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

Webinar Transcript

00:00:02.01 >> I'll give them another minute until 59 to join. Then we can start. Okay, it's 3 on the dot, and I think we can start on the webinar. Good morning, good afternoon and good evening depending on where you are. If you have not already done so, please introduce yourself by typing your name and organization into the chat. My name is Chilunga, and I am a senior immunization data advisor for the MOMENTUM Routine Immunization and Transformation and Equity Project. I'm based out in [Indistinct], and I'm pleased to introduce to you today's webinar on targeted assessment to identify zero-dose and under-immunized children. Our guest goes through basic housekeeping and review the Zoom environment for this webinar, and today's webinar is available in English and French. We are offering some [Indistinct] translation services in French. You can access the French-speaking channel by clicking on the interpretation icon. You can see something like looks like a globe at the bottom, and you can choose the language of your choice. You may use the chat feature to introduce yourself as I said before but please do not use the chat to ask questions. Instead please use the Q and A button you see at the bottom of your screen located at the bottom bar of your Zoom window to ask questions or request technical help. We will collect all your questions for our speakers to answer and will save them for the discussion period following the presentation. The webinar is being recorded, and following today's event you will receive an e-mail with a link to the recording. If there are questions that we do not manage to answer by the end of the session, we will forward them to the presenters and share responses by e-mail. Right, so we come to our excellent speakers. Maybe we can move the slides along, or is it just for me that it's static? Uh-huh, again, so that discovered that. I will not be covering that here. I want the beautiful faces of ... Yeah, that's it. We have four excellent speakers today. The first to be Jessica Shearer, who is our Monitoring and Evaluation and Learning lead for MRITE, and she will give us some background on targeted assessments and service and introduce to us a useful decision tree. Next online will be Dr. Ana Morice, who will share experiences with rapid-coverage monitoring. Ana is a medical epidemiologist and a pediatrician who has worked for both [Indistinct] and PAHO, and then we'll be joined by Dr. Shehu Sambo, who is the Director of the Primary Health Care Agency in Jigawa State, Nigeria, where he is in charge of all the state's immunization, reproductive

health and nutritional services. Right at the end but not least, I will have a very able discussant, Sarah Wanyoike, who is a Vaccine Preventable Disease Team Lead for the WHO-IST in Eastern and Southern Africa, and she will actually discuss some of the discussion link on the assessment to the WHO's, the big catch-up, so that should be quite interesting for all of us because we all want to catch up, and so we will, yeah, we will listen to her at the end of the major presentation. Now to kick us off, I'll introduce the MOMENTUM Routine Immunization Transformation and Equity Project, the zero-dose children's kit and the learning exchange series. Then I'll turn it over to Jessica and our guest speakers to present on the targeted assessment and share their experiences. We'll have about 15 minutes at the end of the webinar to answer your questions. Our speakers will be available during the Q and A so be sure to share your questions in the Q and A box, not in the chat box, please. So our project, the MRITE ... [Indistinct] ... Yeah, and the Momentum Routine Immunization Transformation and Equity Project, our vision is really that all people who are eligible for immunization from infancy throughout their life-course and especially the underserved, the marginalized and the vulnerable populations, that these people are regularly reached with high-quality vaccination services and use them to protect their children and themselves against vaccine-preventable diseases. That is where we want to get to. Can I have the next slide? The tool kit itself and the learning exchange, next slide, the purpose of the tool kit in the first place is to have, to meet the need for a one-stop shop of resources to identify reach, monitor, measure and advocate for zero-dose and under-immunized children. We know that there are many tools and guidance and documents out there, and this tool kit aims to pull them together in a user-friendly way, and the tool kit is linked and complimentary to already-available manuals and guidelines, so it is not being developed in a vacuum. It's linked to what already exists on the ground, next slide. This tool kit is in draft form, and we are refining it, and our methods to refining it, our approach to refining it is three-pronged, has three components. One is we have a design collaborative which has engaged five to 10 countries to provide input into the design and the content and the structure of this tool kit, what it should be like, and how should the different personas be addressed? And so on, we have collected some primary data, and we're at the stage where we want to start actually redrafting it. Secondly, we have a field test in Nigeria. We've conducted some interviews, and we've actually tried to use out the tool kit and get feedback that way, get you the feedback, and then thirdly are these learning exchanges like the one you're attending right now. Here we have different topics. Those of you that have been attending via Web app, we've changed these, but all of them are related to zero-dose and under-immunized children, the goal being that we get you the feedback and experiences to inform the tool kit that will build up demand, increase knowledge and skills for the methods and approaches that are outlined in the tool kit, so that is how we are approaching the refining of the tool kit, next slide. Okay, so today's topic is targeted assessment methods to identify, reach and monitor zero-dose and under-immunized children, and at this point I want to hand over to Jessica, who will take us through the introductory slide, Jessica?

