H2H tracing of Routine Immunization defaulters: Experiences from Tanzania & Uganda

PROJECT OBSERVATIONS AND OUTPUTS

By William Mbabazi,
American Red Cross Measles/Health Delegate

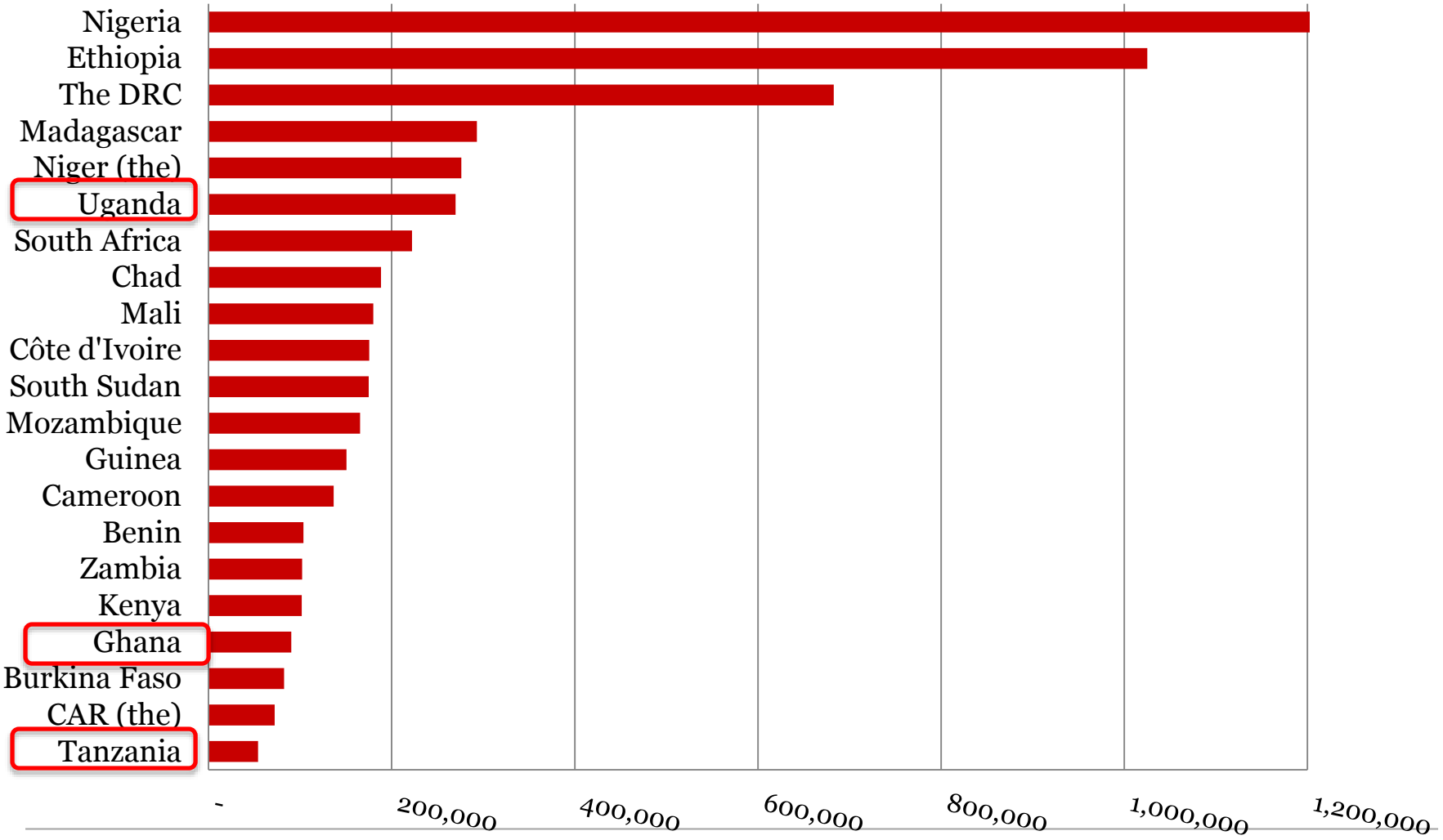
Outline of the Presentation

1. Background and rationale of H2H projects
2. Drivers of Under/un-Immunization in TZ and UG
3. Expectations of the routine immunization strengthening projects
4. Routine EPI Strengthening Project goals/objectives
5. Routine Immunization Strengthening Project outputs
6. Routine Immunization Strengthening Project outcomes
7. Discussion of Project outputs/outcomes
8. Lessons learnt and recommendations

