MOMENTUM

Routine Immunization Transformation and Equity

# TURNING DATA AND DATA SYSTEMS INTO ACTION: REACHING AND MONITORING ZERO-DOSE CHILDREN IN NIGERIA

## Webinar Q&A

**QUESTIONS EXTRACTED FROM THE WEBINAR Q&A BOX EDITED FOR CLARITY, WITH RESPONSES ADDED BY SPEAKERS AFTER THE WEBINAR.**

### WEBINAR PRESENTERS

- **Adam Attahiru**, MPH, Senior Monitoring, Evaluation, and Learning Specialist with the African Field Epidemiology Network (AFENET) – Nigeria.
- **Dr. Sa'adatu Ibrahim Ringim**, Jigawa State Immunization Advisor, MOMENTUM Routine Immunization Transformation and Equity.

**With the evolving context and a deeper understanding of zero-dose children and the factors driving children to remain zero-dose, we recognize the crucial role that gender plays in immunization. Our program conducts concurrent monitoring, and we are considering additional indicators to gather further evidence on gender barriers and to identify more associations and correlations for analysis. Any suggestions other than gender disaggregated vaccination data and maternal education levels? ***

**Adam Attahiru**: Yes, other indicators around gender that could further deepen our understanding include: gender agency (i.e., power to take decisions for their health and the health of the child), participation of the husband in vaccination, preference of caregiver for female/male vaccinator, and caregiver socio-economic status.

*This was answered during the webinar so please watch the recording for the full response.

**Is it possible that if supervisors made it to the hard-to-reach areas and did the community survey there the people in those areas might feel more important and see more importance in immunization? ***

**Adam Attahiru**: Most certainly. Supervisors including State and LGA team visited hard-to-reach and some partially accessible terrains. The settlements were randomly selected using PPS without disaggregating by type of setting - hence all selected settlements were reached and supervised. During supervision, non-compliance cases, sensitization

and dialogue meetings were held in some hard-to-reach areas.

**Dr. Sa'adatu Ibrahim Ringim**: The far and hard to reach settlements, mostly the target for community survey and supervisors, are encouraged to apply the community survey component in these settlements, to gain more insight to the reach and access to service. The supervisors engage the community leader/health ambassador in such communities to conduct the survey along with him, who already feels important for the role he is recognized to play. The caregivers whose children are sampled and as a ripple are informed on the importance of immunization during the engagement for the survey.

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## How frequently you implement LQAS and how cost effective this method might be to use it as a method to monitor the changes? *

**Adam Attahiru**: The LQAs is planned to be implemented bi-annually. This will provide opportunities for adaptive learning during the process of implementation. As for the cost, the implementation of this methodology cost far less than the conventional surveys. In addition to its value add of identifying low performing sub-nationals or lower administrative level for quick and targeted intervention rather than the generalized aggregated coverage estimates. It adopts a sample size of 19 with alpha and beta error of <10%. The estimate from the presentation with large surveys was found to be within 4% and 7% for DPT 1 and DPT 3 respectively. The major cost driver was stipend for data collectors.

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## How much overlap and what differences were observed in the drivers of zero-dose and under-immunized children across these studies?

**Adam Attahiru**: Great question. Yes, having the opportunity to compare variation between under-immunized and zero-dose will further provide guidance and targeted information for implementation. We focused more on understanding key barriers affecting zero-dose caregivers. This will be explored as we already have the data.

## How are noncompliance cases handle in Jigawa?

**Dr. Sa'adatu Ibrahim Ringim**: I hope the following response addresses the question correctly. In households where noncompliance is identified as the reason for being either zero-dose or under-immunized, they are further engaged in dialogue/sensitization to provide information on the importance/benefits of immunization. Other related concerns of access to health services are also attended to such as outreach services where distances of communities are far from health facilities. Such cases are monitored for subsequent doses to confirm their compliance and engagement of relevant stakeholders for advocacy and sustained support with regular awareness creation and mobilization also helps.

## How rigorously are the findings of LQASs used? How does this translate into results? i.e., changes in coverage. *

**Adam Attahiru**: The Learning Hub aimed to synthesize and disseminate evidence to improve and refine program implementations across the different levels using approved engagement and a dissemination plan. Leveraging the Routine Immunization Technical Working Group, findings will be disseminated at the national and state levels to

inform program iteration and adaptive learning in both study and non-study districts. Findings will also be disseminated in a 2-day workshop with program managers, community gate keepers and facility incharge of PHCs. The workshop will leverage on the Zero Dose Reduction Plan already developed for re-design or review while engaging other partners for support and funding.

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How do you manage to access hard to reach settlements with small resources as you mentioned earlier?

**Adam Attahiru**: Data collectors were identified and recruited from hard-to-reach terrains and partially assessable and security compromised environment. These data collectors were centrally trained for 2 days (with hands-on-sessions). This reduced the cost of transportation and overall cost of implementation.

**Dr. Sa'adatu Ibrahim Ringim**: As mentioned earlier, supervisors among state and LGA teams were also assigned to supervise health facilities in their locality. This reduces cost of travel and allows advantage of familiarity of terrain.

## Given the success of these data-based strategies to find zero-dose children, did this lead to change in immunization of other children in the families i.e., catch older unimmunized children and for new babies born into these families after first intervention i.e., change in behaviour?

**Adam Attahiru**: Behaviour change is a gradual process. The findings have shown that trust and confidence in vaccines is a major issue amongst zero-dose caregivers. Strategies will be developed targeting sensitization and awareness creation on the benefit of immunization complimented by ensuring accountability measures on HCWs. Trend will be closely monitored and lessons iteratively feedback into RI programming.

**Dr. Sa'adatu Ibrahim Ringim**: Yes, for the zero-dose children due to reasons such as access issues. But for those due to no compliance or no consent it is indeed a gradual process. In addition, the A (advocacy) in GAVI IRMMA model plays significant role in enhancing the support through identified influencers/stakeholders.

## Is there future support for the Ward Technical Officers to implement their developed work plans to address zero-dose in Kumbotso LGA?

**Adam Attahiru**: To strengthen sustainability, it is key to leverage available resources from government and partners. Currently, there are plans to strengthen the capacity of the program managers on data analysis and insight generation to inform programing. This will be cascaded to Ward Technical Officer.

## Adam mentioned that the focus should shift from the caregiver mainly to the decision maker. HOW do we intend to do that? *

**Adam Attahiru**: The shift in focus should be from mothers (primary caregivers) to head of households to grant permission for caregivers to make decisions on their own health and the health of the children. This can be achieved by developing tailored materials targeted at the head of household at religious gatherings, community meetings, and peer-to-peer gatherings. Health media and social media platforms are other potential fora.

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