TechNet-21
The Technical Network for Strengthening Immunization Services

October 5th, 2022

Reaching Zero-Dose Children: Urban Immunization

Ijeoma Agbo, Health Specialist, UNICEF Nigeria
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Overview of Urban Immunization & Presenters

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unicef

AN URBAN WORLD

This graphic depicts countries and territories with 2050 urban populations exceeding 100,000. Circles are scaled in proportion to urban population size. Hover over a country to see how urban it is (percentage of people living in cities and towns) and the size of its urban population (in millions).

Urban Population
- Greater than 75%
- 50% - 75%
- 25% - 50%
- Less than 25%

https://www.unicef.org/sowc2012/urbanmap/

Why urban lens in programming?

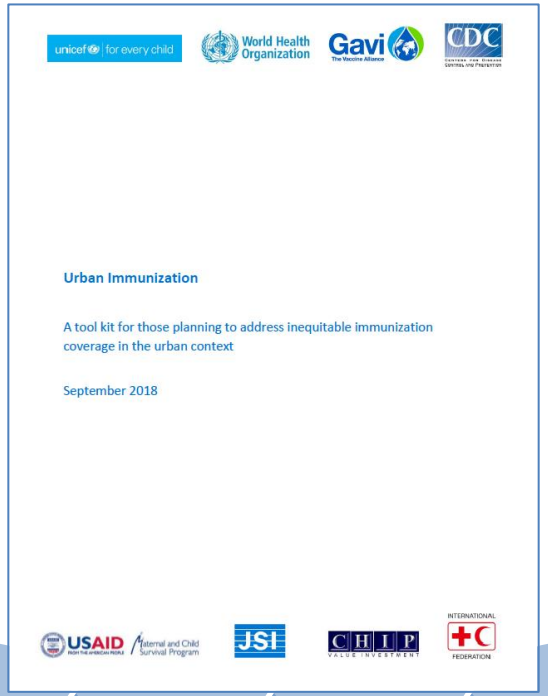
- Growing urban population and concomitant urban poor populations - by 2050, 66% of the world's population
- Widening disparities (urban rich vs poor) – need to improve health outcomes
- Use immunization as entry point for broader health platform
- Use learning from other programmes: polio, measles, nutrition, surveillance to prioritize high risk urban populations and neighbourhoods

Equity Reference Group (ERG)

There is little data on migrants and other disenfranchised people living in dense urban areas who, fearful of public authorities, don't seek health services. Political will to identify and serve them is also often lacking.

Accomplishments of the Urban Immunization WG so far…..

- Urban Immunization Toolkit
- Urban Diagnostics
- INFUSE challenge for urban immunization
- Increasing Country Investments
- Specific or tailored urban immunization strategies developed and being implemented
- Dedicated Page on the ZD CoP for Sharing information and learnings



JSI | US CDC | BMGF | USAID | LSHTM | Gavi | UNICEF | WHO

Overview of Presenters

Ijeoma Agbo will share the Urban Immunization: Experience in Reaching zero dose children in Lagos, Nigeria

Nassor Mohamed will share an assessment of inequities in routine immunization among the urban poor in four cities of Zimbabwe

Khawaja Aftab Ahmed will share the 24/7 Birth Dose Initiative in Pakistan

Urban Immunization: Experience in Reaching zero dose children in Lagos, Nigeria

unicef
for every child

Immunization team, UNICEF Nigeria
October 2022

INTRODUCTION

- Nigeria has **more zero-dose children—defined as not having received the first dose of diphtheria-tetanus-pertussis (DTP) containing vaccine**—than any other country in Africa and among the most worldwide. With 2.4 million zero-dose children, Nigeria represents the second highest zero dose children globally

- Although Nigeria has recorded progress in vaccination coverage, the zero-dose burden continues to be a challenge as 18%[1] of children under two years fall within this category

- Reaching zero dose children means reaching the zero dose communities they are a part of. These unprotected communities are not only potential epicenter's of disease outbreaks, they are also often deprived of other basic services and suffer from entrenched gender inequality. [2]

- Two-thirds of zero-dose children live in households surviving on less than US$ 1.90 per day – the international poverty line. Their mothers are twice as likely to miss out on antenatal care or skilled birth attendance. The homes they live in are less likely to have access to clean water or sanitation. A lack of immunization is just one of a range of problems.[2]

- Understanding the context-specific drivers of zero-dose is critical to developing tailored strategies to reaching the children

Source:

1. National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF). August, 2022. Multiple Indicator Cluster Survey 2021, Statistical Snapshot Report. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund.
2. WHO 'Immunization Coverage' 2022 <https://www.who.int/news-room/fact-sheets/detail/immunization-coverage>

LAGOS profile

Lagos state is estimated to be the 2nd most populous state in Nigeria with a projected population of over 14.9 million people in 2022 distributed across 20 LGAs and 376 wards

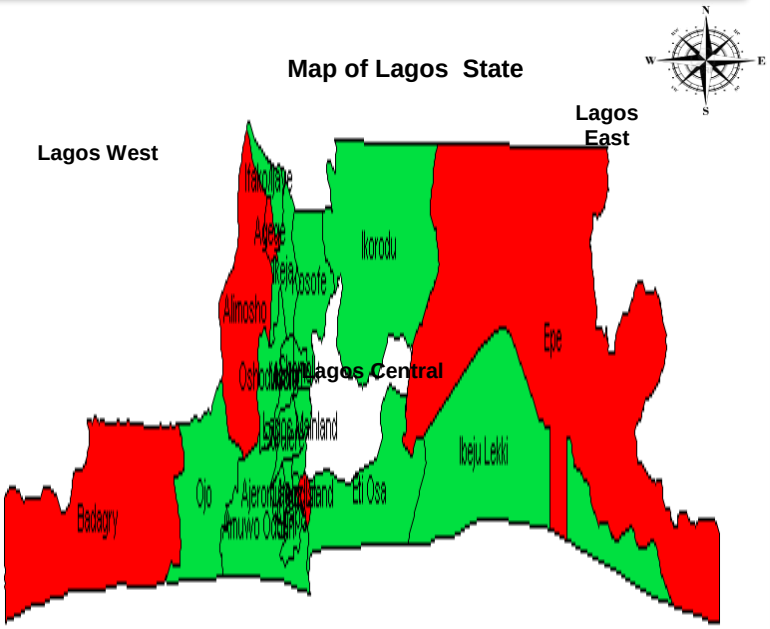
Demographics

Lagos census projected population (2022)	14.9 million
Under 1 yr Pop (4%)	600k
No of LGAs/Wards	20/ 376
Total no of Public facilities	(PHCs - 319, General Hospital - 24, Tertiary - 4, Military Hospital - 21).
Total no of Private facilities	1,816
Total number of Health facilities	1,193 (Public – 319 (27%), Private – 874 (73%)

Context

- In Nigeria, Lagos State is the smallest in land mass and arguable the most populous state.
- Lagos has enjoyed tremendous growth and currently stands as the 8th fastest growing city in Africa. The growth is driven mostly by migration and natural growth.
- The 2022 population of Lagos is now estimated at 14,920,049 with an annual population increase of 3.24% since 2015.
- There are 20 LGAs in Lagos composed of 16 urban and 4 rural LGAs

Map of Lagos State



Lagos has been dubbed the "mega-city of slums". About 66% of the population reside in slums with limited access to roads, clean water, electricity or waste disposal..

Context

- The Lagos State Urban Renewal Authority (LASURA)/ LSMOH formally recognizes 114 slums (92 slums in the urban and 22 slums in the rural LGAs).
- Slum wards account for 30% of the total wards in the state.

What is a Slum?

- A slum is a contiguous settlement where the inhabitants are characterized as having inadequate housing and basic services; a slum is often not recognized and addressed by public authorities as an integral part of the city.

Elements of a slum household

A slum household is one that lacks one or more of the five elements:

- Easy access to safe water
- access to adequate sanitation
- security of tenure that prevents forced evictions
- durability of housing of a permanent nature
- sufficient living area (not >3 sharing a room)

Challenges of Immunization delivery in Urban Slums

- Health not high on political agenda
- Marginalized population
- Social distance
- Catchment population hard to define for Health Facilities
- Weak planning, management, coordination and supervision.
- Focus on curative activities
- Disaggregated data unavailable

Source; Ilesanmi, A.O., 2010, 'Urban sustainability in the context of Lagos Mega-City', Journal of Geography and Regional Planning 3(10), 240–252.
hhttp://worldpopulationreview.com/world-cities/lagos-population/\
World Urbanization Prospects - United Nations population estimates and projections of major Urban Agglomerations

Increasing urbanization with agglomerations of urban poor is increasing the public health risk of disease outbreaks in expanding slum areas in Lagos

