



## Routine Immunization Communication Review

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The PRRINN-MNCH partner state governments and the programme are not yet getting the full value for their investments in building capacity and implementing RI supply and demand interventions. Despite enormous improvements in the immunization supply and demand capacity resulting in the administration of routine immunizations (RI) to many more children in health facilities than ever before, most children are not getting valid vaccinations. Jigawa and Zamfara states were selected as the assessment sites based on the high coverage for key antigens reported in the Nigerian Immunization Coverage Survey (NICS 2010) carried out in November and December. Although Jigawa State achieved more than 85% coverage for both DPT3 and measles, the valid DPT3 coverage is only 51.4% and the valid measles coverage is only 31.5%. Similarly, although Zamfara State achieved more than 64% coverage for the same key antigens, the valid DPT3 rate is only 7.9% and the valid measles rate is 40.2%. Thus, the high levels of vaccination coverage are marred by very high levels of invalid vaccinations given outside the recommended schedule (too soon, too closely spaced, and/or too late with most vaccines being given too late) leaving children at needless risk.

Invalid vaccinations are not included in data reported to the international bodies. RI communication should focus on this underachievement of optimal vaccination protection and enormous wastage of effort.

The role of community dialogue in tipping the balance from normative disinterest in immunization to normative commitment to RI is the most salient finding of the FDGs. The 30-minute FGDs moved virtually all parents from RI non-compliance (never vaccinating their children or dropping out) to voluntarily expressed commitment to immunize their children even though that was not the objective of

the FDGs. Significantly the RI FDGs resemble the community dialogues used to persuade non-compliant families to allow their children to receive polio drops. The traditional leader or his representative gathers participants for a meeting with external facilitators for both FDGs and community dialogues. They encourage the participants to raise their concerns and make recommendations while the external facilitators listen and respond honestly to the concerns. In both these processes, participants discuss their immunization knowledge and attitudes with their peers while the external facilitators restrict their input to the addition of crucial missing information. This process generates informed trust that the government's immunization efforts are genuine along with social approval for compliance. As the participants clarify their fragile awareness and begin to recognize that their peers are reaching a consensus to comply, virtually all participants participate in the consensus.

Without trust in the government's immunization programme and without social approval and pressure from peers to comply, too many people will not act on their personal experience of the need for RI. In an FDG with RI non-compliant men (child never immunized or dropped out), they had been discussing the benefits of RI and then one man confessed,

*Really our children are dying every now and then, especially during the measles outbreak, even my child died and my friend's also and so many others in this town as a result of measles. As he spoke, other participants chorused in saying, Even my own, Even my own Fathers, Fufuri Town, Zamfara State*



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In light of the effectiveness of the FDG/community dialogue process, the Zamfara State Immunization Officer (formerly the State Health Educator) recommends supporting local traditional leaders wherever they command community respect to facilitate community dialogues on RI. These dialogues will be even more effective if they are integrated into a new intervention, Dialogue and Awareness Raising (DAR), by combining RI community dialogue with RI rapid awareness raising (RAR) facilitated by a health worker using the communication approaches developed for CE.

The context for RI communications is improved by the completion of the RI DVD developed jointly with the National Social Mobilisation Working Group, severely constrained by a national vaccine stockout and moderately constrained by diversion of Government focus to the new vaccines in all partner states except Yobe.

### Recommendations

#### A. Increase programme funds and increase advocacy to Government to fund immunization promotion interventions already developed by the programme.

1. Airing of RI jingles: Integrate the airing of the following jingles into broadcast schedules, especially in the period during and around the recommended infant immunization campaign: Vaccination Slogan (timely infant immunization); RI Day (when and where to get information and take your child for RI); swelling (managing vaccine reaction); swelling (managing vaccine reactions)
2. Ensure regular airing of jingles on each health topic with broadcast gaps reduced to a maximum of 3 months per topic
3. Strengthen Reality Radio
4. Scale up Live and DVD-based RAR utilising
  - o Polio DVD (includes Vaccination benefits, schedule and slogan)
  - o RI DVD (includes polio)
5. Scale up Motorcycle Cinema: build equipment and personnel to reduce costs of DVD shows