House-to-House Strategy: Leveraging SIAs experience into Routine Immunization

- **From SIAs, ARC has learnt that:**
  - H2H canvassing reaches populations that are missed by traditional mass media, even in urban areas.
  - Data from 16 African countries showed that higher coverage are reached wherever H2H strategy was used
  - Cost per beneficiary averages $0.32 but can vary, being about $0.16 in cities compared to $0.57 in rural areas
- **Testing H2H Strategy in tracing RI defaulters:**
  - Prevention: ***Baby tracking in Kilindi district of Tanzania***
  - Correction: ***Defaulters tracing in 3 Dar es Salaam districts & 4 selected cities in Uganda***

WHO/UNICEF estimates of MCV1 un-immunized children in 2012, AFRO



Data Driven Selection of targeted Project countries

American Red Cross

Analysis of Drivers for Under/un-Immunization

A. **Immunization Services Delivery System**
   - Availability of Safe and potent Vaccines
   - Good Cold Chain maintenance and coverage
   - Good EPI Services Delivery plans that are effectively implemented
   - Immunization services monitoring (for monitoring of un-vaccinated)

B. **Health and System-wide barriers**
   - Adequate HR
   - Fairly functions Financing mechanism for EPI/Primary Health Care
   - Districts and sub-district management systems (in decentralized context)
   - High IMR/TFR (see Malthusian Theory)

C. **Community demand barriers (Priority for H2H Canvassing)**
   - Low knowledge/education levels
   - Limited Community engagement processes
   - Competing priorities
   - Information clutter
   - Lack of a reminder system among others

Routine EPI strengthening Project Areas

- **Selection criteria of Project Districts**
  - DTP-HepB+Hib/MCV1 coverage stratified by number of unimmunized children (using 2011/2012 WHO/UNICEF estimates)
  - Failed to achieve 95% coverage in the most recent *measles follow* up *(or MR catch up)* campaign
  - Recently trained Volunteers in Immunization
  - Large urban Populations/Historical large measles outbreaks (**+** viral seeding)

Routine EPI strengthening Project Areas Cont..

COUNTRY	Selected Districts	Project Population estimate	2013 Estimated Annual Birth Cohort in Project areas	0-59 months old children targeted for Polio SIAs (2011)	Routine MCV1 Coverage (%) for 2012	Year/Measles SIAs Coverage (%) (using IM Data)
Uganda	4 (including Greater Kampala	4,702,170	235,110	876,315	75	2012/84
Tanzania	**All 3 districts** of Dar es Salaam	3,368,363	168,419	639,989	98	2011/88
	Kilindi (Baby tracking)	186,946	9,348	35,520	126	2011/90.6
Ghana	**Seven** (7) Municipalities of GAR	3,442,090	172,105	619,577	78	2013/92.8
Total	15 Districts	11,699,569	584,982	2,171,401		

American Red Cross

Added Value of H2H Defaulters tracing by Red Cross to correction of Under/un Immunization

A. **Experience in Immunization strengthening**
   - Routine Immunization (2 decades)
   - Measles/OPV SIAs 1999-2012

B. **Organizational Capacity and structures**
   - Symbol of neutrality, hope and assistance
   - Network of volunteers that live and work with their communities
   - Significant number of Volunteers that have been trained in Health
   - Emergency and rapid response systems
   - Transport fleet

C. **Innovations**
   - House-to-house canvassing for immunization
   - Planning/Providing for missed children, even in the second year of life

Routine EPI Strengthening Project Goal

- **Same in All 3 Project Countries**

  House to house Social Mobilisation support for routine immunisation strengthening in selected districts with high numbers of unimmunized children

Routine EPI Strengthening Project objectives

Specific Objectives (in one year)

1. Train Volunteers as community resource persons in routine immunization
    a) 5,781 Volunteers in Uganda
    b) 1,780 Volunteers in Tanzania
    c) 980 Volunteers in Ghana
2. Conduct house-to-house visits to 95% of Households in selected districts to trace defaulters and remind/support them to update their infant immunization series