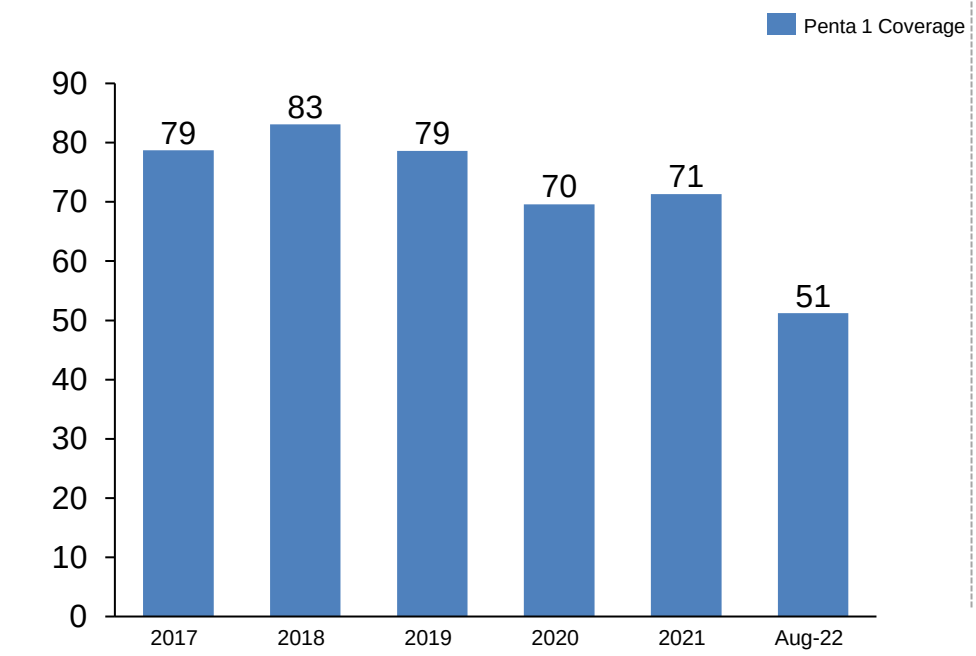
Context

- There has been an increased focus by the EPI programme on improving immunization indices in rural areas. However, recent increase in unimmunized infants and disease outbreaks in the urban areas raises the question about the effectiveness and equity of immunization schemes in Lagos that is undergoing rapid urbanization.
- The evidence of vaccine preventable disease outbreaks in Lagos in the last 5 years points to the potential for underestimating immunization coverage in urban areas, and signals increased public health risks in urban settings.
- Of concern is the likelihood that the populations most affected by such outbreaks are those with the least capability to access health services for treatment.

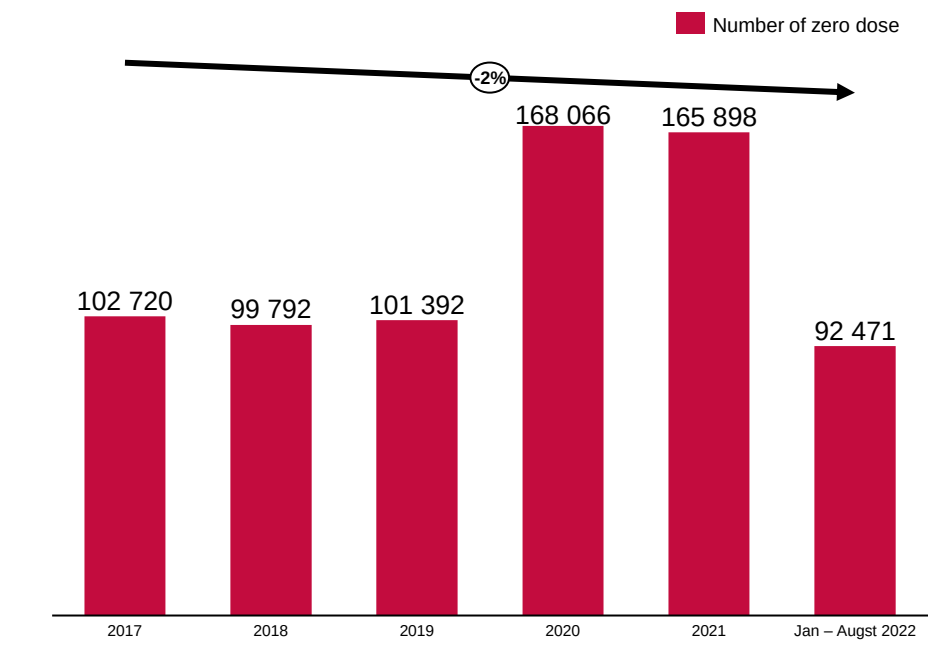
No.	LOCATION	YEAR	DISEASE OUTBREAK
1.	Mushin LGA	September 2022	Circulating vaccine-derived poliovirus type 2.
2.	Lagos Mainland, Ajeromi, Kosofe and Somolu LGAs	March 2022	Measles outbreak Confirmed cases in 4 LGAs
3.	Oko Baba community in Lagos Mainland LGA	Jan 2021	Measles outbreak
4.	Ikeja LGA	Aug 2019	A case of yellow fever was confirmed
6.	Idi-Araba, Mushin LGA	Feb 2019	Three (3) confirmed cases of measles were detected in Idi-

Despite the high Immunization coverage in Lagos, the large number of zero dose children remains a key challenge

Comparative analysis of Penta 1 coverage 2017-2022 (%)