00:08:58.89 >> Thank you, Chilunga, and thank you so much for everyone who has been able to join us today. As Chilunga mentioned, today's topic, our targeted assessments and surveys, these are a module in the tool kit because as we aim to identify, reach, monitor zero-dose children, sometimes we don't have the administrative data or the existing information to know exactly where these children live, why they are zero-dose, how many there are, et cetera. And as Chilunga mentioned, the tool kit

covers a range of topics. In our previous webinars we have covered triangulation methods using existing data. We have also covered using health information systems to identify and monitor zero-dose children, but today we will talk about these situations where, again, you may not have that data, and you have to either do a rapid convenience monitoring assessment or a targeted survey, next slide, please. So what are targeted assessments and surveys? These are assessments where the study population is a targeted subset of everyone who should receive vaccination services and used to identify, monitor and reach these populations. We know that most zero-dose children live in a few different settings so conflict settings, urban areas, other settings where they sometimes do tend to be a subset of a larger population, and we don't necessarily have the information in that specific context or for a specific subpopulation that we need to design and tailor services. So targeted assessments and surveys can use non-probabilistic sampling approaches such as rapid convenience monitoring. They can also use probabilistic sampling approaches, and we'll cover some of those as this webinar continues, and the choice of approach, and, again, we'll get through this today, depends on your information needs as decision-makers, as managers in health systems or as health care workers. We also note here that serology surveys are an option. In some of the settings where zero-dose children live, particularly conflict settings or settings of rapid urbanization, vaccine cards may not be available during surveys, and more and more often we're seeing sero surveys being used in these cases. A big reminder is that with any of these assessments or surveys, we're not only trying to understand whether children are vaccinated but why or why not they are vaccinated, and so we recommend here linking to other questionnaires to understand the drivers and root causes of under-immunization. Those include the behavioral and social drivers questionnaires and the WHO harmonized health facility assessment, so if resources permit you can combine a targeted assessment or survey with a health facility assessment to understand the extent to which the health systems and health services are ready and of appropriate quality to provide immunization services. And finally any targeted assessment should enable the immunization programs to design, implement and evaluate interventions, and you'll hear some really wonderful examples of that today, next slide, please. So as we mentioned, the first step in understanding if a targeted assessment or survey is needed is understanding whether you might have the information you need to identify or monitor or reach zero-dose children without extra data collection. If you have high-quality, fit-for-purpose existing information, you don't need to go through this extra step potentially, but if those data are missing or lacking, and you feel that there are gaps to fill in terms of information, the tool kit that we are preparing helps walk you through those decisions and those criteria and then helps identify different approaches that you could take to do a targeted assessment, and most of those approaches are based on what information do you need to take programmatic action so thinking through what decisions would you want to make at the level where you're working, and accordingly what type of data and evidence do you need to make those decisions? We're going to go to a table on the next slide which also shows the difference between probabilistic and non-probabilistic designs, but essentially if you have a need to estimate vaccine coverage, you probably need to implement a probabilistic targeted survey, and so you can see the list of those designs here, and we'll hear a great example of the use of LQAS from Nigeria later on. If you don't need to estimate vaccination coverage, but you do want to quickly know which children are not vaccinated and then quickly reach them, you can use rapid convenience monitoring, and we'll also hear about that example today from Ana and just to note that in this table here, what we're trying to really, again,