    Quarterly in Kampala and Dar BUT Monthly in Kilindi and GAR
3. Conduct active community search for measles-like illnesses with a view to early outbreaks detection
4. Reduce immunization dropout rates to less than 5%

Interventions for Routine EPI strengthening

1. **Skills enhancement of Community resource persons**
   - 5,777 Volunteers in Uganda
   - 1,542 Volunteers in Tanzania
   - 986 Volunteers in Ghana
2. **Advocacy meetings on under-immunization**
   - Project introduction meetings with selected district leaders
   - With priority community information gatekeepers (cultural and religious leaders)
3. **House to house Defaulters tracing visits**
   - Registering all the <5yrs popn in the households
   - Screen for routine immunization defaulters by antigen provided in the infant series
   - Share information on benefits of immunization (using 5 key messages)
   - Provide RI reminders to those children found defaulting

Routine Immunization Strengthening Project outputs

RI Project outputs (1)

Country	2014 Annual Birth Cohort in project districts	Red Cross Volunteers Trained & deployed (Actual/Plan)	Defaulters tracing rounds conducted	Defaulters tracing rounds paid for	PROCUREMENTS		
					Defaulters tracing Registers	Reminder stickers/ calendars	Red Cross Bibs
Uganda	242,634	5,777/5,781	4	3	6,000 x 2	50,000	6,000
Tanzania (Dar)	173,808	1,542/1,570	3	3	1,700	2,000	1,700
Kilindi	9,647	208/210	8	8	220	220	206
Ghana	177,612	986/980	1	1	1,000	1,000	1,000
Total	**603,701**	**8,513/8541**			**8,920**	**50,000 + 3220**	**8,906**

American Red Cross

URCS RI Project outputs (2)

DISTRICT	Estimated H/Holds	Households Visited				Immunization Defaulters traced			
		Jul 2013	Oct 2013	Jan 2013	Apr 2014	Jul 2013	Oct 2013	Jan 2013	Apr 2014
KAMPALA	298,976	177,725	186,667	NR	153,535	16,348	20,850	NR	24,191
WAKISO	215,170	108,913	169,535	NR	119,736	23,759	10,108	NR	8,183
ARUA	151,851	103,459	131,038	NR	123,981	24,000	5,332	NR	2,443
LIRA	70,719	49,294	62,166	NR	66,297	13,896	4,676	NR	738
Total	736,716	439,391	549,406	NR	463,549	78,003	40,966	NR	35,555

American Red Cross

Source: URCS Quarterly Project Reports

TRCS RI Project outputs (3)

