LNCT
Learning Network for Countries in Transition

# Engaging the Private Sector to Support Immunization

## Day 2 – Social mobilization and service delivery from the private sector

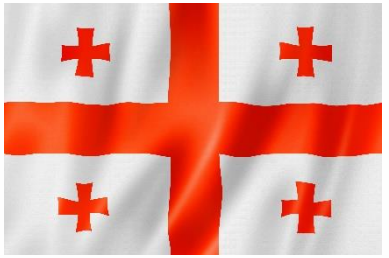
October 2020

# WELCOME BIENVENUE

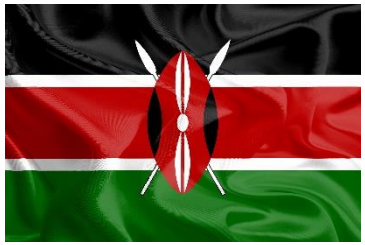
# BEM-VINDO приветствие

Congo

Cote d’Ivoire



Georgia



Kenya

São Tomé e Príncipe

Sudan

# Interpretation for this workshop: SPEAKUS

*Recommendations for joining*

**If you are in a room with others**: We recommend joining the zoom meeting from one computer and SPEAKUS from a second computer

**If you are in a room alone**: We recommend you join the Zoom meeting from your computer and join SPEAKUS from your phone.
We recommend you connect your headphones to your phone.

If you only have **one device** (i.e. one computer or phone) please let us know now and specify what you have.

# Interpretation: computer

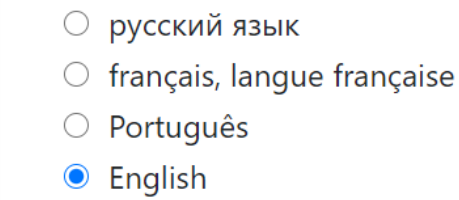
*LNCT recommends opening the interpretation link on a separate computer or device.*

Step 1:

Please follow the link here: https://speakus.club/new/conf.html?id=sco796928

Step 2:

Select your preferred language:

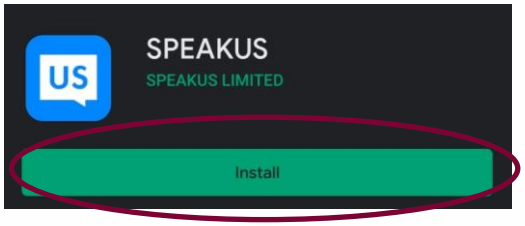


# Interpretation: mobile app

You will need: a smart phone and headphones

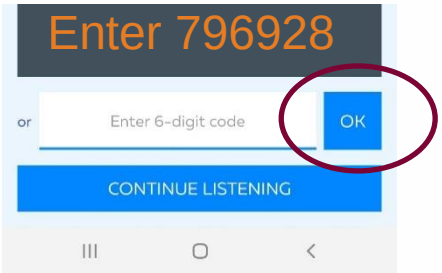
## Step 1:

Download the “SPEAKUS” app from your application store (e.g. Apple or GooglePlay apps)



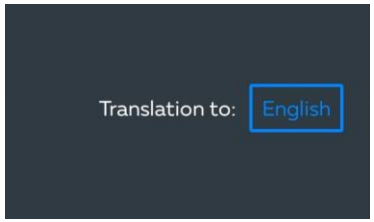

## Step 2:

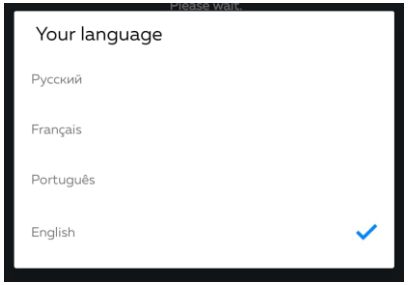
Open your “SPEAKUS” app and enter the 6-digit code 796928. (Prompt should be at the bottom of your screen). Click OK




## Step 3:

Select the language you would like to listen to by clicking the button “Translation to” and clicking your preferred language.



# Day 2 Agenda

| No. | Length | Session Title | Presenter(s) |
|---|---|---|---|
| 9 | 10 mins | **Welcome** | Grace Chee |
| 10 | 45 mins | **Demand Generation** | Sherine Guirguis & Felicity Pocklington |
| 11 | 10 mins | **Break** | |
| 12 | 45 mins | **Private Sector Service Provision** | Helen Saxenian & Miloud Kaddar |
| 13 | 40 mins | **Country Group Work** | Country Facilitators |
| 14 | 10 mins | **Break** | |
| 15 | 10 mins | **Workshop Reflections** | Country Teams |
| 16 | 5 mins | **Closing** | Grace Chee |

# Demand Generation for Immunization

Private Sector Workshop
28 October 2020

DAY 2: LNCT PRIVATE SECTOR WORKSHOP

# Introduction to demand & how CSOs and NGOs can support demand generation for immunization

COMMON THREAD

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# Flow

1. Introduction to demand
    - Scene setting
    - What is demand generation & why is it important?
2. How NGOs and CSOs can support demand
    - Understanding the needs of the under-immunized
    - Understanding the context for NGO and CSO sector engagement
    - Unique strengths of the non-for-profit sector in building demand, including real-world examples

Private Sector Workshop
28 October 2020

DAY 2: LNCT PRIVATE SECTOR WORKSHOP

# 1. Introduction to Demand

COMMON THREAD

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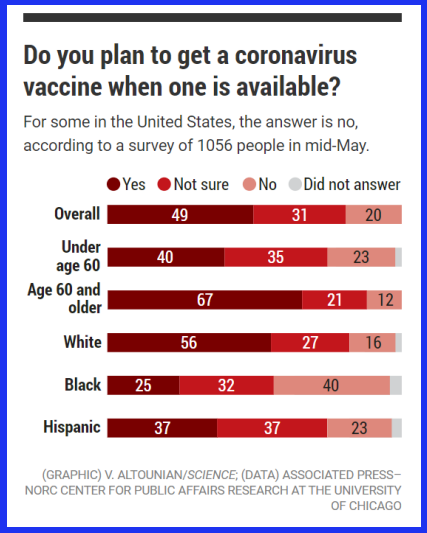
# Why is demand generation important?

# #africansarenotguineapigs

**“The vaccine will be poisonous and not properly tested”**





BBC Sign in News Sport Reel Worklife Travel Future Mo

NEWS

Home US Election Coronavirus Video World UK Business Tech Science Stori

Reality Check

## Coronavirus: False and misleading claims about vaccines debunked

By Jack Goodman and Flora Carmichael
BBC Reality Check

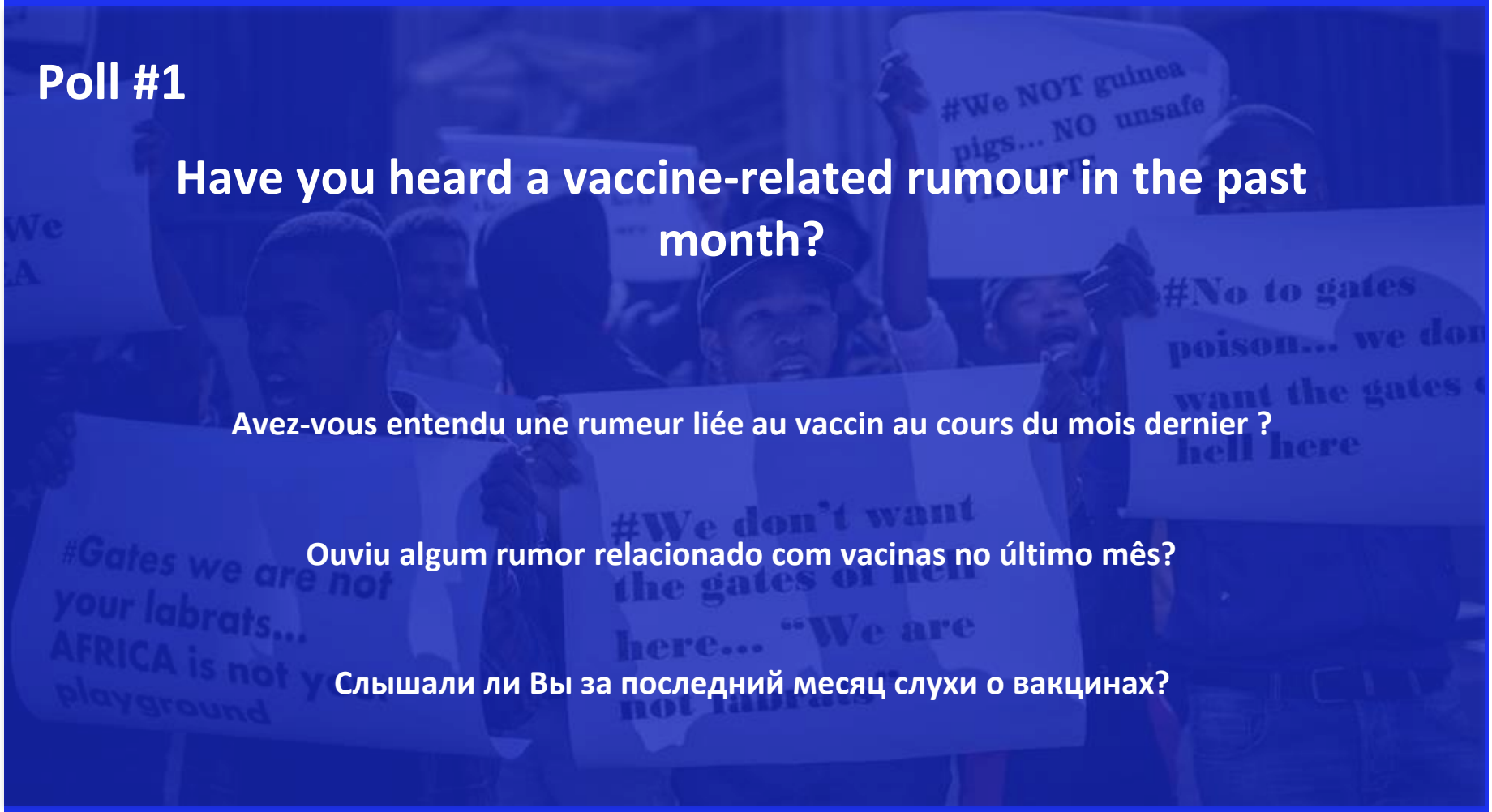
**“Ebola was not a disease, it was a business, and the same people invented COVID-19 to sell things and make money.”**