reinforce is, what is the level at which you want to make any type of inference or want any type of information to make a decision on how to reach children with vaccines? And so that's how this table is organized, helping to think through should it be a probabilistic design or not? And then thinking through at what level do you need information? Next slide, please, so now we are going to walk through two hypothetical use cases for a bit of fun, so I'm going to read these aloud, and people will use the chat function to put in the chat which of the targeted assessment or survey approaches these two stakeholders might use, so there's no right or wrong answer really but thinking through the very brief overview that I've provided, please put in the chat which survey or assessment approach you think might be applicable. So the first example, she's a manager of a health facility in peri-urban Santiago, Chile. One neighborhood in her area has experienced rapid population migration, and she suspects there are many zero-dose and under-immunized children who have not yet been linked with health services. Her team is ready to speak with them and bring vaccines and other services to this community, so what assessment approach should she use? So if you recall from the table that we just went over, and it was quick, but see if you can put in the chat any ideas of what assessment approach might be used for example one. It's a very local need for information, so let's see if anyone has ideas, and we have some responses in there, great. Okay, and we have LQASes coming in, rapid convenience monitoring, rapid assessment and survey, great suggestions. Feel free to continue putting in your ideas there. I'm now going to read example two, which is a bit different. So in example two, you are the EPI focal point for a large state in Nigeria. Some of your LGAs, local government authorities, have weak administrative data, so it's not data that is very useful for you to understand or have a good sense of the prevalence of zero-dose children or the root causes. More accurate information are needed for estimating coverage and planning tailored solutions. In this case, what assessment approach would you use? And for the second case, we have some hints such as estimating coverage, the prevalence of zero-doses unknown, so these are hints that this decision-maker would like a probabilistic approach so that he can make those estimations, and so we have LQAS, which is one of the probabilistic approaches proposed, yep, or probability proportion-based sampling, great, so we just wanted to give a bit of a flavor for the types of decisions, the types of trade-offs that people might be making when you're thinking about targeted investments and surveys for identifying, monitoring and reaching zero-dose children. We're going to hear some excellent examples later today. [Indistinct], if you go to the next slide, I think next we have a poll question for the audience so, Chilunga, over to you for the poll question. Chilunga, I think you're muted, but I'll just remind people that you should see a poll question in front of you ...

00:18:01.03 >> I'm sorry!

00:18:02.03 >> Oh, go ahead.

00:18:04.61 >> Yeah, yeah, you should be able to see a poll question that you need to answer. Basically you have to select one of four options, and it's a multiple choice. Katie, how is this going to ... I'm going to give them ...

00:18:25.49 >> Let's give them about 30 more seconds, and then we'll end the poll, and I'll show the results.

00:18:29.72 >> All right. Right, there we are. Most of you said, 69 percent rapid convenience monitoring, 55 percent household service using probability and proportionate, and then lot quality assurance came in at 41, and EPI 30 cluster survey came in at 17 percent. So these are the approaches that you use in the setting where you work. Okay, great, thank you for informing us. We'll move on to the next presenter, Ana?

00:19:38.46 >> Yes, can you hear me? Good day, everyone. My name is Ana Morice, and I'm going to talk about rapid coverage monitoring. I'm happy to see that many of you have experience on doing this, but I'm going to share experience in the region of, yeah, of the Americas, and the first slide is about what is rapid coverage monitoring? And in the Americas, it is a recommended method. It was recommended by the Technical Advisory Group of Vaccine-preventable Diseases, and they recommended this method because it's a method that rapidly can assess the coverage and also not only to assess but also to guide the local vaccination activities. It is a simple and low-cost tool that quickly assesses the percentage of people vaccinated but also provides additional information about the reasons why, about the whys. It is conducted by the local team and supported by subnational and national teams, but in some countries they use a way, they call it cross-monitoring so that one district goes to another district, so they exchange the experience, and also it works like an external assessment. It is a supervision tool, and in the Americas it has been reported as a good practice to asset not only the coverage but also the program performance and also to increase in in the need and long-term the access to vaccination services. We published this toolbox, and this is the link. We can share it after the webinar, and module three talks about rapid coverage monitoring, so you can review if you want to know more information about it, the next one. But also it is important to note what is not rapid coverage monitoring, and the first thing that it is not a probabilistic survey because it is not based on statistical sampling, and it does not weigh the results, so it's basically the information of the local area that their field teams is assessing. So the data obtained by RCM are not representative of the area, and that's important to take into consideration, and it should not be aggregated to calculate coverage in the localities, just the specific area that you are assessing. So it does not allow to draw inferences from the data of the population, just to make local decisions in a very small area, the next one. We have been using RCM for different purposes in the routine immunization vaccination services, also as a supervision tool. I'm going to share with you some experience about after the outbreaks or during the outbreaks to reach unvaccinated people and also to assess these areas where the virus can be circulating but also doing campaigns and after the campaigns, and in this moment, the [Indistinct] is also a good opportunity to use rapid coverage monitoring because it's a rapid tool, and it provides very helpful information for making decisions at local level. And we select the areas based on different criteria. In the routine, usually they select the areas based on these criteria but also randomly, but it is important to note that randomly, that not implies that it's a probabilistic [Indistinct], just a way about how to select the areas in case you don't have a risk area already selected. During supervision, the supervisor also selects based on risk areas but also randomly. That's another way, and of course in case of outbreaks, the areas are selected to detect new cases and also to assess if the people around the places where the virus are circulating are already vaccinated. And who is responsible? That's another key question. Usually the local health unit, but also it can be done by the outbreak response team in case of an outbreak and also during campaigns or catch-up vaccination, the purpose is to verify if the