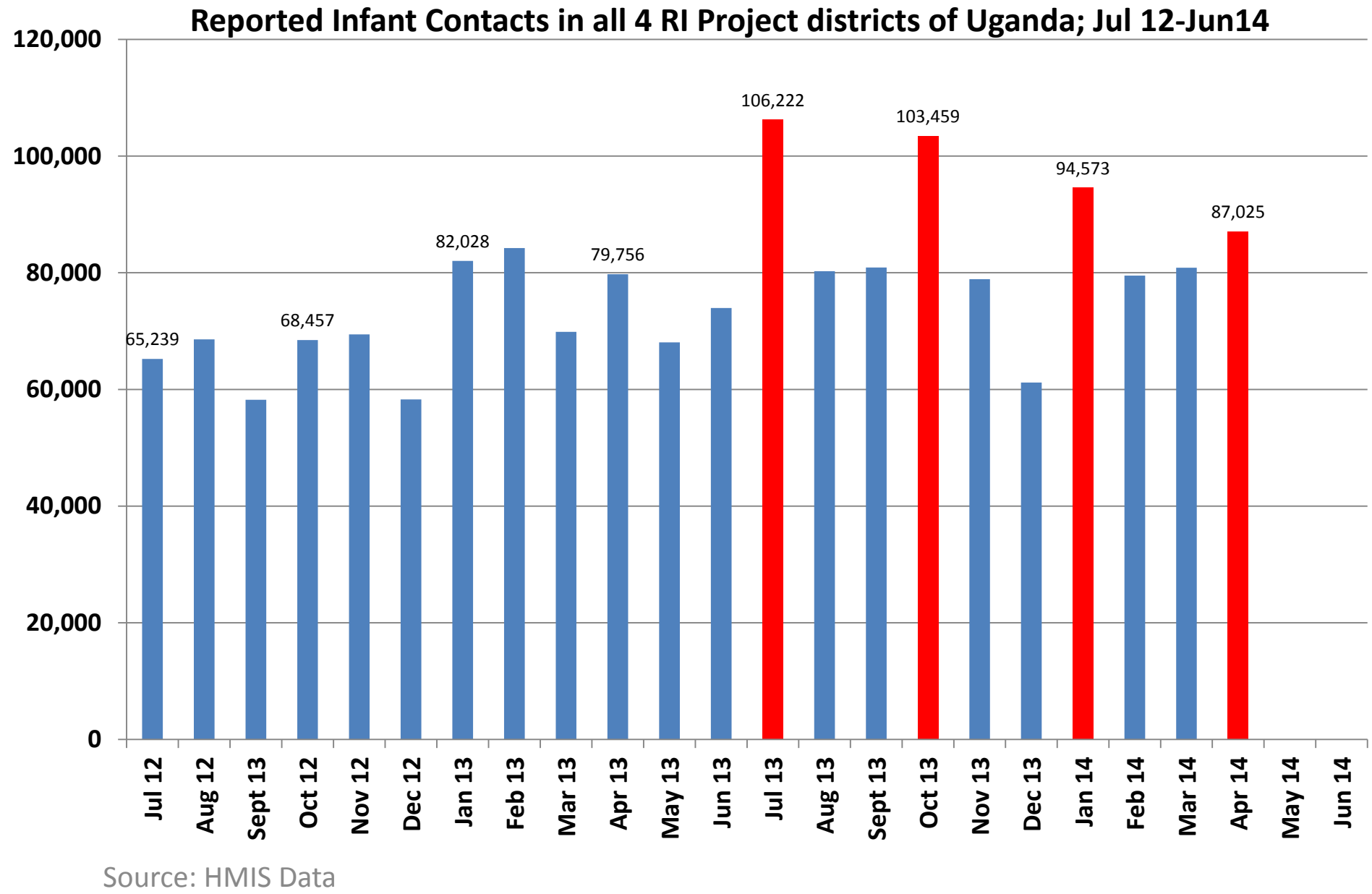
DISTRICT	Estimated H/Holds	Households Visited				Immunization Defaulters traced			
		Oct 2013	Feb 2014	May 2014	Aug 2014	Oct 2013	Feb 2014	May 2014	Aug 2014
Ilala	143,335	127,012	96,808	134,759	ND	22,287	19,430	11,947	ND
Kinondoni	244,289	157,001	168,552	182,338	ND	15,211	18,338	9,854	ND
Temeke	173,770	133,955	105,683	166,745	ND	12,591	9,765	5,729	ND
Kilindi	31,158	NA	28,674	34,855	ND	NA	482	296	ND
Total	592,552	417,968	399,717	518,697	ND	50,089	48,015	27,826	