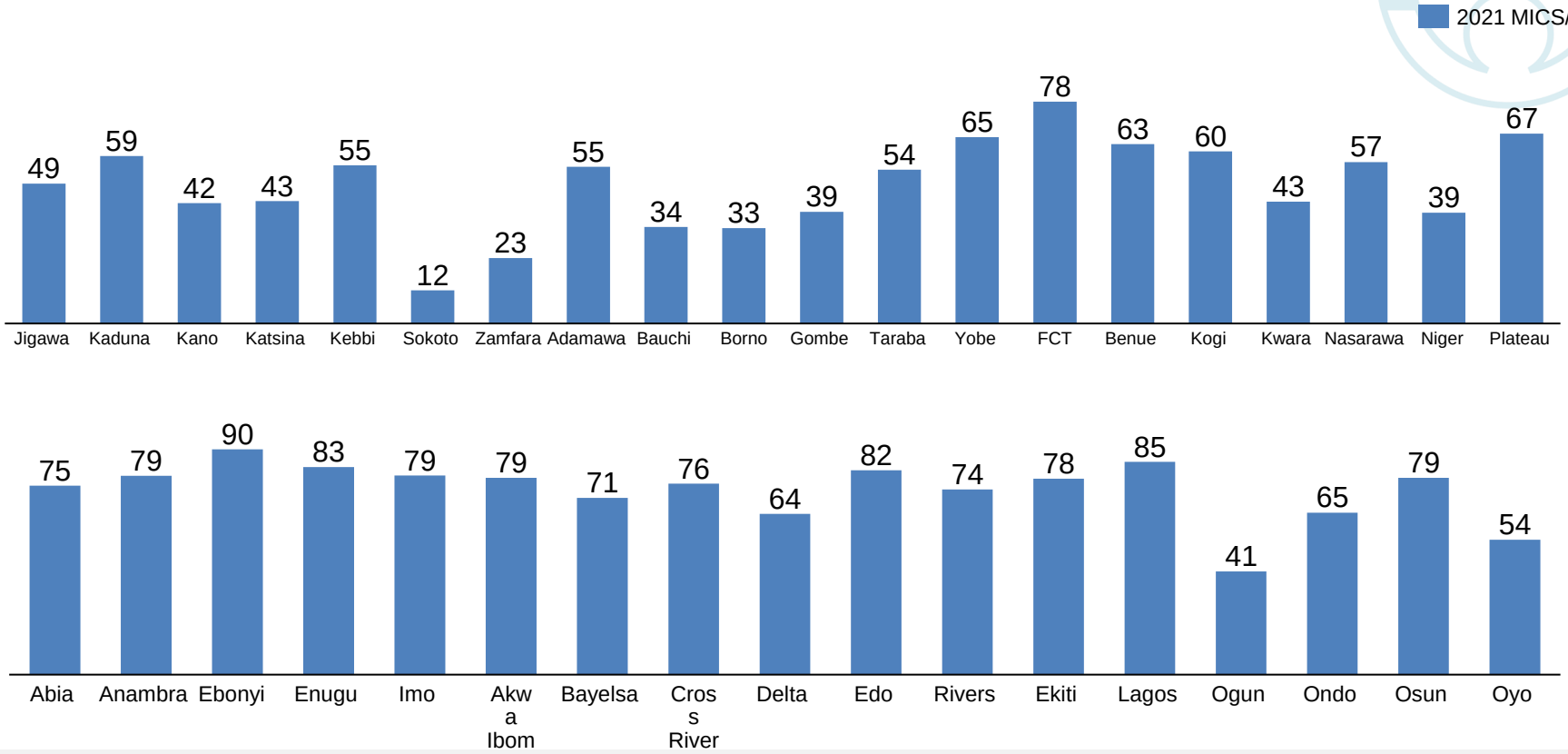


Comparative analysis for trend of zero children 2017 – 2022



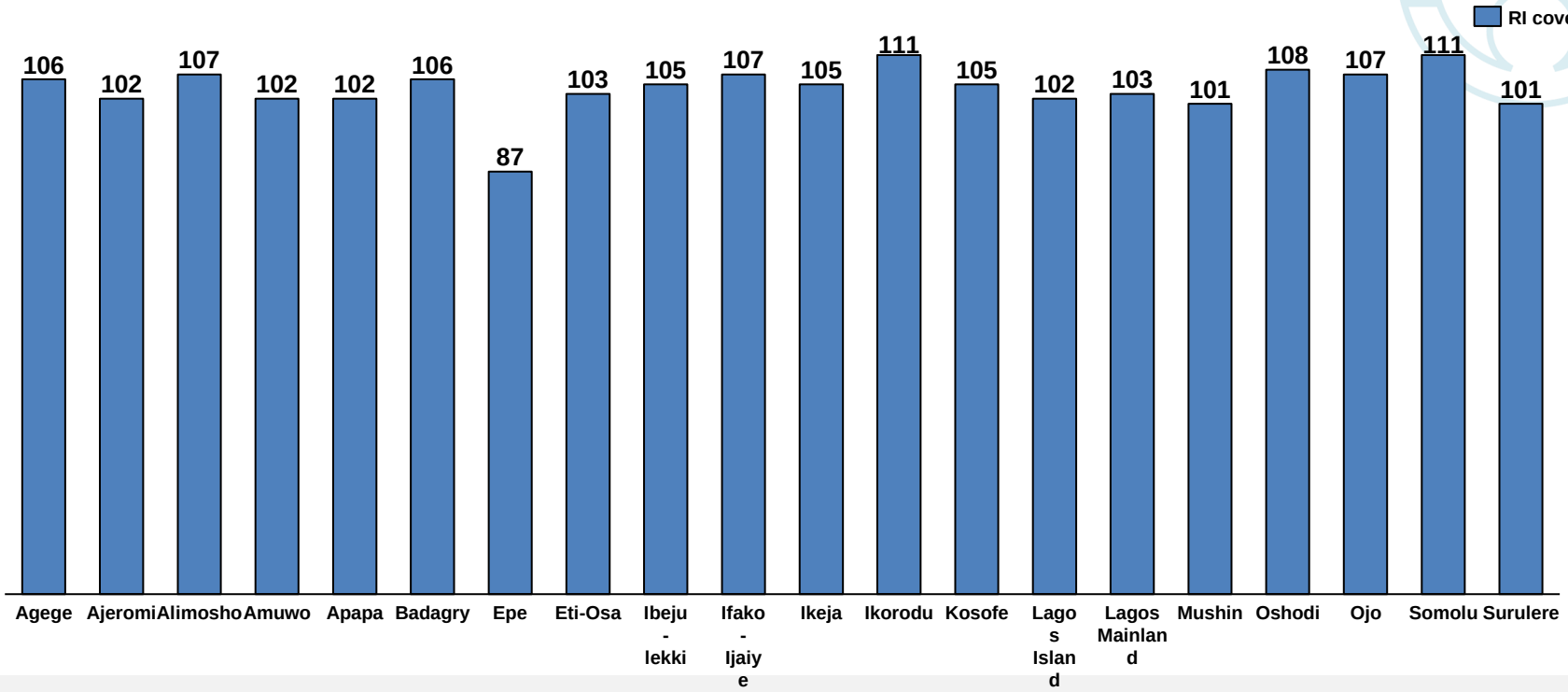
Implication: Despite the high Penta 1 coverage over the years, Lagos still records a high number of zero dose. Administrative data of 2022 shows that only 51% of the expected target has been reached with an estimated cumulative of 92,471 zero dose children.

Comparative analysis of MICS/NICS 2021 Penta 3 data across 36 states in Nigeria



- 7 states achieved at least 80% target immunization coverage in 2021 MICS/NICS with Lagos recording the 2nd highest Penta 3 coverage at 85% in 2021.

Pilot Integrated Non polis SIA campaign



- Lagos State implemented the first integrated non polio SIA campaign in July 2022 comprised of the measles, Vitamin A supplementation, COVID 19 vaccination and RI vacines which contributed in reducing zero dose in the state

The State Primary Health care Board supported by partners conducted a qualitative survey on barriers to immunization service delivery from the community and Health facility perspective

LGA	Wards
Alimosho	Egan
	Egbe Agodo
	Ijegun
	Egbe Liasu
Ajeromi/Ifelodun	Owoyemi
	Alaba
Amuwo	Atunluse Agboju
	Abule-Osun
Eti-Osa	Apese
	Kuramo
Ifako-Ijaiye	Agbule Egba
	Ifako Piele
Ikorodu	Owutu
	Itunpate
Kosofe	Olubori Masafejo
	Odogun Ajegunle
	Erukan
	Ikosi Oke
Lagos Mainland	Botanical
	Okobaba
Mushin	Idi-Araba
	Igbehin
Oshodi/Isolo	Mafoluku
	Aigbaka
Surulere	Baruwa
	Odo-Olowo

Methodology

Study design

- Qualitative assessment (FGD and KII)

Sampling

- Purposive sampling
- **11** LGAs
- **26** Wards
- **26** Focus Group Discussions
- **26** Key Informant Interviews

Inclusion citeria

- The resident must be a permanent resident of study area and resided in the area for at least 6 months
- All categories of PHC facilities

Exclusion criteria

- Temporary residents or visitors of the study area will be excluded.
- Private PHCs, Secondary and tertiary HFs

Data analysis

Qualitative

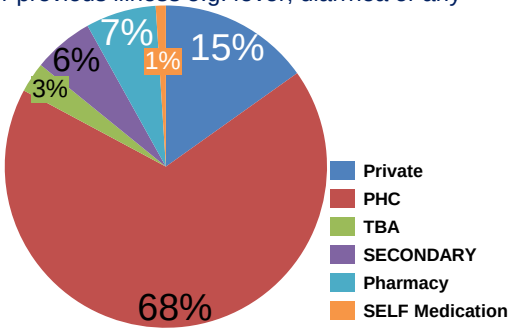
- Audio recorded, transcribed, coded, analysis

Results of Qualitative survey in 11 LGAs in Lagos

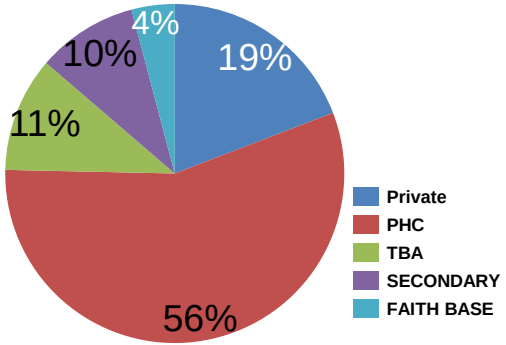
Summary of findings from Focus Group discussions conducted among caregivers in 26 communities in 11 LGAs respectively revealed multiple barriers to immunization service delivery.

Caregiver knowledge or practice of concepts of Maternal and Child Welfare

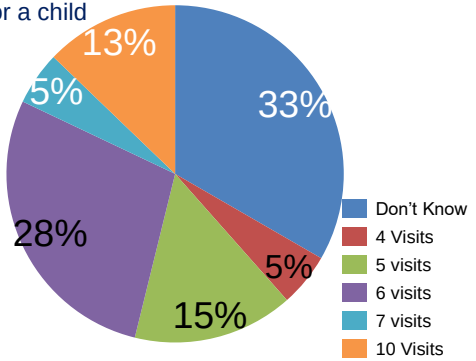
Caregiver choice of access for health care for U5 child for previous illness e.g. fever, diarrhea or any illness



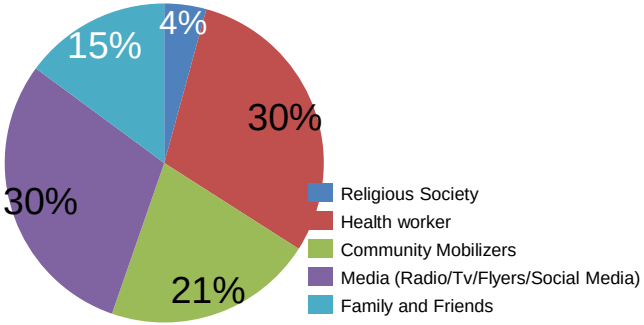
Caregiver access of ANC or delivery services for last delivery



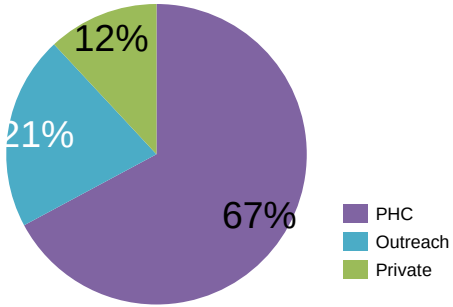
Caregiver knowledge on number of vaccination visits needed for a child



Caregiver source of information on immunization



Site of vaccination for most or all of infants vaccination



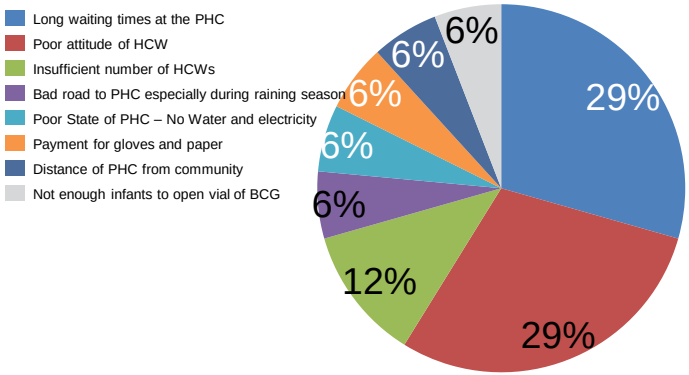
Summary of Findings:

- More than half of the caregivers accessed child health services, ANC or delivery services at a PHC
- Caregivers source of information on immunization were majorly from health workers and the media

Results of Qualitative survey in 11 LGAs in Lagos

Summary of findings from Focus Group discussions conducted among caregivers in 26 communities in 11 LGAs respectively revealed multiple barriers to immunization service delivery.