vaccine coverage was achieved. It is implemented with the support of the subnational staff, or as I mentioned before it can be conducted by teams working in other areas, the next one. And in this moment after the pandemic, RCM can also be used to identify and reach zero-dose and also to conduct or to guide catch-up under-immunized communities because it facilities how to search the unvaccinated people, and it identifies the reason why the children or the people are not vaccinated, but also it provides an opportunity to clarify misconceptions and to guide the communication strategy if it is necessary. It is important for the field teams to go to the field and talk with the people in the houses, so it provides very helpful information at the local level, but also this is a tool that is helpful to assess the quality of vaccination records. Both vaccination cards, the population, they have the cards because this is an important tool to review if they are vaccinated or not but also to assess the vaccination registries in the health unit, so we have been using RCM as a tool when we conduct data-quality assessment. It provides information to support decision-making to whether target intervention. That's why this is one of the tools included in the tool book because this is a targeted assessment, but I think this is a very important one. It promotes better EPI program performance at the local level because it provides information in the reality of the communities, the next one. I mentioned that I wanted to talk about how and how to select the areas, and how many RCMs should we conduct? Well, it depends again. The selection criteria of areas considers risk factors, as I mentioned before, and some of these risk factors are contextual, dependent on the community. It could be tourism in some areas or migration or populations that are facing barriers in access to services or Indigenous population or urban areas, so it depends on the local context. Once those areas are selected based on those criteria, some of the other areas can be selected randomly, but, again, it doesn't mean that it's a probabilistic sampling, and it's just to assess the information at that specific local area. The number of RCM ... I'm going to show you an example in the next slide ... Is assigned at the subnational level based on the type of the target population, and usually 20 children are evaluated in each RCM, the next one. Another important thing about RCM is that the form is a very simple form, just a table, and in addition to assessing if that child is not vaccinated, we ask about the reasons why the child was not vaccinated, and in that case there are simple questions like this one. We ask questions about the reasons related to the population, the knowledge, the attitudes, the practices about vaccination, and it's important to adjust or tailor those questions to the local level. Here are some examples. I don't think it is necessary, or it is against my religion, so these questions should be adjusted to the local context. But also it could be reasons related to the health workers, to the knowledge, attitudes and practices like this one that is very common. "The health workers told me not to vaccinate my child because he or she was sick," so this could be a question to add in the form or reasons attributable to the immunization service. The service is too far. There were no vaccination supplies, so this ... example, and we change these questions considering the local situation, the next one. This is an example of RCM used after a measles outbreak. Here we have Puerto Ayacucho. This is an area located in the Amazonas in Venezuela so the subnational level, they segmented this Puerto Ayacucho in different areas, and they assigned the number of RCM to each one of these areas, two, three, four, two, four depending on the size of the population and also depending on the risk of that outbreak, the next one. And this is another example of a very different country. This is RCM implemented after a campaign, again, but [Indistinct] program campaign in Chile. Chile has a very mature immunization program and a great immunization electronic registry, so it's a country with high coverage and very good quality of the information about vaccines,

