rural, urban, and conflict settings and among mobile and displaced populations. The Alliance is encouraging countries to use the following IRMMA framework to develop and implement these approaches:

- Identify: How many zero-dose children are there? Who are they? Where do they live? And why are they currently being missed?
- Reach: What are the tailored strategies that can be used to reach these populations? How do we bring together the “supply” and “demand” interventions to overcome the barriers they face?
- Monitor & Measure: How do we monitor implementation, learn rapidly what works and what doesn’t work and adapt over time?
- Advocate: How do we make reaching zero-dose children and missed communities with immunization and other PHC services a priority for decision-makers and partners at every level?

Rebecca Fields: Please see this blog written by the MOMENTUM Routine Immunization Transformation and Equity and MOMENTUM Country and Global Leadership projects outlining strategies for reaching zero-dose children. <https://usaidmomentum.org/reaching-zero-dose-children/>

MANY OF TODAY’S PUBLIC HEALTH LEADERS BEGAN THEIR WORK AS FOOT-SOLDIERS IN THE FIGHT AGAINST POLIO AND CORRESPONDING DISTRIBUTION OF VACCINES. GIVEN THE STATED SHORTAGE OF 400,000 HEALTH WORKERS, DO YOU THINK SIMILAR OPPORTUNITIES WILL BE AVAILABLE FOR EMERGING PUBLIC HEALTH PRACTITIONERS TO PARTICIPATE IN THE DISTRIBUTION OF THE COVID-19 VACCINES? (THOUGH I UNDERSTAND THE NEED TO DECOLONIZE GLOBAL HEALTH SO THE TWO SITUATIONS MAY NOT BE ENTIRELY COMPARABLE.)

Dra Graça Matsinhe - Surely this is being considered given the shortage of health workers at all levels. We are mobilizing students in last year of medical training to support COVID-19 vaccine delivery.

YOU STARTED ADMINISTERING THE FIRST DOSE IN MID-MARCH, AND BY APRIL YOU STARTED ADMINISTERING THE SECOND. WHAT IS THE REQUIRED TIMEFRAME BETWEEN THE FIRST AND SECOND DOSES?

Dra Graça Matsinhe - The interval between doses varies by manufacturer. In Mozambique, during the first phase we used Sinopharm vaccine, which has 21-day window between doses. Now that we have started the second phase, we are using Covishield vaccine, which has 8–12 week interval between doses.

ANY COMMENTS FROM THE PANELIST ABOUT THE NEED OF OPERATIONAL COST FOR COVID-19 AND RI: IT SEEMS THAT IS THE ELEPHANT IN THE ROOM!

Dr. Folake Olayinka - This continues to be a big challenge in many countries. The operational cost for COVID-19 and RI needs more attention and support. This includes effective budgeting and ensuring financial flows are smooth. Operational resources need to be mobilized from domestic resources from public and private sectors and other external sources. We will continue to flag it as an important issue in global and regional working groups.

WHAT IS THE THINKING ON SAFETY IF COVID-19 VACCINATION IS DONE IN CONJUNCTION WITH RI? ARE YOU TALKING ABOUT SIMULTANEOUS SHOTS OR AN RI SHOT FOR CHILDREN AND COVID-19 SHOT FOR MOTHERS? INSTEAD OF HAVING INDIVIDUAL VACCINATION CARDS OR COVID-19 PASSPORTS, HOW CAN CAMPAIGN PROOF-OF-VACCINATION CARDS (MEASLES, COVID-19) AND EXISTING HOME-BASED VACCINATION CARDS/MOTHER AND CHILD HEALTH HANDBOOKS BE INTEGRATED?

The target groups for COVID-19 and RI are different. Currently COVID-19 vaccine is approved for administration only to those age 18 and over, whereas children are typically vaccinated in the first two years of life through RI. The difference in target groups for the two types of vaccinations would also make it difficult to develop an integrated home-based record, which typically provides the vaccination history for a single person.

MUCH OF THE POPULATION WORLDWIDE IS CONCERNED ABOUT BLOOD CLOTTING AFTER COVID-19 VACCINES. WHAT WILL BE BEST TO CONVINCE OLDER POPULATION?

Dr. Folake Olayinka - Following detailed reviews, the European Medicines Association has issued a statement that AstraZeneca vaccine benefits outweigh its risks. The best way to convince older populations is to provide facts in clear and transparent ways. Identify and engage trusted voices in the communities to provide information and continue to use multiple channels (e.g., social media) to give information and respond to questions and concerns. U.S. CDC and FDA also investigated plausible causal relationship of Janssen COVID-19 vaccine to thrombosis (with thrombocytopenia syndrome) and has issued a statement of confidence in the vaccine and recommends its use without age restrictions.

Please refer to these tools for generating acceptance and demand for COVID-19 vaccine:

<https://www.who.int/initiatives/act-accelerator/covax/covid-19-vaccine-country-readiness-and-delivery/acceptance-and-demand>