Improving urban immunization services in Cite Soleil, Haiti to address the zero-dose children and dropout rates through a human-centered approach

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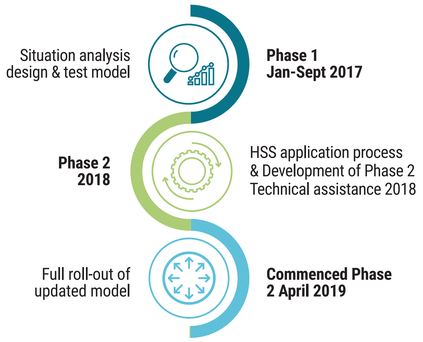
Introduction/Background/ Context

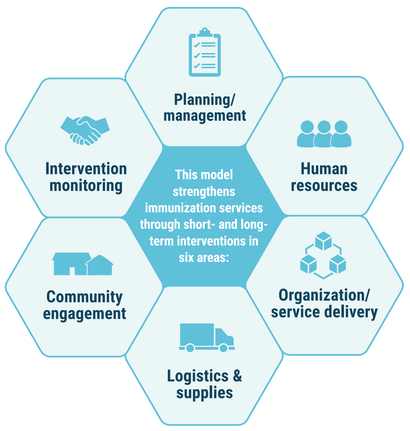
Healthcare in Haiti is extremely challenging, given the country's history of poverty, poor infrastructure, social unrest and vulnerability to multiple types of natural disasters. In 2017, John Snow, Inc. (JSI) launched an intervention in collaboration with the Ministry of Health, with support from Gavi, the Vaccine Alliance, to strengthen the quality and use of immunization services in the urban slums of Cité Soleil. In this densely populated township in Port-au-Prince, Haiti, limited infrastructure, poverty, gang violence, lack of knowledge, poor services, and stigmatization—among many other barriers—severely impede access to basic services, including immunization.



A pilot test of JSI's approach, layering multiple interconnected short-term effective interventions under six central components (see figure 1), led to clear improvements. In 2019, JSI and partners began implementing a second phase of the project in an expanded intervention framework.

In its second phase, JSI upgraded the model to address weaknesses identified through monitoring and assessment, strengthened successful practices, and began full rollout of both short and long term interventions in the urban immunization model. This phase serves a target population of 7,306 in Cite Soleil commune, and is focused on developing tools, processes and building capacity of the EPI program at all levels that can be used to scale up.

Figure 1: Haiti urban immunization model



Methodology/Approach

The strategy developed for Cité Soleil is based on the results of the situational analysis, the root-cause analysis, and contributions from stakeholders.

A. Planning and Management/Governance: An Implementation Committee composed by key actors had been set up by MPHP/ DEPI. And its role was to implement and monitor activities.

B. Organization of services: The capacity of institutions are to provide vaccination services has been increased. The CCHW organized 1-2 times a week outreach stations and have conducted home visits by selecting areas with high numbers of unvaccinated children. Health maps were updated and have been very helpful.

C. Human resources: There were seven (7) health facilities providing vaccination services. There are sixteen (16) (trained) workers in facilities and 108 (trained) CHW in the communities around these facilities. Advocacy was made to renew the contracts for 7 CHW supervisors and get the team complete and ready to work. Job aids were created and have been useful in empowering providers' capacities while on the job.

D. Community Engagement Community engagement: An essential element at every stage. It has been maintained through regular dialogue with community and group leaders who played a vital role in disseminating informative and promotional messages on vaccination.

E. Logistics, Vaccine Supply, and Cold Chain: Vaccine requests were approved based on the demands rather than a predefined quota. A weekly stock check has been set up to rapidly detect and respond to requests for vaccines, reducing the risk of shortage.

F. HMIS and Monitoring: The staff received training on the use of the data forms and all tools were made available at all levels and in sufficient quantities. The monthly reports were regularly analyzed and used for decision-making at all levels.