but even in this context RCM is helpful. In this case, they carry tablets because they have an an electronic information system to verify the vaccination status in the field, in the household, but also the field teams, they take vaccines and supplies in case they find any unvaccinated children. They vaccinate the children or the child they find, one unvaccinated child, and also they use these kind of notes to left in the household in case they need to send a message or they need to revisit at the Health Centre, the next one. And this is how we do the interpretation of the results. After we visit the household, we collect the information. If the community is well-vaccinated, more than 95 percent, that's that [Indistinct] of value that we use, so we use a check. Well, this community is well-vaccinated, and if it is below the threshold level or the expected coverage, we vaccinate the unvaccinated, and we decide an intervention strategy, and also if the coverage level is low, they need to repeat the RCM, the next one. So I think this is the last. This is a helpful tool because it is used for making decisions immediately after they finish the RCM, and here are some of the questions. So the field team asks if the results are showing that the children are vaccinated. It's also important to compare the RCM with the administrative coverage at the health facility. If the coverage levels were not achieved, what are the possible explanations? What did the parents or caregivers state for the target population not being vaccinated? Are there other unvaccinated populations located close that we need to go? What would be the most effective tactic for reaching unvaccinated? And finally, what actions should we take? [Indistinct], okay, thank you so much.

00:32:48.08 >> Thank you so much, Ana.

00:32:49.47 >> Thank you so, so much. That was great. We'll go into the next presentation from Nigeria, LQAS. I noticed most of you picked the LQAS as one of the things you do. I think it came second, top. That was the top, so I'll just invite Dr. Sambo to lead us through their experience of using LQAS in Nigeria, Dr. Sambo?

00:33:18.24 >> Okay, good day to everyone, and my name is Dr. Shehu Sambo, Director of Primary Health Care, Jigawa State, Nigeria. So this is the outline of the presentation. I'm going to talk more on health affairs as well as other assessment tools that we have in this state to reach out to zero-dose and unvaccinated children, introduction Jigawa's efforts in zero-dose reduction, rationale for selecting the survey design, planning and implementation, analysis, result, recommendation, next slide. So Nigeria has a country has made commitment to reduce zero-dose children by 30 percent in the next 2 years. That is by 2025. We have 100 priority local governments selected across 18 high-burden zero-dose states. You can look at the map of Nigeria on your left-hand side. You can see that most of the zero-dose children or the LGAs that have zero-dose children are located in northern part of the country where my state, Jigawa State, belongs. So Nigeria developed a strategy called the Strategy for Immunization and PHC Strengthening, NSIPSS 2.0, which has in its components sustainable financing, data management and innovation, human resource and institutional capacity, leadership management and capacity as well as the effort to have one team, one budget and one plan approach, which is the concerted effort for us to have a donor coordination mechanism so as it have synergy in terms of tackling the problem of zero-dose children in Nigeria, next slide, please. So this is my state, Jigawa State. It's one of the northern states of Nigeria. It has a border with Niger Republic. The population of Jigawa State is a little over 7 million children. It is an M-RITE state. That is the MOMENTUM Routine Immunization Transformation and Equity is supporting us in this state. If you look at the breakdown of