American Red Cross

Source: TRCS Project Reports

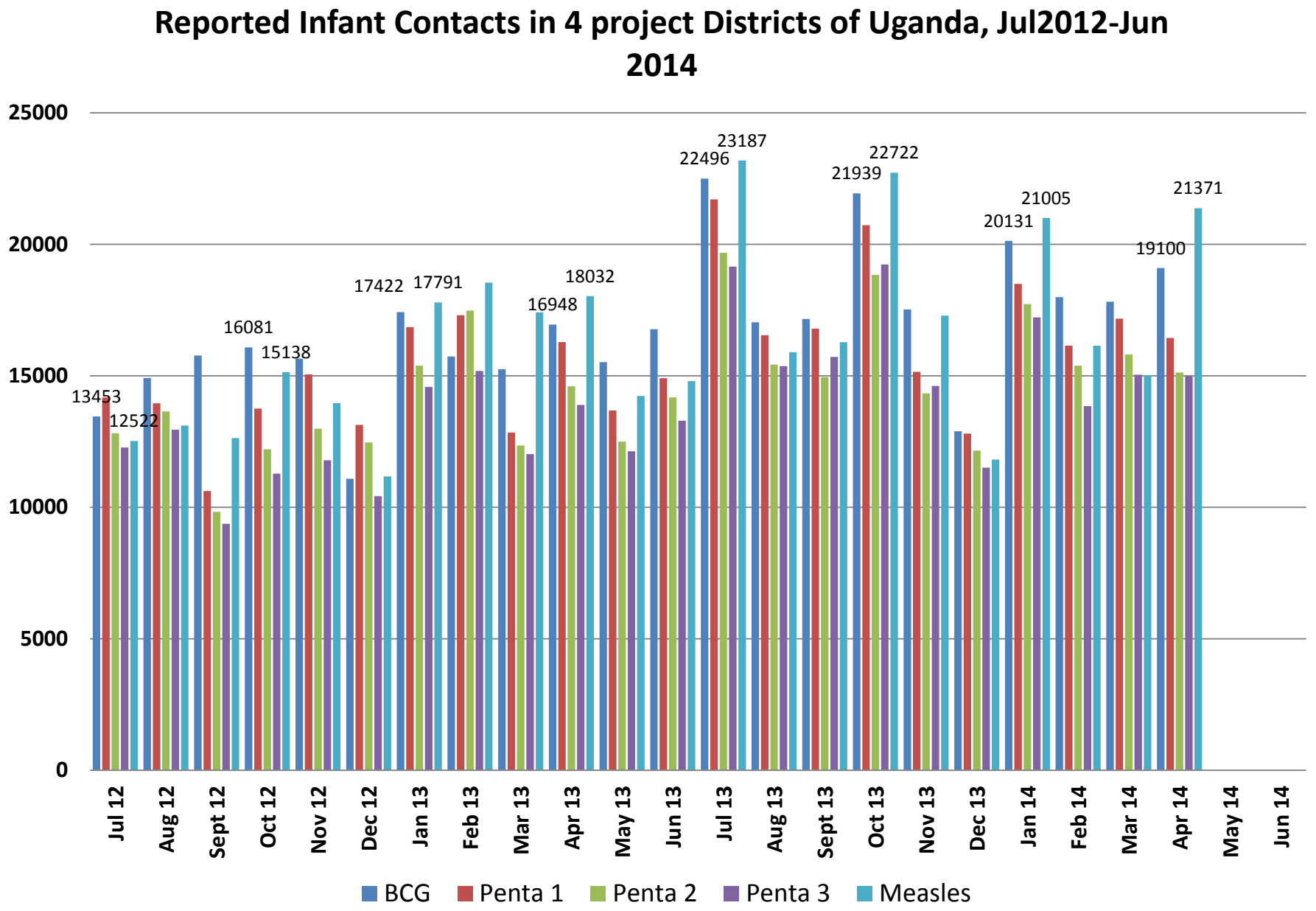
Routine Immunization Strengthening Project Outcomes: Only URCS Project has outcomes data

URCS RI Project Outcomes (1)