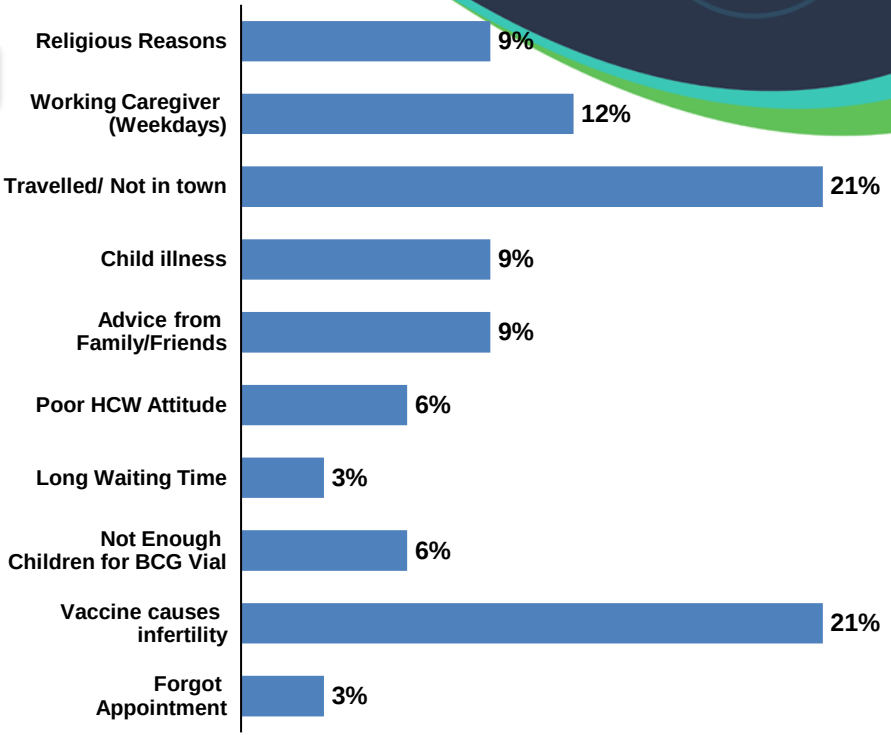
Caregiver feedback on barriers to access of services at PHCs



Key Insights

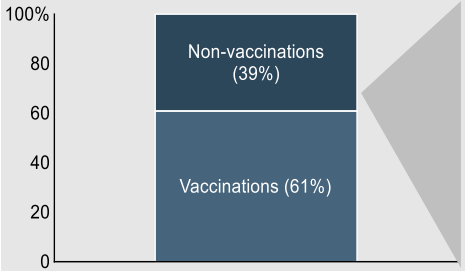
- Waiting Times and Poor HCW attitude are the major (58%) barriers to access

Reasons why child has had "only some or none of the eligible vaccinations"

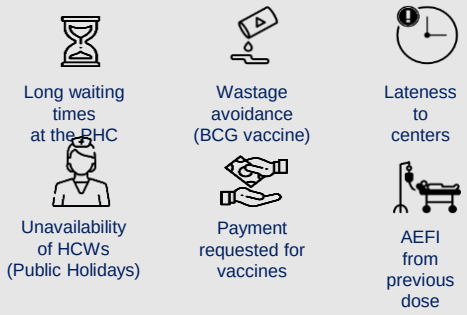


~40% of focus groups indicate least one case of non-vaccination when caregiver visit the PHC

Vaccinations vs non-vaccinations at PHCs by focus groups



Reasons for non-vaccination incidences during caregiver visit to PHC



Concerted efforts were instituted by the State EPI programme to develop a state urban strategy to respond to the sub optimal RI coverage and PHC indicators in underserved areas in the State

LAGOS STATE URBAN IMMUNIZATION MODEL

MANAGEMENT AND GOVERNANCE

1. Development and quarterly update of REW micro plans.
2. Monthly technical working group reviews.

HUMAN RESOURCES

1. Built capacity of health staff on the zero dose strategy and on Interpersonal communication.
2. Ad-hoc staff(vaccinators and data clerks) recruited reduce HR gaps.
3. Leveraged the Immunization Academy and peer led learning for Health worker capacity building.

COMMUNITY ENGAGEMENT

1. High-level engagement with key community leaders and structures in communities with high influx of immigrants to improve demand for PHC services
2. Strengthen government led efforts to implement community to health facility linkages for identification and tracking defaulters
3. Awareness raising and engagement activities with key community influencers and groups.

VACCINES, LOGISTICS AND SUPPLIES

1. Leveraged on CCEOP for cold chain expansion at district level.
2. Vaccines delivery to last mile through the Push model and calculated based on vaccine consumptions.
3. Cold chain equipment management to ensure safe and functional vaccine storage.

SERVICE DELIVERY

1. Implemented 3 rounds of LIDs in 11 high zero dose LGAs.
2. Conduct weekly integrated outreach services.
3. Engaged Private health facilities offering RI to conduct planned fixed routine immunization activities.
4. Institutionalized weekend operations of comprehensive PHCs in urban areas to access working caregivers.

MONITORING AND HMIS

1. Supported government-led Routine Immunization Supportive Supervision (RISS).
2. Re-emphasized good practice during supportive supervision and review meetings.
3. Quality analysis (analysis and validation of data) for review, planning and prioritization.

CONCLUSIONS/LESSONS LEARNED

- A detailed, comprehensive context specific urban immunization strategy needs to be endorsed by the State Primary Health Care Board along with development partners and the private sector.
- More private sector engagement needs to be leveraged on for opening of new vaccination sites, vaccines supply and logistics, in immunization operations and in social and behavioural change.
- The state needs to focus on community engagement strategies to identify and reach zero-dose children and under-served populations through tracking of births, missed children and new entrants using community informants and trackers.
- Monitoring & supportive Supervision of vaccination sites through mobile apps has improved real time monitoring of services, in on-the-job mentoring and in strengthening data quality.
- Establishing weekend vaccination services in urban comprehensive health centres has improved access to immunization and PHC services.
- Improved synergy between routine immunization and covid vaccination/Supplementary immunization activities has reduced the number of zero dose children

Data Sources: 1) NHC SMNCS 2018/19 2) DVD_MT March 2018


Thank
you!

ASSESSMENT OF INEQUITIES IN ROUTINE IMMUNIZATION AMONG URBAN POOR COMMUNITIES

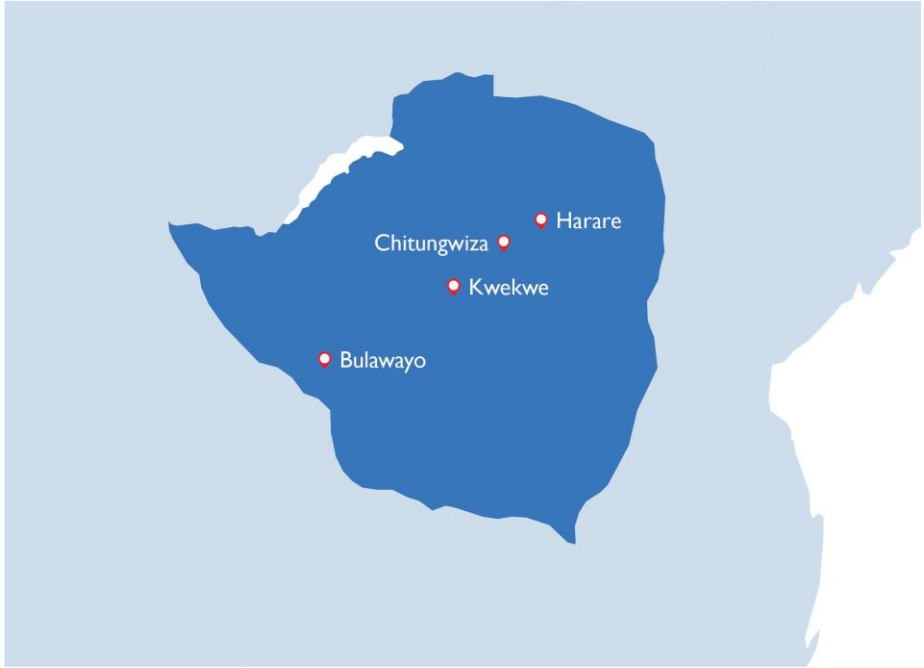
A study of 4 cities in Zimbabwe (Harare, Chitungwiza, Bulawayo, and Kwekwe)

- Nassor Mohamed, Senior Technical Officer, JSI Research & Training Institute, Inc. (JSI)

Background

Background

- While 2018 immunization coverage estimates showed a national DTP3 coverage of 89%, numbers of unvaccinated children in districts with emerging and unplanned urban settlements were increasing
- According to ZDHS 2015, the percentage of children with no vaccinations at all was 10% nationwide, with Harare having 2.5%, Bulawayo 7.2%, and Masvingo 20.7%
- High immunization coverage was reported in cities; it masked low immunization coverage in areas where the underserved populations lived.
- The findings and recommendations from the assessment intended to provide a basis for making strategic decisions to increase coverage and reduce immunization inequity among the poor urban populations in the cities assessed
- Other cities not included in the study are expected to draw lessons and similarly improve immunization coverages in their cities



Goal and Objectives

Goal and Objectives

Goal: Identify the un/under vaccinated urban poor children and where they lived, reveal intra-urban differences in RI coverage, highlight the main reasons for low access and use of RI services and make recommendations to increase coverage for these populations.