the population, you have migrant population accounting for 18 percent of the population. There are areas where we have block rejection settlements, seasonal flooding, the international markets, and then you look at the hard-to-reach areas. Those are settlements which are very difficult to actually reach, 18 percent of that. So according to our numbers, the zero-dose children in the state account the number up to 115,129, and if you look at the proportion of under-1 children that is the target for [Indistinct] immunization from the whole population of the state is 4 percent, which is close to 300,000 children, and each year we are expecting 5 percent of the women to be pregnant, which is also over 300,000. During COVID, Jigawa State did very well because we had 100 percent coverage of our targeted population, which is around 3.7 million children. You can look at from the last multiple indicator cluster survey of which focuses more on immunization. The birth dose for hepatitis 0, 60 percent according to that survey, and had 3 coverage, 49 percent, measles one coverage, 56 percent, so we have a lot of work to do. We had diphtheria outbreak. In some local governments there are issues with measles, pertussis, CSM. These are all vaccine-preventable diseases, which shows that we haven't covered the population. There are a lot of work to do. As I mentioned, there are international borders. Then if you take the rural LGAs ... We have 27 LGAs, local government areas ... The rural local government account for 90 percent of that. There are interstate borders and 17 local governments, and the vehicle for delivering immunization and primary health care services is the Jigawa State Primary Health Care Development Agency, next slide, please. Okay, so now strategies in Jigawa State for addressing the zero-dose and immunized children, number one, you can see the assessment and the co-creation. First we need to identify where are the zero-dose and under-immunized children. That is where our selection of the method comes in. We are doing the lot quality assurance sampling as well as ... The lot quality assurance sampling, that's the LQAS. It's driven by the National Primary Health Care Development Agency and conducted every quarter, while in Jigawa State we have added what we call RIRA. That is routine immunization, rapid assessment as well as the routine immunization supportive supervision. All of these methods help us identify zero-dose children as well as under-immunized children. We then engage the communities to show them the gravity of the problem where those children are located. Then we move to number two with the capacity building. We train our health care workers. We mentor them, and if there is any adaptive learning, we incorporate that into the capacity building to be ready to take the task of reaching out to those children already identified. And then with demand generation and commitment, we pay a lot of advocacy visits to communities, to community gatekeepers, stakeholders and immunization community engagement, demand generation, behavior-change programming, so all that is into the demand-generation activity. So we move to service delivery. We start with updating our micro-plans, making sure that you incorporate every child, every settlement so that you cannot miss anyone. Then you star targeted outreach services, optimized your fixed session. Then you follow up that with routine immunization supported supervision and also integrate all of that with any program going on be it polio campaign, be it nutrition program, into natal services, and women ... some of the women come with the children, so that's where the integration comes in. And then finally we monitor what happens, monitoring and supervision, review meetings, data-quality assessments. A lot of the data, the quality is much to be desired, so we do a lot of that, so that is the whole strategy assisted where we feel that all hands on deck would be able to reach out to all the zero-dose children, next slide. Okay, so now service delivery, I think we have said that, supportive supervision. We triangulate demand, service and commodity data, community mapping and

outreach planning then provider behavioral change. Some respondents, caregivers, parents, mothers tell us that it's the behavior of the caregiver that's making them not to come, so we are also working on that, so monitoring, community and social listening, feedback loops. We give a lot of feedbacks especially to our traditional religious leaders. We collect data, analyze, manage rumors and misconceptions around immunization. We also report the adverse effects following immunization, though some of that also prevent ...

00:42:40.51 >> Uh-oh, we seem to have lost then Dr. Sambo.

00:42:44.46 [Chatter]

00:42:46.28 >> Okay.

00:42:49.20 >> Okay.

00:42:50.28 >> Carry on.

00:42:51.82 >> Oh, okay, so you can see much we reach out to March 2023, seven percent of the zero-dose children and then April 12 percent, June 2023 8 percent cumulatively. We reached 27 percent of the children, which are close to 30,000, so if we go by these numbers, Jigawa State is going to come out of the states with zero-dose children by the year 2023. Nigeria is targeting 30 percent. Jigawa State is targeting getting out of states with zero-dose so next slide, please. Next slide, okay, good, so this is the lot quality assurance sampling table for Jigawa State. We started this activity way back in quarter four of 2017. As I said, Jigawa State has 27 local government areas. You can see them on your left-hand side of the screen, their names, so you can see the best LGA sampling that was conducted. We had no local government area in green, so all of these local governments, the lots were not accepted, so they failed the lot. Coming to the next quarter, let me say that the LQAS is conducted every quarter, every 3 months, so four times in a year. So you can see quarter one 2018, we started having a green local government, which is very key in that quarter. Quarter two we had two local governments, quarter three, and we started moving. We reached our peak in quarter three 2019 where we only had a yellow LGA in that quarter, which was green. The yellow LGA means that for you to be green, you need to have eight or less children sampled that were not vaccinated out of 60 children, so that's the guideline. So quarter three 2019 to quarter one and two and three 2020, something big happened to the global community, which is the outbreak of COVID-19, and that hugely affected the immunization services who were able to come back to do the LQAS sampling in quarter four of 2020. You can see the results. Actually a lot of local governments were in yellow, and we moved on to 2021 where now we are trying to pick up the pieces. More green LGAs that are coming out, so that is the picture for Jigawa State when the lot quality assurance sampling was started, and we give feedback to all the LGA team members for immunization every quarter. After every result is shared, we come together. We look at the results. We map out strategy, mitigation plans and all that is needed, community engagement, everything to be put in place for us to reach out to those children across the local government in yellow or in red, but those that are in green are rewarded and then told to do more to maintain the status, next slide. Okay, let's move to the next slide, so you can see if we embed the RCM in supervision, which is the routine immunization supportive supervision community survey in ... from October this year to ... from January to October this year, we're able to sample 65,000 children, 650.