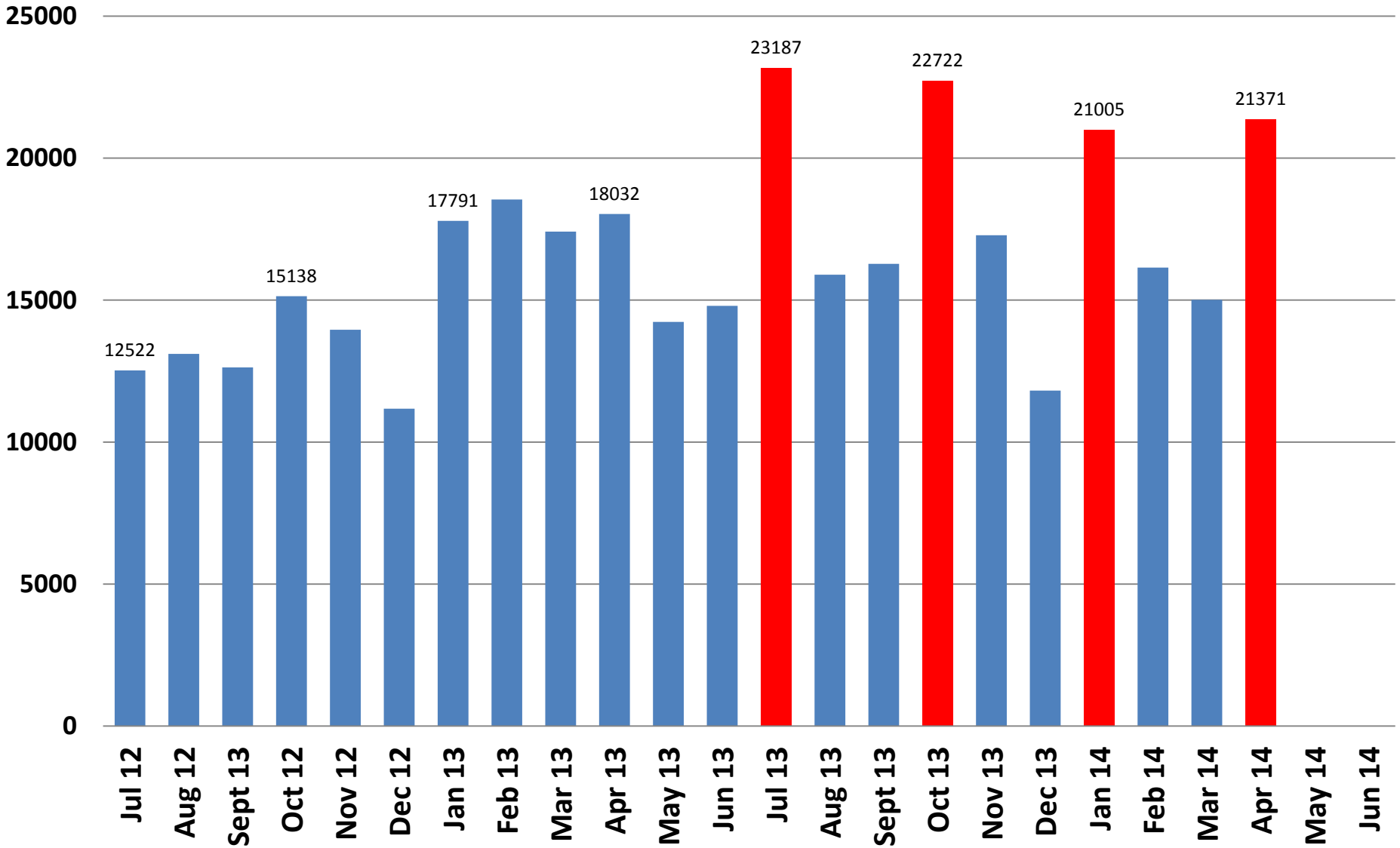
Source: HMIS Data

URCS RI Project Outcomes (2)



Source: HMIS Data

Reported MCV1 Immunizations in all 4 RI project districts in Uganda; Jul 2012-Jun 2014



Source: HMIS Data

URCS RIS Project outcomes (4)

DISTRICT	BCG Coverage (%)		DTP-HepB+Hib 1 Coverage (%)		DTP-HepB+Hib 3 Coverage (%)		BCG-MCV1 dropout Rate (%)		**Annual MCV1 Coverage (%)**	
	2011	2013	2011	2013	2011	2013	2011	2013	**2011**	**2013**
KAMPALA	115	103	115	101	100	87	15	0	**96**	**116**
WAKISO	83	86	100	98	100	97	00	-8	**94**	**86**
ARUA	39	102	41	117	35	98	26	3	**33**	**112**
LIRA	109	94	110	103	101	97	32	10	**84**	**96**
Total	86	94	91	106	82	97	22	8	**75**	**97**

Source: HMIS Data

Discussion of Project outputs/outcomes

1. **Recruitment of volunteers** was largely good. However, there was over-selection of volunteers in Kampala
2. **Training of volunteers was done in all project branches**. Also learnt that re-orientations were done before each round to fill in for volunteer dropouts. However, the training:
   a. Did not provide training/reference materials to trainees
   b. Had no standard trainer to trainee ratios
   c. Did not follow a standard training agenda to assure standardized delivery
   d. There were no pre and post training tests to assure that the volunteers would deliver on their tasks
   e. Missed the opportunity to engage national EPI staff in training and design of the information management system for the projects
   f. Duration of volunteers training varied from 4 hours to 8 hours.