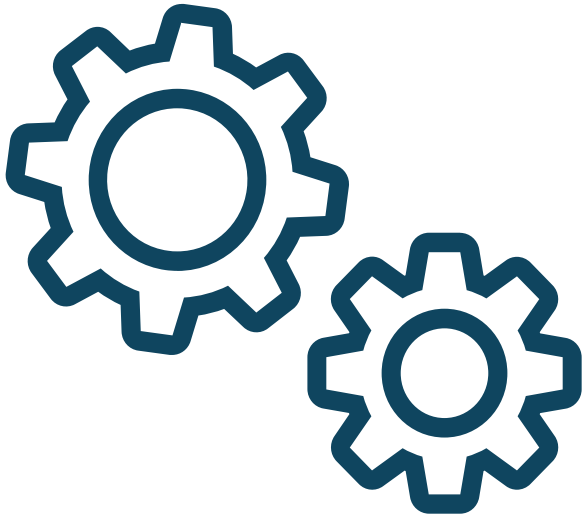
Specific objectives of the situational analysis were to:

1. Determine vaccination status of children aged 24 - 35 months in underserved populations in four priority cities
2. Identify factors associated with unvaccinated and under vaccinated children 24-35 months
3. Develop strategies to address the factors resulting in unvaccinated and under vaccinated children
4. Share real time quality improvements and experiences with other cities using the Community of Practice (CoP) immunization model
5. Document and share best practices and lessons learnt

Methods

Methods

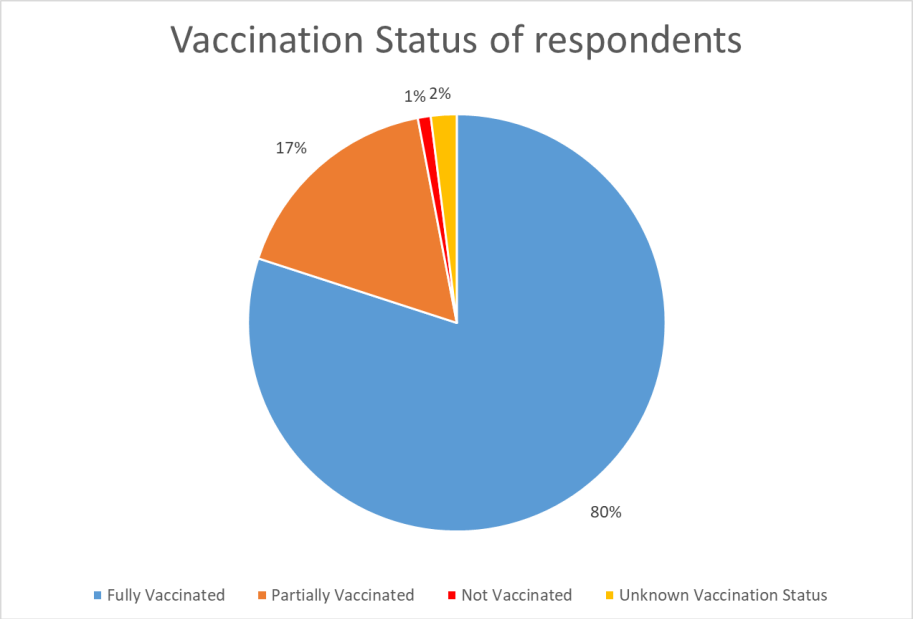
- The situational analysis used mixed methods and collected both **primary and secondary data**
  - Primary data was collected from health providers and key informants, 11 FGDs with CHWs and 22 FGDs with mothers/caregivers
  - Secondary data was largely in the form of reports and existing datasets from DHIS2
- Study cities were selected in collaboration with MoHCC and ZEPI
- A multistage process was employed to identify participating urban centres, and within these, participating localities
- The criteria used to select 4 urban centres included **rapid population growth, existence of underserved populations, and recent preventable disease outbreaks or increase in unvaccinated children**
- In each city, the study focused on 3 clinics and their surrounding underserved poor settlements



Study Findings: Vaccination status of children aged 24 to 35 months in underserved areas

Vaccination status of children aged 24 to 3! months in underserved areas

- Out of 493:
  - 17% of the children aged between 24 and 35 months in the household survey were under vaccinated,
  - 1% were not vaccinated,
  - 80% were fully vaccinated, and
  - 2% did not know the vaccination status of the child
- The national level data for 2020 showed that:
  - un vaccinated: 7%
  - under vaccinated: 14%
- The national trend of under vaccinated children ranged between 11% and 14% for the past five years
  - 2016: 11%
  - 2017:12%
  - 2018 & 2019: 11%
  - 2020: 14%



N=493

Study Findings: Factors associated with unvaccinated and under vaccinated children aged 24-35 months

Factors associated with unvaccinated and under vaccinated children aged 24-35 months

The study found that the following caregivers were significantly more likely to have under vaccinated children are those who;

- Cannot read and write,
- Incur costs (paying more than 1 USD) and time to access vaccination
- Lost Child Health Cards
- Employees

Other reported factors contributing to under vaccination included: stock outs, shortages of Child Health Cards, staff shortages and attitudes, and waiting time at clinic

Factors associated with unvaccinated and under vaccinated children aged 24-35 months

- **Failure to receive vaccination at clinics on the scheduled visit due to vaccine stock**. In exit interviews, 23% reported to miss vaccination on a day of visit in Harare (31.9%), Chitungwiza (26.0%), Kwekwe (23%) and Bulawayo (9.3%)
    - *"I went to the clinic 2 times and failed to get a service one day I was told I was late and when I went back the vaccine was not available so I just stopped bothering as the clinic is very far" A mother in FGD at Riverton in Stoneridge – Hopley*
- **Limited numbers of children were being vaccinated per day**, pressuring caregivers to arrive early to secure a number to be served on a particular day
- **Vaccine Objectors on basis of religion** was reported mainly in Harare, Chitungwiza and Kwekwe cities. Some religious objectors were reported to be vaccinating their children secretly.

Factors associated with unvaccinated and under vaccinated children aged 24-35 months

- **Competing Priorities:** Some caregivers were prioritizing livelihood activities, such as: vending, artisanal mining and household responsibilities, resulting in them missing vaccination opportunities

- **Community Linkages and Engagement**: All the four cities stated that they had CHWs who were assigned to areas within the city suburbs.
  - CHWs including those in Kwekwe who were recently trained (2020) reported **lack of information**, particularly on new vaccines recently added to the schedule.
  - All clinics had Health Centre Committees. These were not functioning due to COVID-19 lockdowns.

Study Findings:
Strategies to address the factors resulting in unvaccinated and under vaccinated children

Strategies to address the factors resulting in unvaccinated and under vaccinated children

- **Strengthen regular immunization services** both through fixed and outreach services
  - Provision of **adequate staff** for immunization services
  - **Provision of reliable transport** for outreaches and mobile services
  - Ensure availability of **adequate vaccines** and related **supplies**
  - **Strengthen community education, mobilization and infant tracking**
  - **Recruitment of more CHWs** to enhance linkages with communities
- Provision **of integrated outreach** with other programs to extend EPI services to more areas
- Implementing **regular catch-up campaign and PIRI** covering all RI vaccines

Implementation of Study Findings

Implementation of the Study Findings

- JSI supported the 4 cities to **develop city-specific action plans** to address some of the identified key issues and bottlenecks for RI
- JSI also supported all health facilities in the 4 cities to **develop/update their micro-plans** to incorporate some of the recommendations from the study including session re-planning, community mobilization activities
- **Consolidation and documentation of best practices and lessons learned** to support adaptation and scalability of urban immunization technical approaches to other urban areas in Zimbabwe and beyond.

Picture taken by Ministry of Health/EPI Unit during the Microplanning Training workshop at Mazowe Hotel

Implementation of the Study Findings

- Establish **Community of Practice (CoP)** with additional of nine other cities not included in the assessment to share lesson learned including how to conduct assessment and adapt the tools used in the 4 cities
    - Identified members from the 9 cities and oriented them
    - Determined preferred communication channels through a rapid assessment (4 channels identified were WhatsApp, Boost, Zoom and e-mail)
    - The CoP group of 67 members was then formed and launched. The group included the National EPI team members and partners WHO, UNICEF, Crown Agency, World Vision and CHAI and 2 representatives from the cities
    - Multiple sessions were held through **Boost platform** to share lesson learned from the 4 cities including findings and provided guidance on how to conduct a situational analysis through the CoP?

Challenges

Challenges?
What does it take? CoP and urban immunization realities

Challenges?

- Limited short-term funding
- Delayed implementation due to Competing priorities
  - COVID-19 Pandemic and approval processes during implementation
- Lack of funding to implement some of the recommendations
- CoP: Choice of platform, internet connectivity, identification and orientation of CoP members, lack of regular participation, etc.

What does it take?

- Support beyond the assessment
- CoP is a new concept to both MOH and Cities; it needed more time & effort to persuasion
- Link with Gavi HSS and realignment of MOH immunization programming to address urban needs
- Strengthening absorptive capacity and technical management with MOH/EPIs to lead urban immunization and CoPs

Conclusions and Recommendations

Conclusion and Recommendations

- Implementation of urban immunization needs multi-sectoral and multi-partner collaboration
- More resources in terms of human and financial need to be allocated to address inequity in poor urban areas
- Community linkage in provision of health services is vital
  - Ways to improve community linkage in poor urban areas need to be identified and implemented based on specific areas
- Short implementation period / funding (through PEF) was a limitation
  - To continue to support the target cities for implementation of the suggested strategies, and
  - To continue addressing issues with COP cities

Reaching Zero dose communities and Children in densely populated areas with limited capacities