Out of that, fully immunized accounted for 55,138, partially immunized 5,303, not immunized, those are the zero-dose children, 1,173. So you can see this is a routine immunization supportive supervision. It's not the LQAS I presented, so all the unvaccinated children and partially vaccinated were reached out with antigens and linked up with service subsequently. That is the advantage of this over the LQAS. You later go and find out the children. This one you immunize them there, and then when you reach any partially immunized child, you update this immunization status and call on the immunization status provided covering that locality using the micro-plan they have. All the REW micro-plans are reviewed, hundreds of them, hundred health facilities who are supported. Four of the REW micro-plans reviewed incorporated a missed identified settlement and population. You can imagine a whole settlement or a population missed, so that's the importance of these RISS survey, to next slide. Okay, so on the rationale for selection of these methods, the other method is RIRA, as I said, routine immunization rapid assessment. So these are already funded activities, is they are into the state plans. The routine immunization, supportive supervision and the RIRA, they have existing tools already. The personnel are trained to conduct this assessment using them, so the lessons that were learned from planning and implementing the RISS community survey. In particular one, as I said, tools already exist for community survey to identify, reach zero-dose children, and they are cheaper to deploy and more sustainable. Health care providers have been trained on deploying these tools. This approach enhance linkage between health facility and the community. The state actually developed these into the plan as a response to what we get out of the lot quality assurance sampling that comes out every quarter where this supportive supervision happens every week. RIRA, too, happens every 2 or 3 months in the state depending on the plan so recommendations now is thinking that we need to sample more children, more than the 10. Because of time I didn't tell you the methodology, how to select, how to select the number of settlements and all of that, so we want the selection to be from 10 to 30, more children to be sampled, then timely release of back end data for decision and action. This concerns the nationally driven lot quality assurance. The LQAS is a probabilistic approach of sampling that we do, as it was highlighted before so improve monitoring and mentoring on the conduct of the routine immunization supported supervision, and then more accountability measures need to be put in place for us to do better as a country and a state. So I think I ...

00:51:31.40 >> Thank you.

00:51:32.25 >> ... first slide, if I'm not, so thank you very much for listening, thank you.

00:51:38.95 >> Thank you, Dr. Sambo, and you for the interesting questions that you'll discuss afterwards. Before I turn it over to Sarah for her perspective on [Indistinct], you'll see poll questions there. There are a couple of them, and, yeah, they relate to approaches and use cases. Could you answer them? Katie, how long do they have?

00:52:02.68 >> Since we're short on time, let's do about 30 seconds, and just to make it clear, it's two questions for folks to answer.

00:52:09.70 >> Okay, there you go, 30 seconds, half a minute. All right. So which approaches would you want to learn more about? Top is rapid convenience monitoring, and then there's household surveys, but almost at tie is LQAS and AP 30-cluster, so our biggest need according to this is rapid convenience monitoring. What use cases do you have for a targeted assessment where you work

[Indistinct] there? It's identified specifically who they are and where they live. Yeah, it's true. That makes sense. And then following on that is [Indistinct] interventions and then identify the problems and then to inform catch-up and recovery strategies. So with that I'll move on to Sarah. Sarah, can you do 5 minutes because we're really short of time?

00:53:40.52 >> Oh, yes. I'm from Kenya. We run marathons, so, yeah, I can do even less. Yes, thank you very much, Chilunga and facilitators. Thank you very much to the presenters, also. I think this has been a very useful and insightful session, very good to learn about the different experiences from the countries with the rapid convenient surveys as well as the LQAS. I think in terms of reflecting, I think maybe mine is a question that I didn't put there, but I think one of the issues I'd like to bring for consideration is costing of how much these surveys cost to do because I think that's a question most of our countries are asking right now. Another thing to think about is, as we are doing all these catch-up activities and there's different partners on the ground doing catch-up activities, how do we ascertain that we are ... Because in a big catch-up that we're doing there is recovering, coming back to 2019 numbers, but then also there is restoration, which now also goes into building now sustainable health services, so it's about resilience, and it phases into it. So I just wonder how all these numbers as we're monitoring, as we're thinking about it, at one point have we recovered? At what point have we restored our programs? At what point do we now start re-engaging a little bit and shifting gears to talk about sustainable programming? So maybe just reflect on a meeting we had here in Brazzaville with original technical advisory group, and these are discussions we've had extensively. One thing we have talked about, a lot of the investment has gone into identifying zero-dose children, zero-dose communities, and I appreciate some of the presentations are actually asking the why. Why are they zero-dose in the first place? So that we can actually address and modify as we go. The issue with this here is, is it really a one-off activity to do catch-up activities? Or is it something that should be built into annual program planning, next screen.