DANGEROUS RUMOURS C

According to UNICEF’s communication unit in Kinshasa, the most dangerous rumour on social media is that people refuse to believe that the COVID-19 exists in DRC and that it can kill people. This is supported by the findings of a survey by the Kinshasa School of Public Health, which highlighted that 20.2% of people interviewed in the capital did not believe that COVID-19 is real.

**“COVID-19 vaccines already killed people in Senegal”**

https://www.sciencemag.org/news/2020/06/just-50-americans-plan-get-covid-19-vaccine-here-s-how-win-over-rest
https://www.gavi.org/vaccineswork/how-creative-communication-strategies-helping-fight-covid-19-misinformation-drc
Coronavirus Feedback Communautaire, Croix Rouge & Mercy Corps combined.



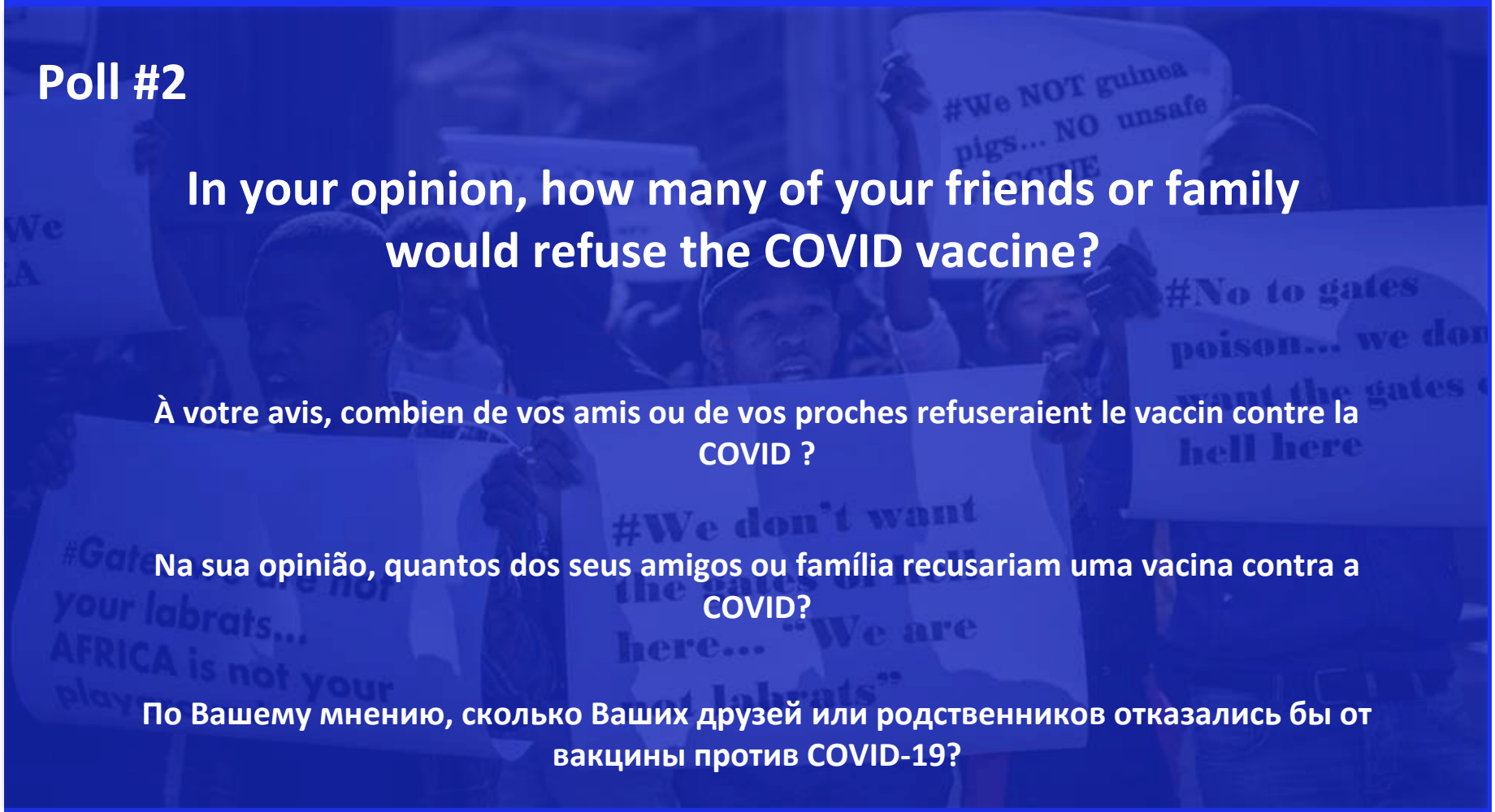

## Poll #1

**Have you heard a vaccine-related rumour in the past month?**

**Avez-vous entendu une rumeur liée au vaccin au cours du mois dernier ?**

**Ouviu algum rumor relacionado com vacinas no último mês?**

**Слышали ли Вы за последний месяц слухи о вакцинах?**




## Poll #2

**In your opinion, how many of your friends or family would refuse the COVID vaccine?**

**À votre avis, combien de vos amis ou de vos proches refuseraient le vaccin contre la COVID ?**

**Na sua opinião, quantos dos seus amigos ou família recusariam uma vacina contra a COVID?**

**По Вашему мнению, сколько Ваших друзей или родственников отказались бы от вакцины против COVID-19?**

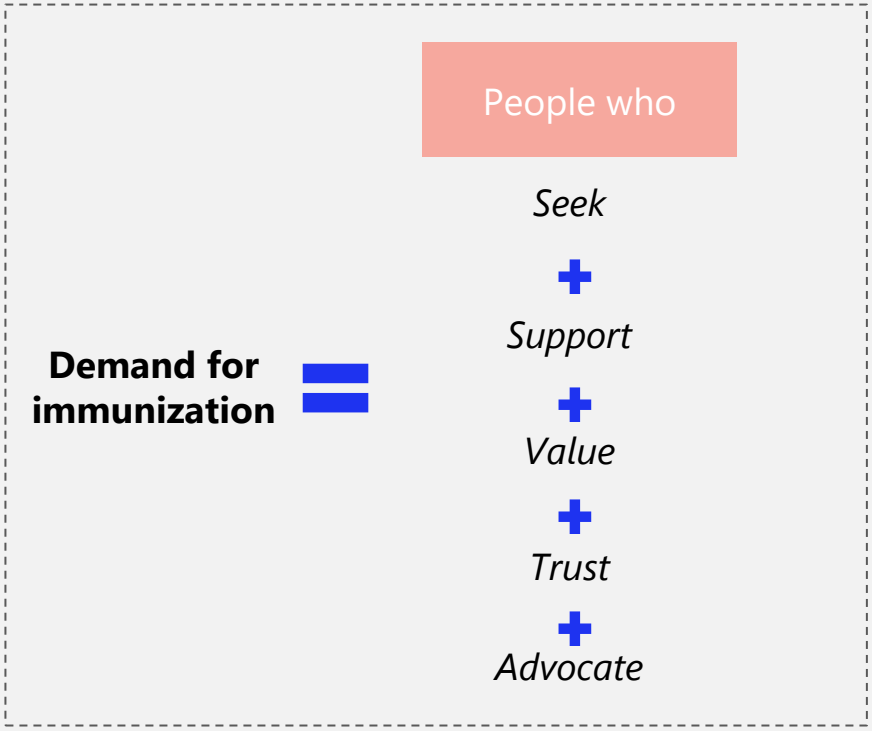
# What is demand generation for immunization?