UNICEF Pakistan

October 4, 2022

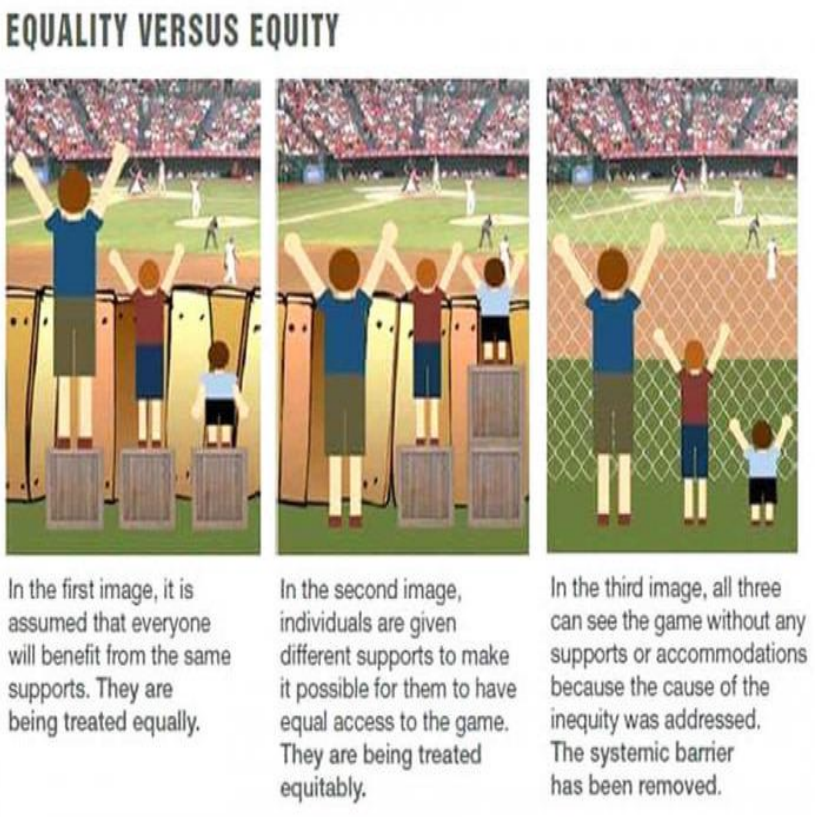
Dr. Khawaja Aftab Ahmed
Health Specialist – Health System Strengthening HSS
UNICEF Pakistan

Why Urban Immunization

- Over 38% (75 million) of Pakistan's population in urban areas
- More than half of urban populations in 10 megacities
- More than half (32 million) of urban population live in slum environments
- Slums characterized by poor sanitation and unsafe water, overcrowding, constant mobility, not recognised, insecurity, improper shelter, disease outbreaks etc.
- Significant proportion of the >1.4 million unvaccinated children could be in hard-to-reach urban poor communities

Guiding Principle: Adopted from Global Urban Toolkit

- **Government Lead** and **Government Owned**
- **Context specific** -Province, Area, District, Union Council (Equity Focused)
- **Acceptable and with visible results**
- **Contribution to Routine Immunization** (RI) and Polio Eradication Initiative **(PEI)**
- **Integrated Service Delivery Approach** through Health /Immunization System Development / Strengthening
- **Based on Effective Partnerships** – with private service provider, CSOs and etc
- Reinforcing **sustainable community linkages** and social mobilization – CBVs,LHWs,Community volunteers



Key Interventions: Urban Immunization

The following key interventions implemented are:

1. **Bottleneck Analysis (BNA), Balochistan, Sindh**
2. Development of **Province Specific Road Maps, Submitted to Gavi for allocation of USD 16 Million**
3. **Supported development of Karachi Road Map**
4. **Profiling of Urban and Peri-Urban Slums**
5. **Vaccination Coverage Survey in slums**
6. Development of **Integrated Service Delivery Package**
7. **Provision of mobile vans**
8. Micro census in selected areas, Peshawar with EOC
9. **Partnership with CSOs**

Key Interventions: Urban Immunization

The following key interventions implemented are:

6. **24/7 birth dose initiative, integrated outreaches, branding of sites, evening and weekend shifts**
7. **Detection and referral of Zero dose children from Household level**
8. **Independent intensified field monitoring, provinces – handing over to Provincial EPI Programs,**
9. **Scaling up Independent intensified field monitoring to targeted areas under FDI oversight**
10. **Implementation research /Documentation of lesson learned , publications**
11. **Capacity development** of frontline workers and managers,
12. **Partnership** with civil society organizations, Private sector

Strategy: 24/7 Birth Dose Vaccination Initiative

Added value:

- Increases access to vaccination services
- Recording newborn at birth and followup
- Contributes to TAG recommendation (OPV0 within 72h)
- Integrated EPI with other interventions with poor utilization (birth registration, nutrition, malaria control).
- Opportunity for PPP
- IPC at enrolment time increases likelihood for completion of vaccination schedule
- Overall contribution to SDG and UHC

- **Hepatitis – B vaccine:** @ birth or as early as possible within 24hrs;

- **OPV-0:** until 15 days of birth;

- **BCG:** until 11 months of age;
- **TT** vaccination
- Vaccination as close to the time of birth as possible

Strategy: 24/7 Birth Dose Vaccination Initiative

Two (02) components:

1. Institution based:

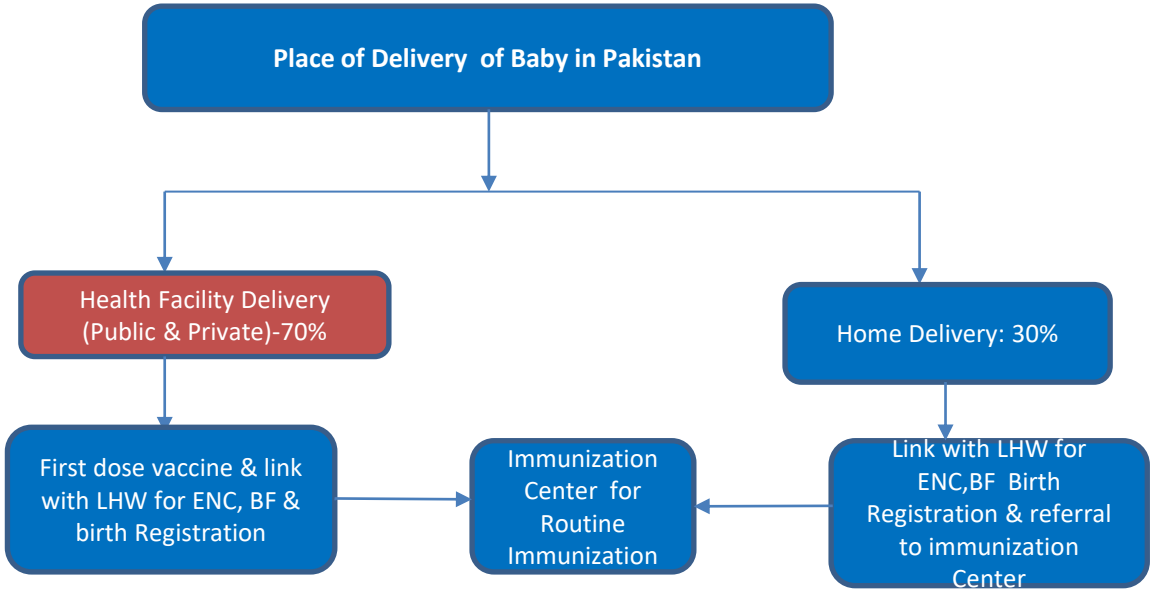
- Secondary and tertiary care Hospitals, public and private sector

2. Community based: provide vaccination within 24h of birth, through LHWs or other community-based health work force and modalities available based on field realities.

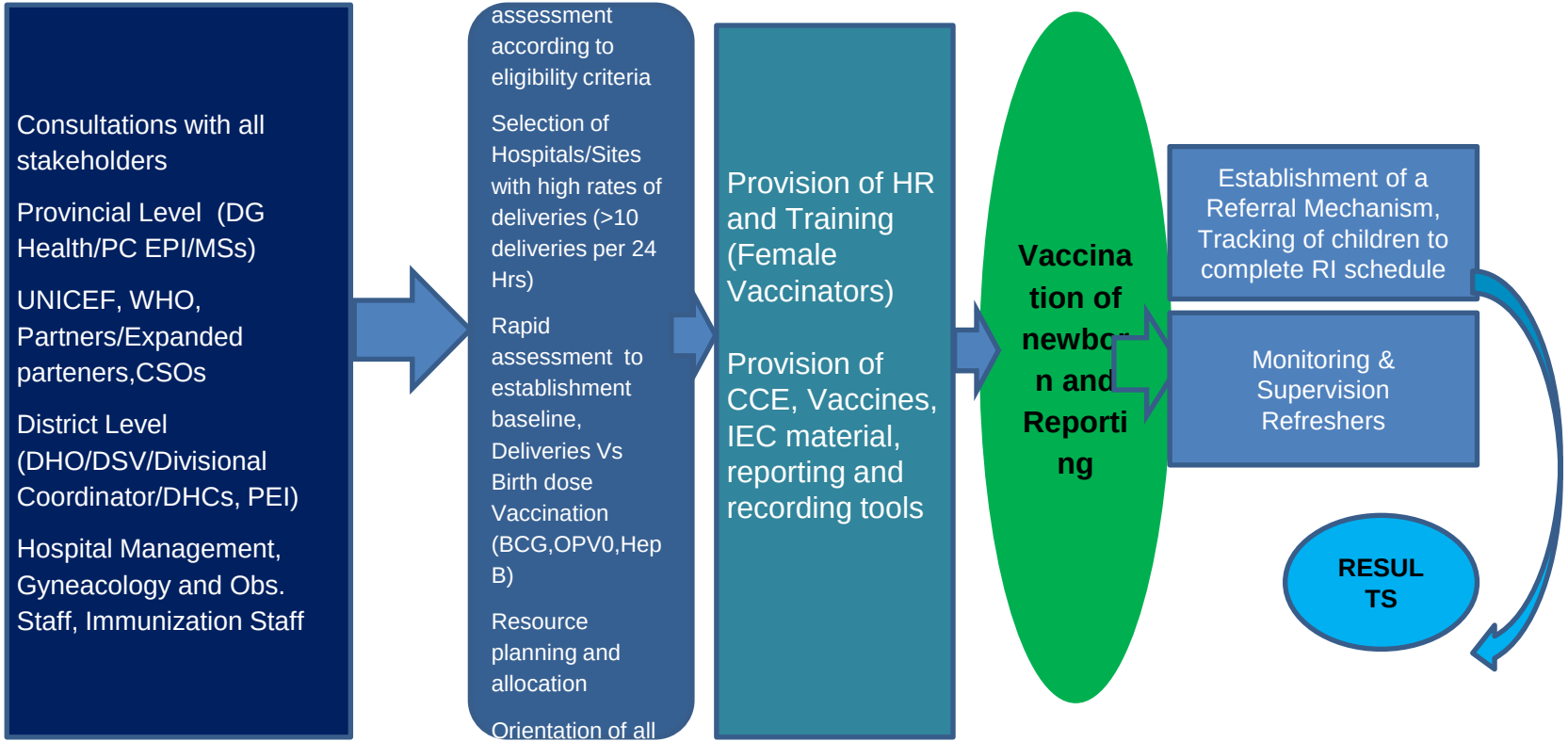
Implementation:

- Brainstorming started more than 2 years ago, as part of the urban strategy (EPI team)
- Framework was developed, agreed with all key stakeholders
- Implementation started from 1 hospital (BMC) in Quetta in Feb 2020, expanded to 04 facilities in July 2020 - Now in 48 sites (Public and Private)
- Establishment of vaccination site in the labor room, with female vaccinators. 3 shifts of vaccinators, to ensure 24h coverage
- Based on Quetta successful model, rolled out to 48 Sites in Quetta,Karachi ,Hyderabad, KP and AJK.