#### B. Improve regular assessment of communication value for money based on

#### coverage data and RI communication level of effort

1. February KAP2011: Release the results from the February KAP2011 for each state.
  2. Radio jingle dissemination records: Ensure that radio contracts contain clear tables showing the exact name (reflecting the topic addressed) for each jingle and programme and the exact airing times to enable comparison with coverage data
  3. Prepare quarterly RI communication level of effort tables for radio jingles and programmes, RAR (live and DVD-based), clinics with improved Health Talks and CE and CE light communities that have completed the Immunization Module in order to provide a rapid snapshot of the current RI communication coverage
  4. Continue to collect rapid assessment data during communication interventions; however, once the health system recognizes the value of the interventions, reduce the number of rapid assessments and use them merely as monitoring tools.
  5. Systematically collect and report on pre and post clinic data in selected sites that have benefited from a communication intervention. LEOs or local consultants can do this for two or more clinics per state depending upon the intervention as a basis for advocacy for communication intervention funds.
- #### C. Develop/strengthen materials and interventions that build on existing capacity to increase immunization uptake:
1. Integrate the specific information that RI prevents measles, whooping cough and polio in all communication materials to respond better to the public's felt need to prevent measles and whooping cough and the programme's need to integrate polio within RI.
  2. Pilot a Dialogue and Awareness Raising (DAR) intervention integrating the community dialogues into the RAR interventions to increase uptake of RI, especially in urban communities and in under-compliant outreach communities in Jigawa and Zamfara.



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- Support state and cluster rollout the dialogue and awareness raising (DAR) process.

1. Support a Health Talk Development Workshop to integrate the communication capacity developed within Community Engagement into the clinic Health Talks with participation of the MCH coordinators and health institution trainers working with the master trainers from the Community Engagement State Teams.
  - Support state and cluster rollout of an improved Health Talk system.
2. Support a Radio Jingle Development Workshop to create jingles addressing infant vaccination, facility delivery and newborn care.
3. Support strengthening of Reality Radio programmes ensuring that the information and dialogue topics coherently build upon each other in order to maximize retention of new knowledge and attitudes

### **D. Maximize the value for money of the supply and demand capacity and level of effort.**

1. Prepare for and implement simultaneously with rollout of the Cluster 2 Immunization Module an infant routine immunization campaign in all four partner states to ensure that parents and health workers understand and act on the need for full immunization prior to the first birthday (FIC).

### **Next Steps**

#### **A. PRRINN-MNCH should hold meetings to integrate the RI assessment findings into operational plans.**

1. Present the RI Rapid Assessment Findings to all the STMs at the next appropriate technical team meeting.
2. Hold an immunization demand-side meeting with the PODs and the Programme Officers

Supply responsible for immunization to review the RI Rapid Assessment Findings and plan the rollout of a Protect our Infants RI Campaign within one quarter after the re-stocking of vaccines at LGA level.

3. As preparation for the Protect Our Infants RI Campaign and for promotion of outstanding maternal and newborn care topics:
  - Support facilitation of the Health Talk Development Workshop for all MNCH health topics
  - Support facilitation of an RI Radio Materials Development Workshop to develop jingles and targeted Reality Radio episodes to:
    - a) Personalise the dangers and benefits of timely vaccination
    - b) Focus on measles vaccination as the sole MDG vaccination target
    - c) Introduce the new vaccines

#### **B. Support Zamfara State and Jahun and Ringim Gundumas in Jigawa State to implement their RI plans.**

1. Jigawa State: LECs in Jahun and Ringim Gundumas to lead support for improved RI promotion and monitoring in under-performing outreach sites technically and with minimal funds
2. Zamfara State: Support SPHCMB to further develop and pilot test DAR (integration of traditional leader-led dialogue and health worker-led awareness raising with and without DVDs)

#### **C. Support materials development workshops for Health Talks and jingles.**

Please email [info@prinn-mnch.org](mailto:info@prinn-mnch.org) for the full report