# ...And why is it important?

# What is demand for immunization?

When people have demand for immunization, they seek, support, value, trust and/or advocate for vaccines and immunization services.

People's demand for immunization can change based on the vaccine, the immunization services provided, the time and the place.




Gavi. Programming guidance - demand generation.
https://www.who.int/gho/immunization/en/

# Demand generation is important for two reasons

1

**Demand generation can help increase immunization coverage**

2

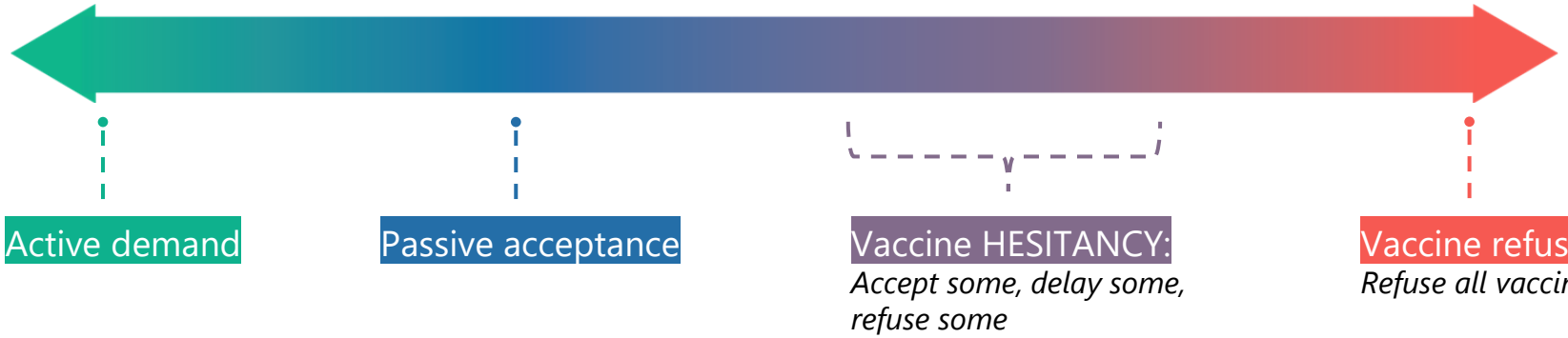
**Demand generation can help combat drops in immunization demand (or backsliding)**

# Demand is not stagnant

Demand is not as simple as people always wanting or not wanting vaccines.

Instead demand lies along a continuum. And people's choices may vary at different moments in their lives.

**Vaccine demand continuum:**




**Active demand** for vaccination is the goal

SAGE Working Group on Vaccine Hesitancy. Report of the SAGE Working Group on Vaccine Hesitancy (revised November 2014). 2014. Available from: https://www.who.int/immunization/sage/meetings/2014/october/1_Report_WORKING_GROUP_vaccine_hesitancy_final.pdf

# Characteristics to recognise across the demand continuum

## Active demand

**The active demand caregiver**

- Considers vaccines safe & important
- Trusts healthcare providers
- Will go out of their way to get vaccinated

## Passive acceptance

**The passive acceptance caregiver**

- Think vaccines are relatively safe
- Doesn't perceive disease risk to be high
- Would get vaccination if convenient

## Vaccine hesitancy

*Accept some, delay some, refuse some*

**The vaccine hesitant caregiver**

- Significant doubts on the safety & necessity of vaccines
- Conflicting feelings on who to trust
- Influenced by social networks

## Vaccine refusal

*Refuse all vaccines*

**The vaccine refusal caregiver**

- Strong willed & committed against vaccines
- Tend to use natural approaches to health
- Religious/moral considerations

SAGE Working Group on Vaccine Hesitancy. Report of the SAGE Working Group on Vaccine Hesitancy (revised November 2014). 2014. Available from: https://www.who.int/immunization/sage/meetings/2014/october/1_Report_WORKING_GROUP_vaccine_hesitancy_final.pdf

# What may demand for immunization look like in your context?

PHOTO: © MONIQUE BERLIER/PATH

**People** lining up for immunization

PHOTO: © LISA MURRAY

**Families and caregivers** traveling long distances **to get immunized**


PHOTO: © CAROLINA DANOVARO/PAHO

**People** returning to health facilities **for subsequent vaccine doses**


PHOTO: © BULLIT MARQUEZ

Locals **advocating for vaccines**

Private Sector Workshop
28 October 2020

DAY 2: LNCT PRIVATE SECTOR WORKSHOP

# 2. How CSOs and NGOs can support demand generation for immunization

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# How can we generate demand?

Demand generation is the process of empowering people to access immunization, and to claim their right to immunization.

We can create demand by **engaging people**, trying to **influence behaviour** and by **communicating** in a way that considers **local norms and beliefs and community structures.**

Demand generation can occur in three ways:

1. **Increase vaccine uptake: Create new uptake of vaccines** - convince caregivers who have never immunized their children to start.

2. **Sustain vaccine uptake: Help existing caregivers continue immunization** - convince caregivers who have partially immunized their children - or dropped out - to continue immunizing until they've completed the full schedule.

3. **Support timely vaccine uptake: Convince caregivers to seek immunization immediately,** instead of seeking immunization when an illness has occurred.

WHO/AFRO, UNICEF/ASARO & UNICEF/WCARO Positioning demand generation in National EPI Planning and Implementation process. Brazzaville: World Health Organization; 2017.

# How does demand generation differ from communication?

## Communication

Communication focuses on raising knowledge and awareness, and engaging people on the importance of immunization. This is an important component of demand generation, but much more is needed to change behaviours.

Communication

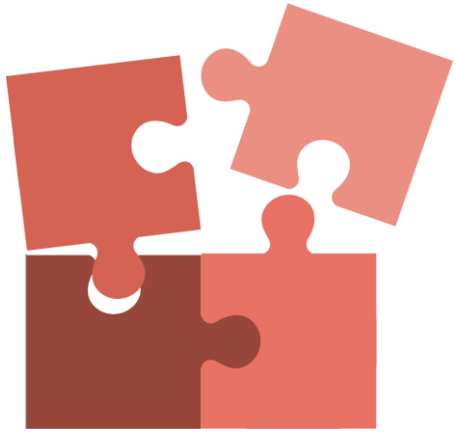
VS

## Demand Generation

Demand generation recognizes that communication is only one piece of the demand puzzle and that in order to influence behaviour, many different strategies - at all levels - must occur together.

Communication

Community Engagement



Incentives

Training

## Who are the unimmunized children?

Across most contexts, the unimmunized child is likely to:

### Live in a poor household

In all countries reviewed, the poorer the family the less likely they were to vaccinate their child

**India:** Poor children have a 59% higher risk of not being fully immunized compared to wealthier children.[3]
**Indonesia:** Poor children are ~3x more likely to be unimmunized compared to the wealthiest quintile.[5]
**Pakistan:** 23.4% of the poorest children are fully immunized compared to 75.4% among the richest quintile.[7]

### Have parents, especially mothers, with limited education

Children whose mothers have higher levels of education uniformly have higher immunization coverage

**Afghanistan:** Women with some formal education are 64% more likely to vaccinate their child.[1]
**Indonesia:** Children born to mothers without formal education are ~6x less likely to be immunized.[4]
**Pakistan:** Women with less than a high school education are less likely to complete basic immunization for their child.[6]

### Belong to a minority group

Ethnic/religious minorities often have distrust with the government, leading many to be left-out of the formal health system or opt-out of the system

**Afghanistan:** Pashtuns are less likely to vaccinate their children compared to Hazara and Tajiks.[1]
**India:** Muslim and Christian children have lower immunization compared to other religions.[2]
**Pakistan:** Gilgitis, Magris, Pashto and Kashmiris are less likely to have complete immunization.[7]
**Indonesia:** In 2018, Islamic clerics declared the MR vaccine haram and Indonesia saw MR vaccine rates plummet[8]