Referral Mechanism for Newborn and Zero dose to complete RI schedule



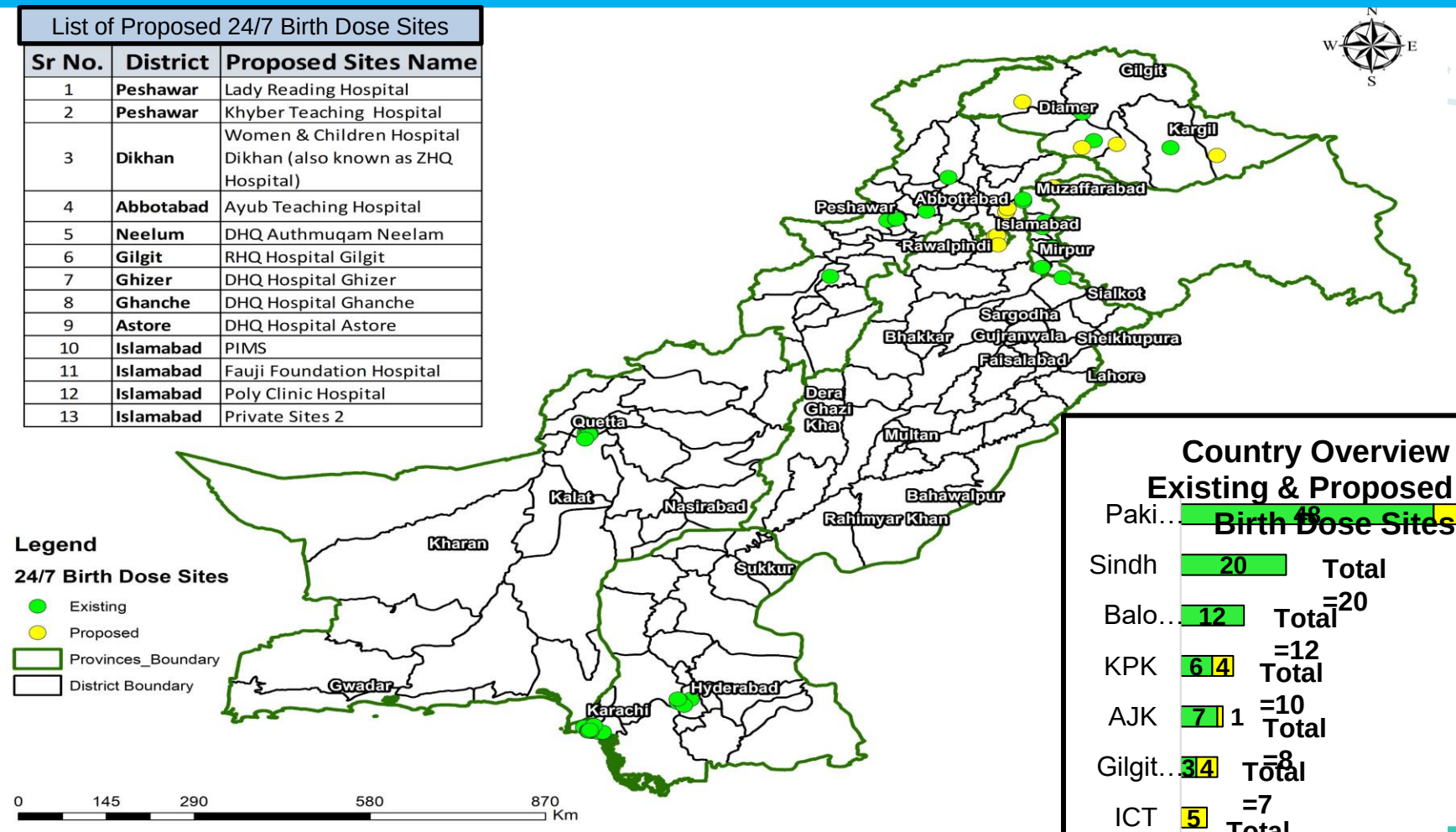
Strategy: 24/7 Birth Dose Vaccination Initiative

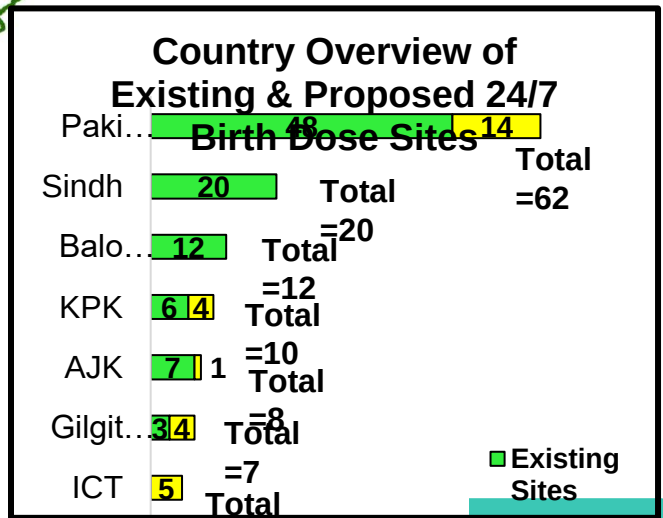


Results: 24/7 Birth Dose Vaccination Initiative

List of Proposed 24/7 Birth Dose Sites

Sr No.	District	Proposed Sites Name
1	**Peshawar**	Lady Reading Hospital
2	**Peshawar**	Khyber Teaching Hospital
3	**Dikhan**	Women & Children Hospital Dikhan (also known as ZHQ Hospital)
4	**Abbotabad**	Ayub Teaching Hospital
5	**Neelum**	DHQ Authmuqam Neelam
6	**Gilgit**	RHQ Hospital Gilgit
7	**Ghizer**	DHQ Hospital Ghizer
8	**Ghanche**	DHQ Hospital Ghanche
9	**Astore**	DHQ Hospital Astore
10	**Islamabad**	PIMS
11	**Islamabad**	Fauji Foundation Hospital
12	**Islamabad**	Poly Clinic Hospital
13	**Islamabad**	Private Sites 2