SITUATIONAL ANALYSIS, CAUSES ANALYSIS, CONTRIBUTION OF SPEAKERS

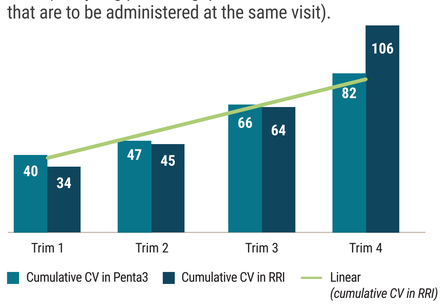
GOVERNANCE, LEARNING, AND DOCUMENTATION

Planning & Management	Human Resources	Organization/ Service Delivery	Logistics & Supplies	Community Engagement	HMIS & Monitoring
SHORT TERM SOLUTIONS					
▪ Examine the health center catchment area ▪ Consistant update of microplans ▪ Monthly management reviews	▪ The ToRs of ASCPs must be communicated to their assigned institution (make assembly stations, conduct community encounters, report data, etc.)	▪ Identify the vaccination room and vaccination info available ▪ Provide services in advanced sites	▪ Update the target population ▪ Have adequate stocks of vaccines	▪ Commitment of the municipal health committee ▪ Preparation of communication materials and key messages.	▪ Make the updated SIS tools are available. ▪ Training on updated forms.
▪ Multisectoral coordination committee revitalize and involve local partners and representatives of future local health committees ▪ Set up a local health committee in the service area of each sites in need	▪ Effectively and efficiently deploy ASCPs in their service areas ▪ Capacity building and mentoring on interpersonal communication and customer service for existing providers	▪ Improve the reception of service recipients ▪ Ensure availability of immunization services ▪ Extend vaccination hours - 1 additional day/week - Or 1 weekend / month - Compensation: small transport-costs	▪ Take into account the quantities usually used to adjust input orders ▪ Set up a satellite vaccine depot ▪ Coordinate with local partners for the transport of inputs from the Delmas BCS to the institutions ▪ Weekly monitoring and replenishment of vaccine stocks using digital devices	▪ Monthly meetings between the municipal health committee and the community ▪ Honor community members for their participation as an incentive for successful activities ▪ Use existing groups to contact young mothers and other members of the community in order to mobilize and transmit information ▪ In times of civil rivalry, work with neighborhood chiefs and religious leaders through health committees to gain support. "Laissez-passer" for vaccination in times of great civil rivalry.	▪ Improve the completeness and timeliness of data (supervision, callbacks telephone, SMS etc.) ▪ Establish/update situation rooms. ▪ Regular supervision
LONG TERM SOLUTIONS					
▪ Set up a communication system to improve interactions between DDS and BCS (phone cards, SMS, WhatsApp etc.) ▪ Mirco-census ▪ Mapping of the sanitary catchment area using GIS. ▪ Advocacy to redefine the Public Private partnership (legislation for the reporting of private data, memorandum of understanding with the Haitian pediatric society, etc.)	▪ Recruitment and training of service providers additional services and ASCs ▪ Supervision of ASCs ▪ Periodic training and updating sessions for institution-level providers and ASCPs.	▪ Additional NGO structures needed to reach the population with immunization services. ▪ Newborn registration and monitoring from a database and SMS reminders.	▪ Use SIGL and stock tools vaccines such as starter stock	▪ Awareness raising and engagement activities community, women's groups in daycare centers, community radios ▪ Social analysis of mobility and communication models ▪ Collaboration with other NGOs and CBOs working in humanitarian, WASH, HIV/AIDS	▪ Monthly supervision ▪ Analysis and feedback regular data. ▪ Quality analysis (analysis and validation of data already at the institutional level and successively at the MSPP and UCNPV *). ▪ Strengthen the monitoring of newborns: - Maternal health and PEV integration. - Strengthen coordination with the civil status office. - Geospatial Information System: strengthen, update and use existing data.