## Who are the unimmunized children?

Across most contexts, the unimmunized child is likely to:

### Be on the move often

Migration internally or across countries results in infrequent access to services leading to immunization drop-out

**Pakistan:** Families traveling between Afghanistan and Pakistan and settlements in Balochistan, KPK, Karachi and Sindh are difficult to reach and vaccinate[5]
**Bangladesh:** Migration from urban to rural between the birth of the child and the child's residency decreases the likelihood they will get fully vaccinated[6]

### Be born outside of a health facility

Mothers with limited contact to health facilities are less likely to be informed of the benefits of immunization

**India:** Mothers who have even one ANC visit show a 13% jump in immunization rates[1]
**Pakistan:** Women in Sindh without assistance during childbirth have the lowest immunization status (24%)[2]
**Indonesia:** Children not born in a health institution are 40% less likely to be immunized[3]

### Have many siblings

In some countries, younger children in the family generally have fewer vaccinations than first born children

**Indonesia:** As birth order increases, the likelihood of being unimmunized linearly increases[4]
**Philippines:** Families with more than 1 child are more likely to drop out[7]
**Myanmar:** 6th or higher order children are less likely to be immunized compared to their siblings[8]

# Where are the unimmunized children?

## Conflict-affected areas

These areas have damaged health infrastructure and depleted human resources leading to interupted outreach services.

## Hard to reach areas

Mountainous, water-logged or high-rise buildings make it difficult for vaccinators to gain access to communities for outreach services.

## Urban slums

Urban slums tend to have higher levels of violent crime, insecurity and closer living conditions which create higher risk of disease.

## Rural areas

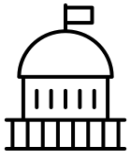
Families in rural areas generally have less access to quality health services and have to travel longer distances to find a health facility.

# Unique strengths of the non-profit sector to build demand and reach the underserved

## What are the competitive advantages of CSOs and NGOs in building demand?

Innovators

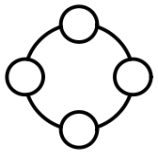
Advocates and Champions



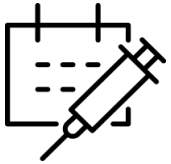
Political Will-Builders

Knowledge Producers

Awareness Raisers and Conversation starters



Community and Social Mobilizers



Service Providers

*Source: GAVI. An Atlas of Vaccine Demand.2020*

Non-profit organisations as Innovators

# CSOs and NGOs can identify local challenges

Operating “on the ground” helps them see opportunities that remain unnoticed by governments

Being small and agile means they can develop and test new services quickly

Being in or close to the field speeds means they have to innovate every day to solve difficult problems

Local innovative solutions can inform governments and expand to policy

*GAVI. An Atlas of Vaccine Demand.2020*

# Reaching nomadic communities during market days (Mali)

In the region of Sèguè, many of the 6 360 inhabitants are nomadic without a vaccination history.

**A women-led CSO *Projet d'Appui au Développement Communautaire* sent local women to talk with trading nomads about immunization. During their discussions, they came up with an idea.**

**Nomads go the city on market days. Offer Immunization to women at places they are already going.**

**"Meet them where they are."**


*CRS (2019) Civil Society Organization Platforms Contribute to National Immunization Programs, www.coregroup.org*

Non-profit organisations as Advocates & Champions

## CSOs and NGOs can keep governments accountable:

"Ringing the alarm bells" if governments are not keeping to their promises

Identifying, shaping and reinforcing key messages about vaccination to decision makers, donors, and media

Informing public officials about the needs of underserved and forgotten communities