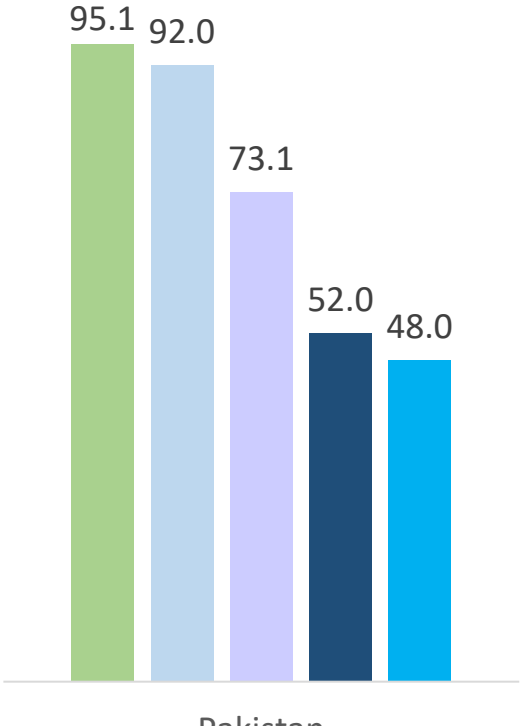


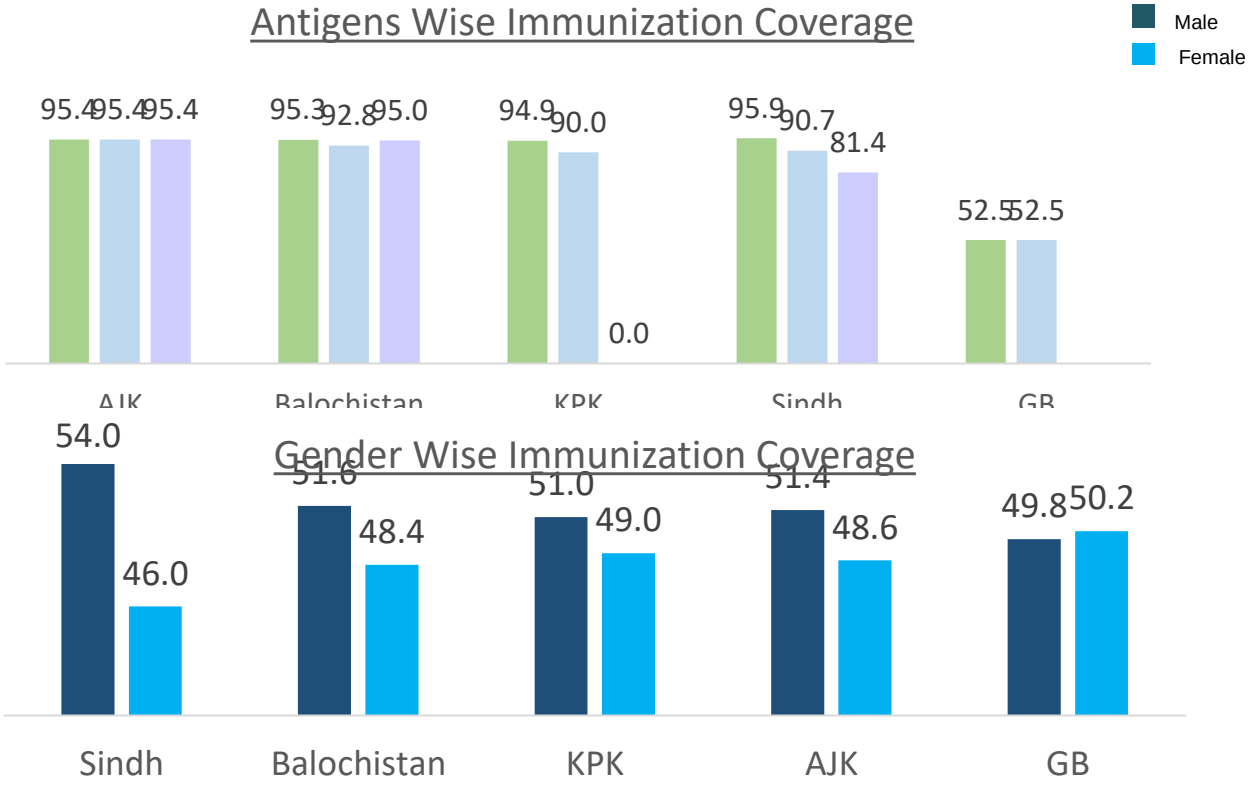


95.1 % Newborn were Vaccinated At 48 Birth Dose Sites Since Feb 2020 Till Aug 2022 in Pakistan

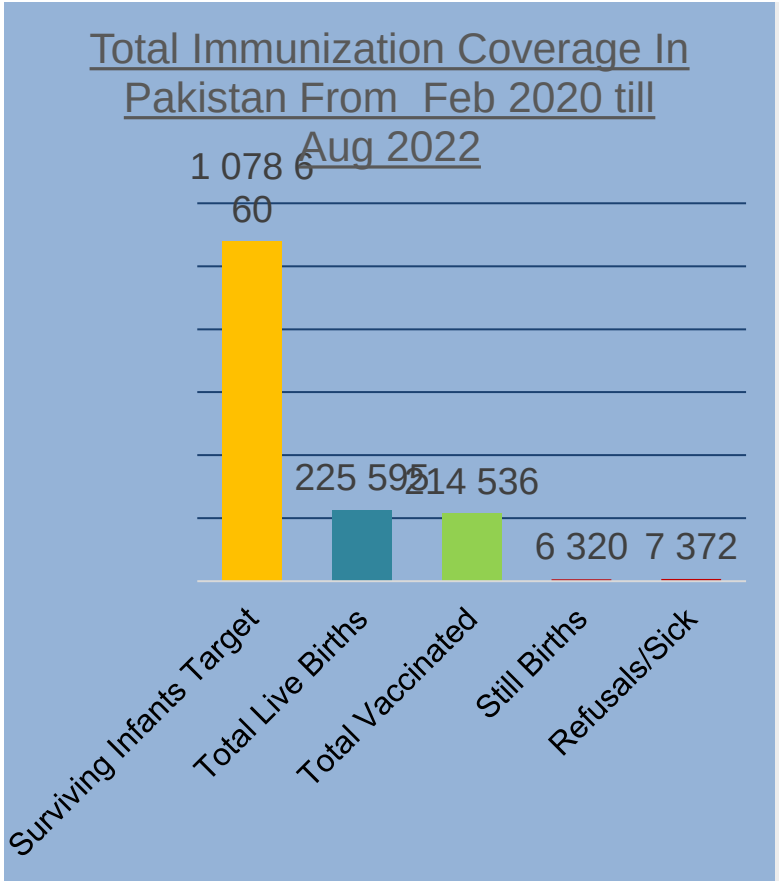
Immunization Coverage

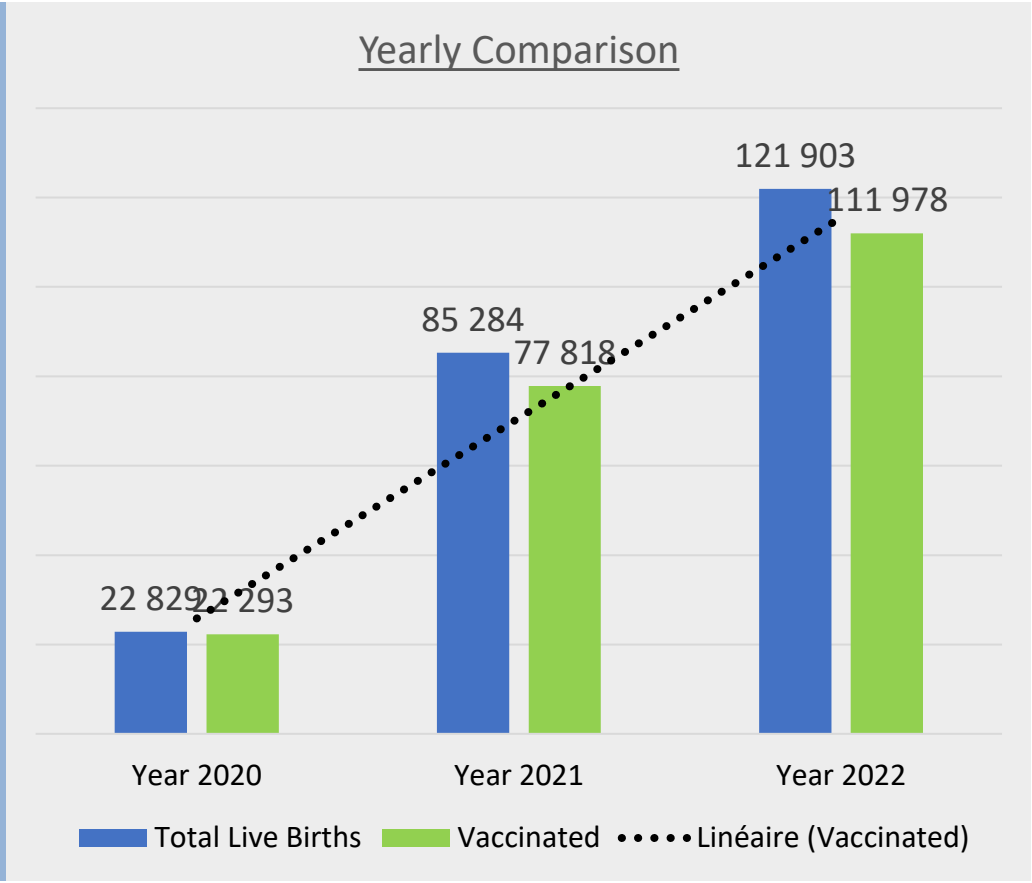
% of Children that received Antigens at 24/7 Birth Dose Sites





Results Achieved : 24/7 Birth Dose Vaccination





*No of Surviving infants are the Target Infants for Total No of Months of Initiative from start to Till Aug 2022

Challenges and Way forward

Challenges:

1. Tracking mechanism for completion of RI schedule (Linked with existing EPI MIS systems, ZM and etc)
2. Availability of Female Vaccination staff
3. Vaccine Wastage, HepB vaccine availability

Way Forward:

1. Establish a functional Tracking System for completion of RI schedule embedded in existing EPI information systems
2. Roll out in all tertiary care hospitals, maternity homes and district Headquarter hospitals, including private sect.
3. Assessment of 24/7 birth dose centers in private sector to offer full range of RI antigens
4. Establishment of Homebased model and implementation
5. Documentation of processes and key learnings for Knowledge management

TechNet-21
The Technical Network for Strengthening Immunization Services

Questions & Answers

Slums and Underserved Areas of 10 Mega Cities

Khyber Pakhtunkhwa (KP)

- Peshawar
  - 1970042
  - 552
  - 1455398
  - 53%
  - 16 %

Balochistan

- Quetta
  - 1001205
  - 315
  - 712404
  - 27%
  - 27%

Punjab

- Rawalpindi
  - 2098231
  - 138
  - 966999
  - 69%
  - 18%
- Gujranwala
  - 2027001
  - 247
  - 1469550
  - 65%
  - 24%
- Lahore
  - 11126285
  - 993
  - 4650254
  - 53%
  - 20%
- Faisalabad
  - 3203846
  - 466
  - 1340376
  - 36%
  - 9%
- Multan
  - 1871843
  - 320
  - 923520
  - 76%
  - 8%
- Islamabad
  - 1095064
  - 69
  - 157420
  - 51%
  - 16%

Sindh

- Hyderabad
  - 1732693
  - 331
  - 712600
  - 59%
  - 10%
- Karachi

- Total Population 2017 census
- Number of Slums / underserved
- Population in Slums/ Underserved
- Fully Immunised in Slums/ Underserved
- Zero dose in Slums /Underserved