00:55:52.16 >> Hi, have you dropped? Or are you finished? Okay, okay, are you back?

00:56:02.25 >> No, this is Jessica. It sounds like she maybe dropped, and so why don't you go ahead with some ...

00:56:06.81 >> [Indistinct] questions.

00:56:07.58 >> ... questions?

00:56:08.19 >> ... Yes, so since our discussion has unfortunately dropped but we don't have a lot of time anyway, this brings us to the end of our presentation, and we'll just spend the last few minutes to look at the questions better in the chat, and there are quite a few interesting questions, and I'll address these to the panelists that are actually left. Muhammad [Indistinct] asks, there are a significant number of zero-dose and unimmunized children among the nomadic populations between Nigeria, Chad, Cameroon and Niger. Could you please share specific and tailored strategies to vaccinate them? Is there any collaboration between the countries? Maybe I'll address this to our Nigerian colleague.

00:57:04.73 >> Okay, Dr. Sambo is speaking.

00:57:10.37 >> Yes, sir.

00:57:12.00 >> Yeah, what we do, that nomadic population actually crisscrossed countries looking for greener pastures for their cattle, goats and sheep, so usually we have cross-border meetings, but those concern mostly campaigns generally, not [Indistinct] In Nigeria, a lot of the countries in borders speak French, and our child health card which contains the immunization data of the child is in English, so I think here is a great question telling us that there's more to be done in collaborating between the countries because this nomadic population crisscrossed the countries. They don't have any border, international border, and now we need to sit down and harmonize our child health cards so that when they cross into Niger Republic or Chad, they will be able to read what we have done, and they carry on from there. When they are coming back, we should look at the cards and see, okay, which immunizations are pending for the children and update that, so by the time they are going back, the child could be fully immunized. In Jigawa State, as I said, there is the border of Niger, and they crisscross down to Cameroon, as he said. Muhammad is right there and into Chad, so we need to do more there. Right now we do a bit. We have groups, immunization teams that target nomadic population. We also have support from African Field Epidemiology Network and CDC targeting exactly nomadic populations, and we incorporate those into our plans. We know their route, where they pass, how they pass, through which LGAs, and we do catch up. We meet them. We discuss, and there are people that speak their language in Jigawa State, so we do that, but more on this to be done. Thank you. I hope somebody can add on this.

00:59:34.97 >> Thank you. Now we've only got 1 minute. Can somebody add on briefly? And while we are waiting for somebody to add on briefly, please don't forget to do your feedback. You can scan the code, the [Indistinct] code at the end of the presentation or use the link that has been provided. There was another question from Nancy Foreman, and it has been answered by Jessica, but I think just so that everybody hears it. "Based on the zero-dose tool kit work to date, what type or types of data collection would you recommend for more deeply understanding why children are zero-dose or underimmunized in local context? And will such data collection be included in the zero-dose children tool kit?" And Jessica responded, "Hi, Nancy. The tool kit to link the existing tools for understanding why such as the BeSD questionnaire. We also hope to build out more goal creation and root cause analysis tool." Thank you so much. We are on the hour, on top of the hour, and therefore I'd just like to thank everybody, please. For all those who have attended, thank you for your time. For me it has been a very exciting webinar, a lot of learning, and we hope that you'll continue the learning going forward, and please don't forget to do that evaluation, yes, and any questions that have not been answered, we'll follow them up, and, yes, we just want to thank you again. Have a good morning, day, afternoon, evening as the case may be wherever you are. Thank you very, very much, but please do, do the evaluation. Scan the [Indistinct] code there and do the evaluation. Thank you so much, everybody. Thank you.