Acting as trusted representatives on behalf of hard-to-reach regions

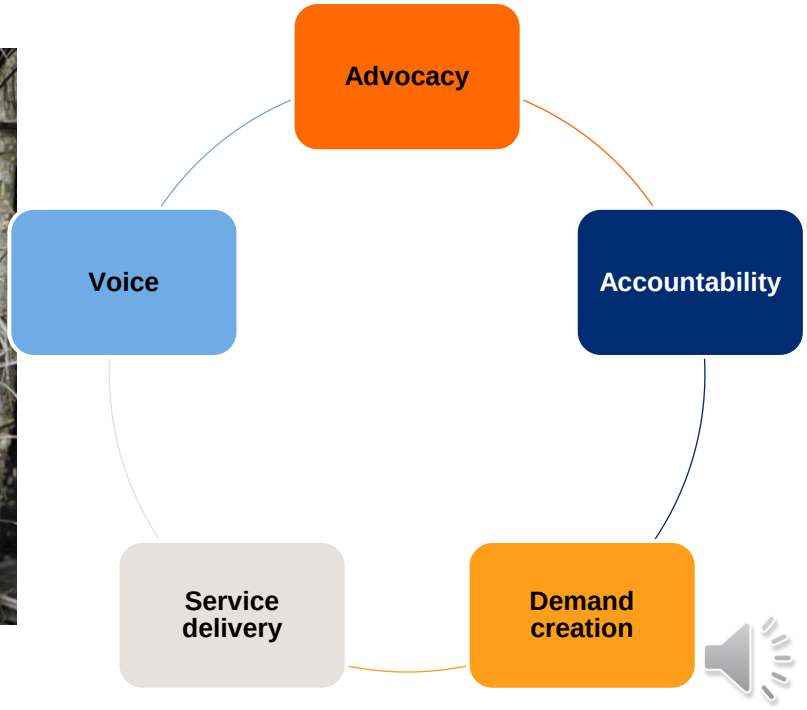
*GAVI. An Atlas of Vaccine Demand.2020*

# Country presentation

# Advocacy in Nigeria

**Dr. Chizoba Wonodi,**
**on behalf of WAVA and Gavi CSO Steering Committee**

# CSOs play a variety of important roles in the immunization program

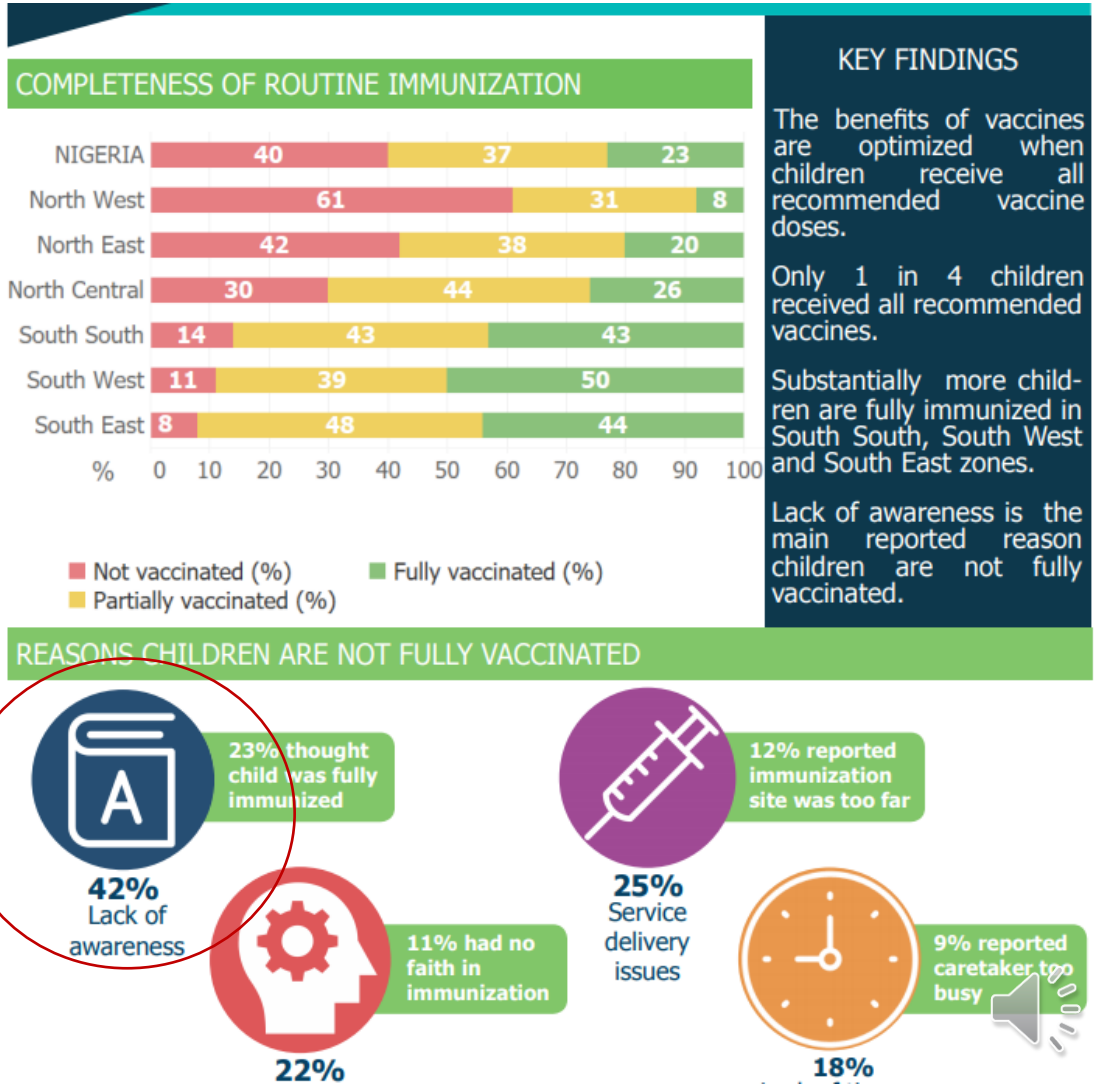




IVAC

**Strong need for demand-side interventions**

The 2016/2017 NICS MICS demonstrates that lack of awareness is a major reason for children not being fully immunized, highlighting the importance of demand generation in achieving immunization coverage goals

CSOs play an important role in demand creation and could play an even bigger role if their social assets and reach are harnessed and optimized

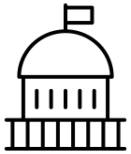



IVAC

# Challenges with government's formal engagement with CSO

- Absence of a clear structure and mechanism for sustainably engaging CSOs are partners
- Need for a well funded-structured platform to coordinate CSO activities and contributions to immunization
- Absence of a well-defined funding mechanism for CSOs
- Poor recognition of the broader developmental value CSOs bring to immunization
- Government concern about CSOs' motives and impact of their watch-dog role

IVAC



Non-profit organisations as Political will-builders

## CSOs and NGOs can help in framing health as human right:

Highlighting the unequal access to health care to motivate policy makers to act

Giving voice to individuals who otherwise don't have means to speak up to the social and political discourse

Using grassroots advocacy to improve access to health care in marginalized communities

*GAVI. An Atlas of Vaccine Demand.2020*

# **Evidence-informed advocacy** (Malawi)

In Malawi, unequal access to healthcare has been further exacerbated by a reduced national healthcare budget.

**A health advocacy platform Malawi Health Equity Network (MHEN) analysed the inefficiencies in the state budget and used the data to successfully lobby an increase of the healthcare budget by $17 million in 2015-16.**

**Lessons learned:**

- **Local communities, such as regional Mother Care Groups, provided MHEN with invaluable grassroots information, which helped advocate and build pressure against budget cuts.**

*CRS (2019) Civil Society Organization Platforms Contribute to National Immunization Programs, www.coregroup.org*

Non-profit organisations as Knowledge producers

## CSOs and NGOs have a wealth of knowledge about the communities they serve:

Data from qualitative interviews

The implicit knowledge the organisation has accumulated throughout the years

Data from quantitative surveys, observations and experiments

*GAVI. An Atlas of Vaccine Demand.2020*

# Using surveys to understand under-vaccination (Sierra Leone)

In 2014, there was a rapid increase of missed vaccination appointments - about 30% of children in Sierra Leone did not show up for their visits.

**The Scaling up Nutrition and Immunization Civil Society Platform carried out a survey to caregivers. It found that many parents believed that health facilities were transmitting Ebola - and thus did not take the vaccination.**

**Lessons learned:**

- **Sudden disease outbreaks can lead to panic within communities.**
- **Traditional and religious beliefs may come to the forefront, causing caregivers to become suspicious about modern treatments**
- **Engaging religious and village leaders is vital when tackling false beliefs**

*CRS (2019) Civil Society [illegible] Tackling False Beliefs in Programs, www.coregroup.org*

Non-profit organisations as Awareness raisers & Conversation starters

# CSOs and NGOs can highlight challenges others cannot:

CSOs and NGOs are first responders in the communities

They have insight into locally circulated misinformation and influencers

They can translate scientific evidence into simple actionable stories picked up by the local communities

Local organisations are trusted by people, which helps spark conversations and motivate behaviour change

*GAVI. An Atlas of Vaccine Demand.2020*

# The Dangerous Speech Project (Kenya)

In the past 20 years, inflammatory speech has proliferated Kenyan media.

**NGOs and academics created "Umati" - a platform where Kenyans report hate speech and learn how to limit the spread of misinformation, including misinformation about vaccines.**

**Lessons learned:**

- **90% of hate speech goes through Facebook**
- **Much of the reported speech was a reaction to events that were witnessed off-line**
- **Most of the hate speech concerned ethnicity and religion**

*https://dangerousspeech.org/kenya/*

Non-profit organisations as Community and social mobilisers

# CSOs and NGOs are natural mobilizers:

CSOs and NGOs operate on the ground (and often in remote areas), which makes them uniquely positioned to engage local communities

They also possess knowledge of social and cultural context, which helps them develop tailored and respectful vaccination programs

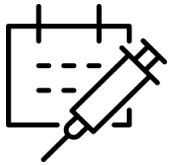
*GAVI. An Atlas of Vaccine Demand.2020*

# Barber's Initiative
(India)

Indian fathers often have a decisive say over vaccinating their child. However, they often know little about vaccination and dismiss the topic.

**Barbers form an integral part of Indian culture and interact with men on daily basis. India's *CORE Network* trained barbers to provide accurate information about vaccination, which helped to sensitize fathers on the importance of vaccinating their child.**


CRS (2019) Civil Society Organization Platforms Contribute to National Immunization Programs, www.coregroup.org



Non-profit organisations as Service providers

# CSOs and NGOs can fill the gaps in immunization provision

CSOs and NGOs have a unique ability to reach underserved communities

Understanding the local context, CSOs and NGOs can provide immunization services that are respectful to religious and cultural customs in the area

Operating on different budgets, CSOs and NGOs can often provide better quality services than public health facilities

Their small size allows them to offer personalized service to families and children

*GAVI. An Atlas of Vaccine Demand.2020*

# **Immunization Sundays** (Kenya)

Some caregivers do not want to immunize their children for religious and cultural reasons.

**The Kenyan Health NGO Network (HENNET) partnered with Christian and Muslim religious leaders, who talked to congregants on the importance of immunization and invited them to a health service check provided right after. In total, 299 children attended the medical check.**

**Lessons learned:**

- **For some caregivers, a health check right after Sunday service is more convenient than visiting a clinic in routine hours**
- **Involvement of grassroots stakeholders is vital to address caregivers' cultural concerns**

*CRS (2019) Civil Society [illegible] Can Help Reforms Contribute to National Immunization Programs, www.coregroup.org*