Discussion of Project outputs/outcomes

3. **Suspension of project funding in Uganda (October 2013), was not effectively communicated to all project implementing branches. In turn, the branches deployed volunteers in the January round of FHDs but could not pay for the days worked**
4. **In Uganda, defaulters tracing registers were developed and printed twice with revisions in between. Noted that the revisions:**
   a) Were not a technical improvement as the revised tool missed reasons for immunization failure, a core project deliverable
   b) Interrupted the quality of data as volunteers did not have training on use of the revised tools
   c) Made loses in continuity of variables being collected
   d) No instructions on completing the defaulters tracing registers were provided
   e) Eliminated the summary forms that was essential to collation and analysis of defaulters tracing data
   f) Caused doubling of production costs for the registers

Discussion of Project outputs/outcomes

5. H2H Defaulters registration Data analyses

- Can quickly provide community estimates of Routine immunization performance indicators:
- Shows that 31% of children found, had defaulted on their infant immunization series
- Identified major reasons for immunization defaulters as:
  - Vaccine stock outs
  - Lack of Money to pay for child health cards
  - Fear of vaccinating sick children (both parents and vaccinators)
  - Fear of Vaccine reactions
  - Several family issues (Separation off children from mother, husbands refusal and lack of time in a busy urban lifestyle being the most cited reasons)
- Indicates that 89% of Immunization defaulters traced during H2H visits were corrected.

Discussion of Project outputs/outcomes

6. **H2H canvassing in all four rounds implemented in the UGA project was associated with increases in total number of immunization contacts**. This calls for coordinated planning of Red Cross social mobilization activities with service delivery provision. Alignment of H2H canvassing days with FHDs in Uganda is one such good example
7. **The majority of immunization contacts in the H2H canvassing days were MCV1, BCG, and 1st dose of DTP containing vaccine**. This made H2H strategy:
   - ❑ A good initiative for correction of missed immunizations after months of vaccine stock outs in Uganda.
   - ❑ An alternative initiative for raising population immunity against measles given the significant associated increases in MCV1 coverage
   - ❑ An innovation in EPI programming that targets correction of missed opportunities

Lessons learnt from RI social mobilization projects

Lessons Learnt/Recommendations (1)

1. **Improving the immunization defaulters tracing guidelines**
   - ❑ Develop a field guide to provide reference material for the volunteers while conducting H2H canvassing
   - ❑ Standardize instructions on management of households where child's mother/caretaker is absent
2. **Improving the quality of volunteer training in EPI**
   - ❖ Increase duration of volunteer training from 1 to 2 days
   - ❖ Team leaders/volunteer coaches should get extra and more detailed training on communication for EPI
   - ❖ Volunteer training content should be standardized and include pre and post training assessment of trainees before deployment
   - ❖ Trainer to trainee ratio should also be limited to at least 1:20

Lessons Learnt/Recommendations (2)

3. **Improving the quality of H2H canvassing**
   - ❑ Equip the volunteers with mobile phone-based technologies for real-time transmission of data collected
   - ❑ Include phone contacts on H2H registration formats
4. **Improving the coverage of H2H canvassing**
   - ❑ Increase the duration of H2H canvassing days
   - ❑ Provide minimum daily target of H/holds per volunteer

Lessons Learnt/Recommendations (3)

5. **Improving the information management system for H2H canvassing**
   - ❑ Train coaches in collation and summary reporting of H2H registration data
   - ❑ Provide instructions for completing the H2H registration on the back cover or 2nd page of the tool
6. **Dissemination and use of H2H canvassing data and its analyses**
   - ❑ Red Cross branches to provide quarterly reports to the District Health Authorities
   - ❑ Create linkages and cross-tabulations with HMIS

Lessons Learnt/Recommendations (4)

7. **Eliminating service delivery barriers to EPI services utilization**
   - ❑ Root-cause analysis and implementation of strategies for elimination of vaccine or EPI supplies stock outs
   - ❑ Training vaccinators in EPI communication
   - ❑ Establish a behavioral surveillance mechanism for detection of cruel/rude vaccinators
   - ❑ Eliminate charges for immunization services/supplies
   - ❑ Re-establish and monitor functionality of EPI outreaches

For Supporting American Red Cross Build Measles Resilient Communities