RESULTS

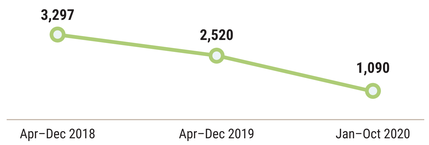
Results

Progression of Penta3 (DTP3) and RR1 (MR1) doses in 2020 (Analyzing possible gaps in sticks for the doses that are to be administered at the same visit).

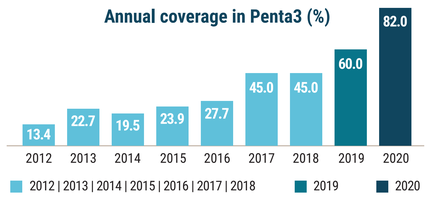


- Halfway through 2020 (end of quarter II): cumulative CV in Penta3 was almost 50%
- The evolution of vaccine coverage (Penta 3 and RR1) had progressed in a linear fashion and was satisfactory.
- The number of non-vaccinated Penta 3 fell by 30% between Dec. 2018 and Dec. 2020.
- The curve for monitoring the number of unvaccinated persons follows a significant regression over time
- Before 2017: the coverage remained below 30%
- In 2017 for phase I (pilot): interventions carried out: 45%
- In phase II, the coverage increased to 60% in 2019 before it has reached 82% in 2020.

Curve for monitoring the number of non-vaccinated in Penta 3



Annual coverage in Penta3 (%)



Lessons Learned

This experience in an urban setting such as Cite Soleil was rich both in information and learning. Among the most relevant lessons have been learned so far, we can list the following:

- When health facilities experience high demand for services due to migration, Methods to ensure proper immunization services include a fast line for vaccination. That is, a line made specifically for children receiving a vaccination. Additionally, experience shows that it is very helpful to get personnel from other departments (family planning, nutrition, etc) to provide temporary contributions for the immunization department.
- When facing high demands of health-related services in thee health facilities, flexibility has been needed to get the process of vaccine supply based on the level of consumption rather than on predefined quotas that can't meet the demands in changing contexts.
- While performing supportive supervision visits as a means to identify gaps and provide recommendations, the most effective approaches are on-the-job-training and the learning-by-doing-approach. This requires careful planning and coordination with relevant stakeholders and health workers.

Recommendations & Conclusions

Dealing with low immunization coverage in a setting with so many uncertainties (political protests, local gangs' violence, countrywide lockdown) has been a continuous learning process that has led to constantly test resiliency. Acclimation to the changing context has provided opportunities to test new specific strategies of implementation that can be recommended. These include:

- It is strongly recommended that the immunization department and supporting partners encourage the basic immunization training for personnel from other departments.
- It is really important that key immunization stakeholders and decision makers show enough flexibility to switch from quotas-based to consumption-based vaccine supply for facilities in areas with changing contexts (demands alternating between high and low).
- When the progression and the performance are still slow despite running several supportive supervision visits, organizing coaching visits to specifically target the areas of weakness can be a good component to supportive supervision visits.

As a conclusion,the key routine interventions have demonstrated favorable impacts on the immunization situation in Cité Soleil. The average waiting time decreased in 2018 from 99 to 43 mins as of 2019 and had slightly increased to 63 mins in 2020. The coverage rate increased from 45 % in 2018 to 73% as of 2019 and finally reached 81% in 2020.This successful experience required the full participation of all the influencing immunization actors : not only the health providers but also the parents of the targeted children and the local community surrounding the facilities.

The urban model implemented in Cite Soleil has a well defined structure with each identified component.However, adaptations within each component are context-driven.Such a model is open-minded and its flexibility makes it adaptable and suitable to various contexts.

Based on the results being achieved and the current tendency, this model provides new hope for Cité Soleil and similar areas in Haiti and in the rest of the world.

https://www.jsi.com/urban-immunization/

RÉPUBLIQUE D'HAITI Ministère de la Santé Publique et de la Population

Gavi The Vaccine Alliance

JSI