# A Common Thread for CSOs and NGOs:

# Advancing equity

## NGOs and CSOs are well placed to:

**Reach** remote and marginalised communities where help is most needed

**Represent** the voice of underserved and excluded groups

**React** to vaccination challenges as local first-response teams

**Revolutionize** approaches to addressing under-vaccination by adopting innovative approaches and new technologies

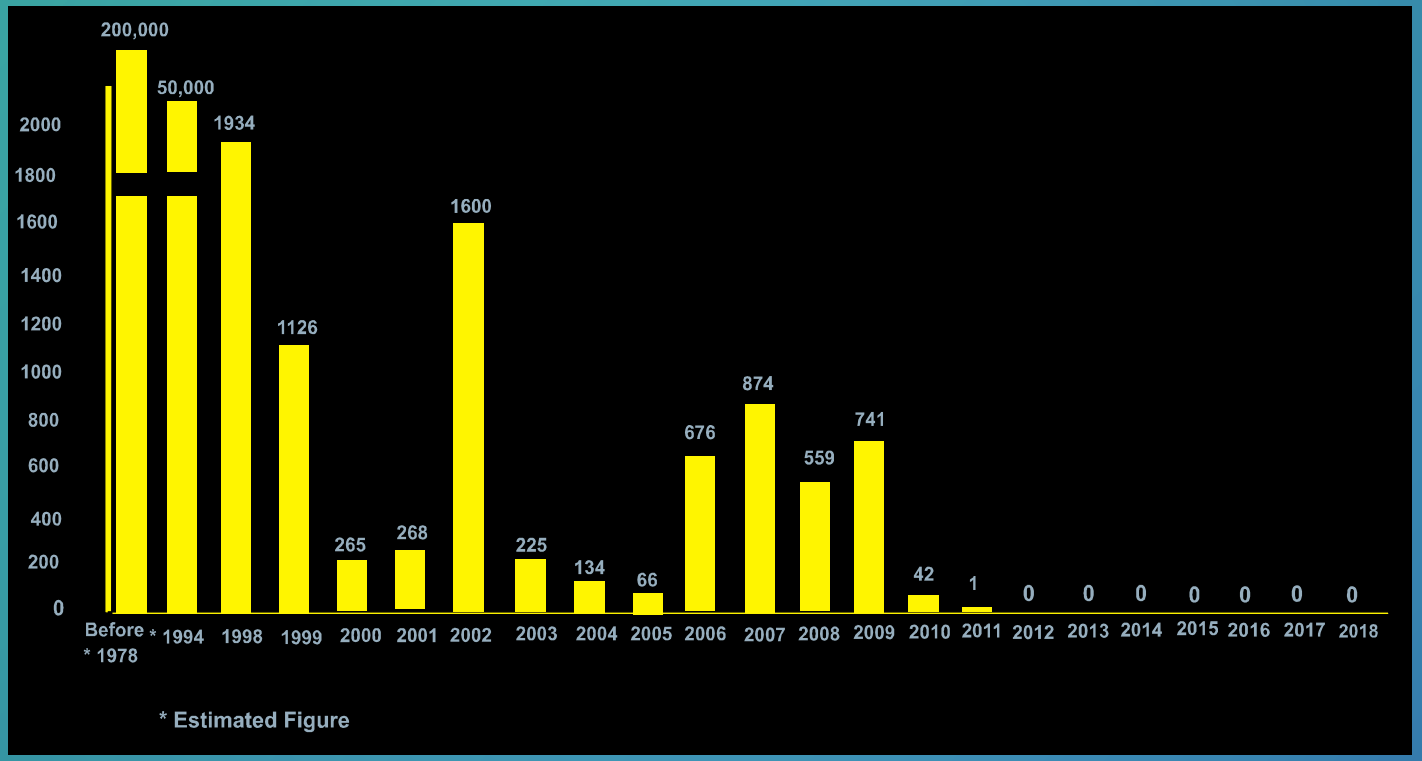
# Country presentation

# Presentation from Lokesh Gupta:

# Rotary's role in eliminating Polio in India

Rotary

# Wild Polio Cases in India




Rotary

# Rotary's Role in India

**Advocacy**

- Political
- Bureaucratic
- Religious
- Corporate

**Financial**

**Social Mobilization**

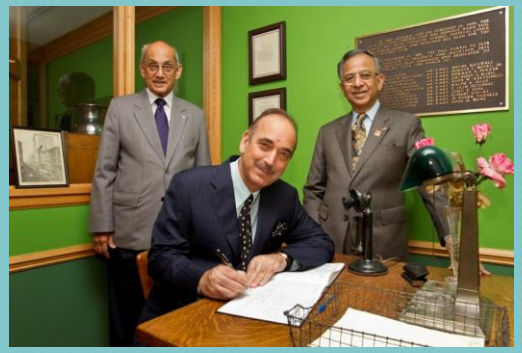
**Operational Support**

Rotary

# Advocacy with Politicians

Former President of India Late APJ Abdul Kalam Immunizing child

The launch of first National Immunization Day in 1995 by the then Prime Minister of India



Former Health Minister's visit to R.I. Evanston office

Meeting with the Former Prime Minister of India with Senior Rotary Leaders

Rotary

# RELIGIOUS ADVOCACY

## Muslim Religious Leaders' Conclave

In a symbolic meet to address the issue of polio resistance in the Muslim community, 98 Muslim religious leaders and scholars from UP, Delhi, Uttaranchal and Rajasthan gathered in the capital on August 10, 2006, held under the auspices of the Rotary International's India National PolioPlus Committee.

60% of the total polio cases were from Muslim Community, Rotary International formed a State Level Committee of Muslim Ulemas in U.P. in 2007. The Committee contributed significantly to reducing Polio incidences in their community by educating and informing them about the importance of immunization of children.

# INNOVATIONS/INITIATIVES – India Rotary

*MEDIA CAMPAIGN*

*FINGER MARKING FOR IMMUNIZED CHILDREN*

*LONGEST BANNER*

*SAND ART*

*RADIO PROGRAMS*

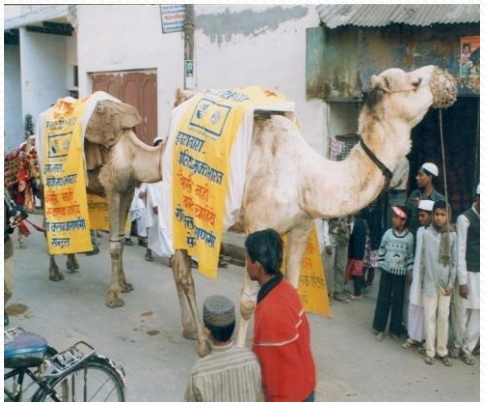
*CARTOON FILMS*

*EFFIGIES(POLIO VIRUS)*

Rotary

# INNOVATIONS/INITIATIVES – India Rotary

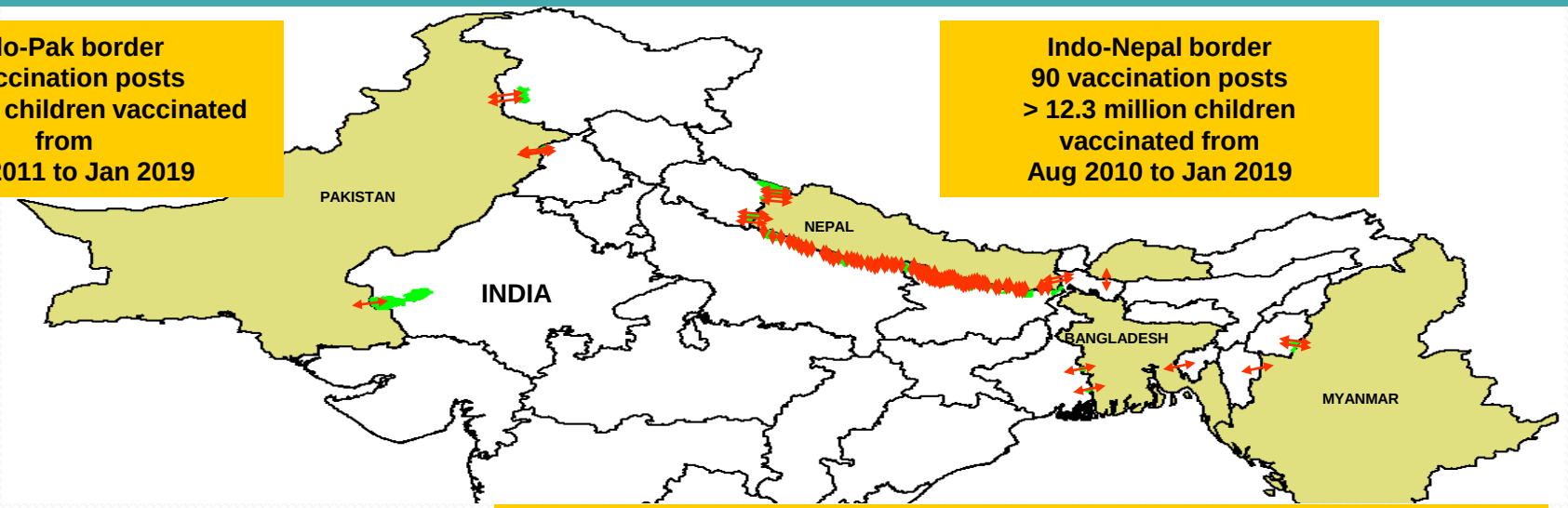
***RALLIES***

# CONTINUOUS VACCINATION OF CHILDREN AT BORDER CROSSING POINTS

**Indo-Pak border**
**5 vaccination posts**
**> 392,000 children vaccinated from**
**Sep 2011 to Jan 2019**

**Indo-Nepal border**
**90 vaccination posts**
**> 12.3 million children vaccinated from**
**Aug 2010 to Jan 2019**




Vaccination post

Blocks with vaccination post

**Indo-Bangladesh border: 3 vaccination posts (> 132,000 children vaccinated from Mar 2013 to Jan 2019)**

**Indo-Myanmar border: 3 vaccination posts (> 45,000 children vaccinated from Apr 2013 to Jan 2019)**

**Indo-Bhutan border: 1 vaccination post (>131,000 children vaccinated from Jul 2013 to Jan 2019)**

**Greater focus on border populations**

**Polio Free India human image made by more than 6,000 school students in Delhi on World Polio Day (October 24, 2016)**



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# NORTH INDIA CAR RALLY FOR PROMOTING IMMUNIZATION (Measles Rubella And Polio)






Rotary

# IEC MATERIALS


Video Vans


Boats


Posters


Cinema Slides


Mobile Stand

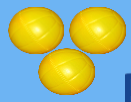
Apron


Cassette

Tiffin box


Banners


Marker Pen

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# SUPPORT FOR SOCIAL MOBILIZATION





# Involving CELEBRITIES through spots on various TV Channels

Film Star Shahrukh Khan

Film Actress Priety Zinta

Film Comedy King Johnny Lever

Film Actor Kadar Khan

Former Miss World Aishawarya Rai

Film Actress Rani Mukherjee

Film Actress Priyanka Chopra

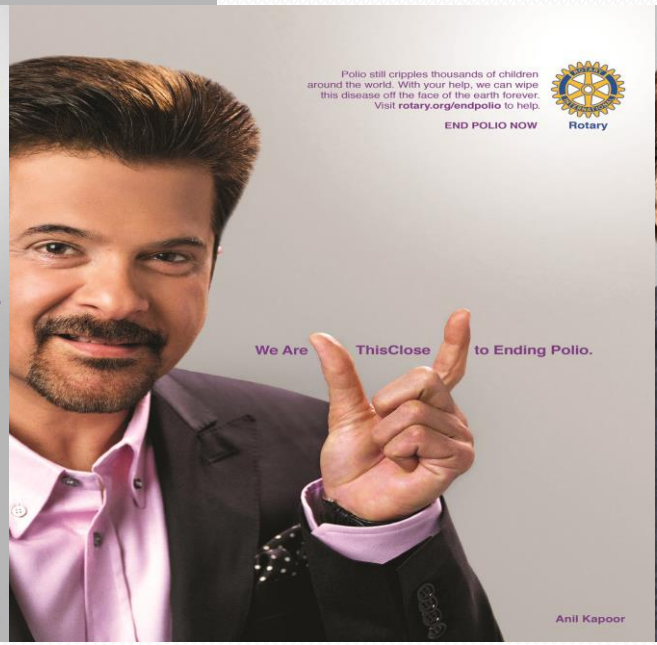
Film Star Akshay Kumar

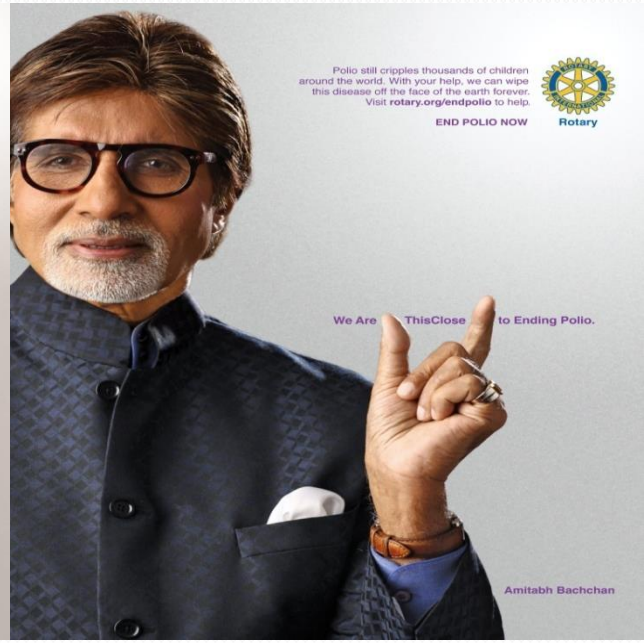
Rotary

Rotary

# Rotary's 'This Close Campaign'





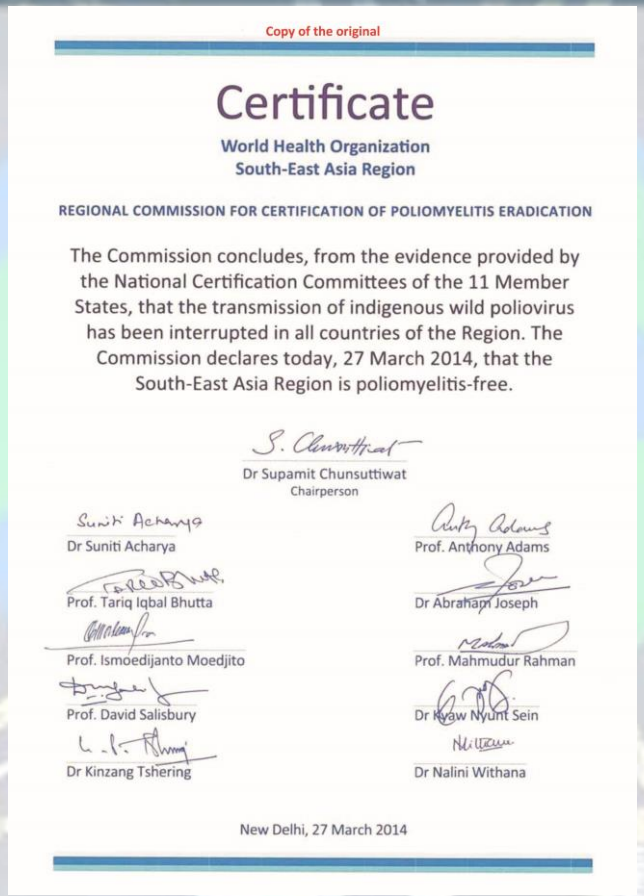
# ACHIEVEMENT

**During the Years from the start of the Polio program, India was able to protect the life of**

**5Million children getting paralytic.**

Rotary

# ACHIEVEMENT



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## Certificate

**World Health Organization**
**South-East Asia Region**

**REGIONAL COMMISSION FOR CERTIFICATION OF POLIOMYELITIS ERADICATION**

The Commission concludes, from the evidence provided by the National Certification Committees of the 11 Member States, that the transmission of indigenous wild poliovirus has been interrupted in all countries of the Region. The Commission declares today, 27 March 2014, that the South-East Asia Region is poliomyelitis-free.

Dr Supamit Chunsuttiwat
Chairperson

Dr Suniti Acharya

Prof. Anthony Adams

Prof. Tariq Iqbal Bhutta

Dr Abraham Joseph

Prof. Ismoedijanto Moedjito

Prof. Mahmudur Rahman

Prof. David Salisbury

Dr Kyaw Nyunt Sein

Dr Kinzang Tshering

Dr Nalini Withana

New Delhi, 27 March 2014

Rotary

- **What worked well to make the partnership a success?**
    - Regular meetings with the Core Group at the National Level to discuss challenges and shared solutions.
    - Strong coordination of the Partnership at State and District levels.

***"To make a success of the partnership, the idealism needs to start from the top and that is what we did. We were four partners but with one voice."***

- **What were the key challenges to overcome?**
    - Funding in the initial years: Rotary financially supported the programme.
    - Resistance from minority communities: The Muslim Ulema Committee was formed.
    - Resistance at the village level in endemic states: UNICEF deployed social mobilizers at village level, aiming to change behaviours.
    - Inaccessible areas: The government supported logistics to ensure there was no area unreached.

- **What are the key lessons learned?**

***"The Public-Private partnership played a key role in the success of the India polio programme. Involving the CSOs could be a game changer for the health programmes."***

***"While working [at the community level], CSOs build up the confidence of the community, engaging those organizations will be quite supportive [to your efforts]".***

# Question and Answer session

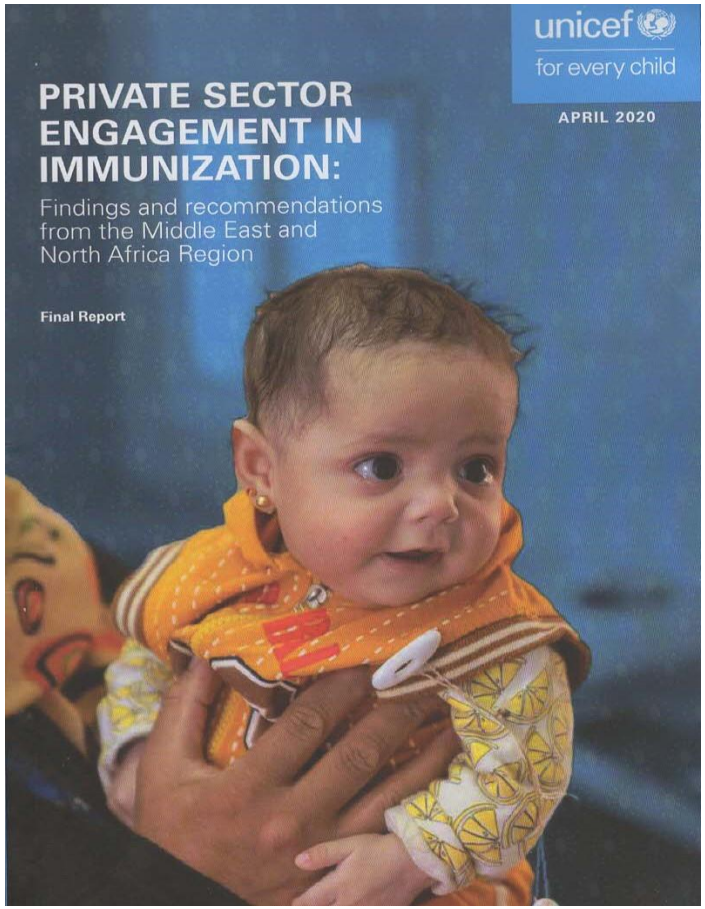
hello@gocommonthread.com
www.gocommonthread.com

# 10 MINUTE BREAK

# Private Sector Service Provision

# Findings and Recommendations from the Middle East and North Africa Region

# Private sector engagement in immunization: findings and recommendations from the Middle East and North Africa region



# About the study

Private provision refers to both for profit, ranging from solo providers to large hospital clinics, and not-for-profit providers

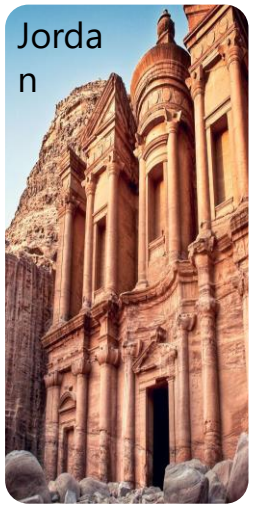
- Study objectives
  - understand current role of private sector in immunization
  - identify options to improve *existing* public private engagement
  - identify steps to engage private providers *longer term* to ensure system *as a whole* meets needs of immunization program goals
- Carried out in partnership with UNICEF, Middle East and North Africa Regional Office in 2018/2019

# Survey and case studies

**Breadth**: 70 respondents, 16 countries

Survey covering 16 countries

**Depth**: Face to face discussions structured by in depth questionnaires for public sector stakeholders, not-for-profit providers, for-profit providers, procurement agents, and pharmacies. Five full days of interviews in each country.

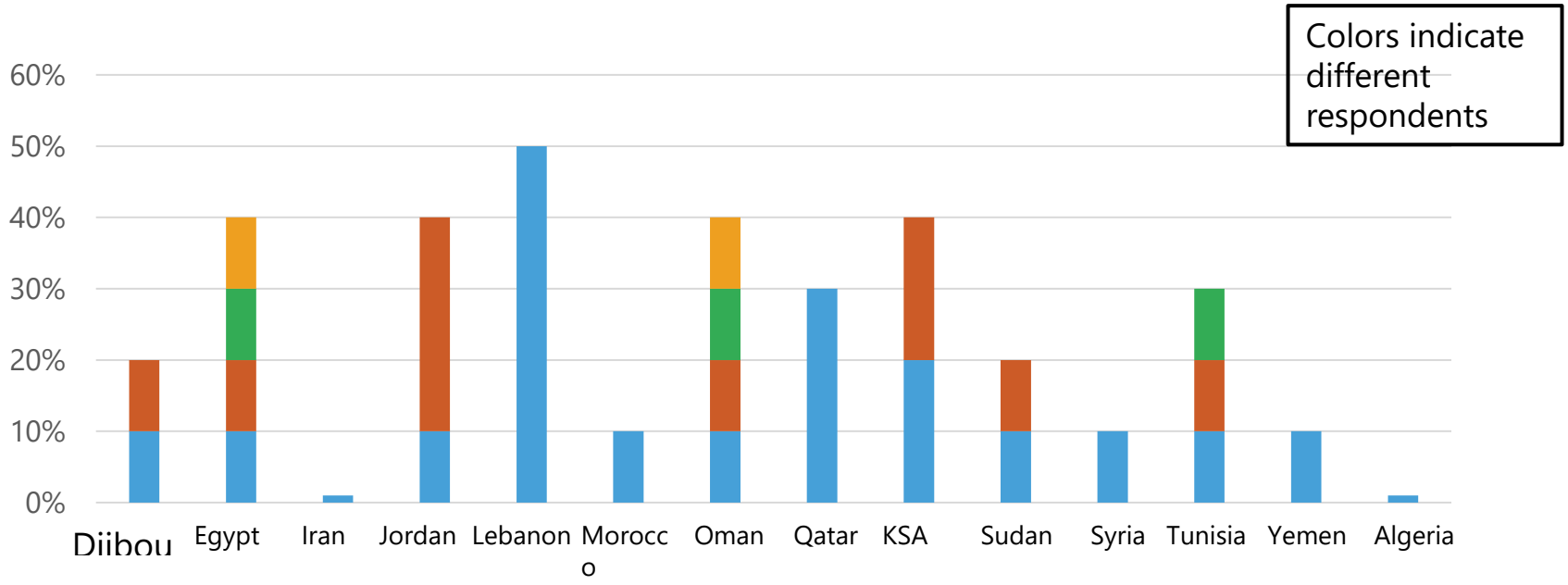




# Understanding the landscape of private provision of immunization services

- What types of private providers are operating in the context of your country's immunization program (if any)?
- What services do different providers offer?
- What socioeconomic groups do different providers reach?
- What types of reporting are done by different providers?
- What are the most important quality challenges for different provider types?

# Survey respondents were asked what is the percent contribution of private vaccination to coverage? Little consensus in some countries




Source: online survey

# Range of approaches: some countries do not permit private provision of immunization, others encourage this and even provide vaccines (for free) to private providers

| Government provision of vaccines to private providers (for free) | |
|---|---|
| Not applicable: no private providers in immunization | Iraq, Libya |
| No provision of vaccines to private providers | Algeria, Egypt, Morocco, Syria |
| Pilot provision to private providers | Tunisia |
| Government supplies vaccines to not-for-profit providers only | Jordan*, Palestine |
| Government supplies vaccines to all providers | Djibouti, Lebanon, Oman, Saudi Arabia, Sudan, Yemen |

*Jordan also provides a few of the less expensive vaccines (such as OPV) to a few for profit providers

# Restrictions vary on what vaccines private providers are allowed to provide

| Vaccines that private sector is permitted to provide: | |
|---|---|
| No private providers in immunization | Iraq, Libya |
| National Immunization Program (NIP) vaccines only | Algeria, Oman, Sudan, Yemen |
| NIP and non-NIP vaccines | Djibouti, Egypt, Jordan, Lebanon, Morocco, Palestine, Saudi Arabia, Syria, Tunisia |

# Some quality concerns reported by survey respondents

- Lack of strict adherence to National Immunization Program schedule
  - Responding to parental concerns and financial constraints
- Cold chain equipment and maintenance may not meet recommended standards
- Lack of government supervision of private for-profit vaccination
- Private providers receive materials from pharmaceutical industry rather than NIP

# Key observations from our country case study results: Jordan, Sudan, Tunisia

**Private providers contribution to immunization coverage (DTP3) at roughly similar levels, but very different models**

- **Not-for-profits**: important roles in Jordan and Sudan, particularly with refugees. Not present in immunization in Tunisia.
- **NIP vaccines only?** In Jordan and Tunisia, private providers administer vaccines outside of NIP and those in NIP. In Sudan, private providers only administer vaccines in NIP
- **Provision of free vaccines to private providers**
  -In Sudan, gov. gives all vaccines, on condition providers do not charge for the vaccines
  -In Jordan, gov supplies vaccines to not-for-profits
  -In Tunisia, gov. supplies a few vaccines to a few for profit providers on pilot basis
- **Pharmacies emerging** as both administrator of vaccines and distributor to households in Jordan and Tunisia

# Are private providers contributing to high and equitable coverage?

- Not-for-profit providers are extending reach to most vulnerable and improving coverage in Jordan and Sudan, particularly for refugees and internally displaced persons
- NGOs may have geographic reach where governments cannot go, for example, Darfur
- For-profit providers and hospitals can potentially also reach poorer groups if public sector provides financing (or vaccines, at the very least, as the case of Sudan)
- Private clinics can potentially relieve some of the burden on crowded public clinics

➢ Is there scope for a greater role of for profit and not-for-profit providers in reaching the most vulnerable and how can government promote this?
  - For example, beyond free vaccines, recognition and feedback on importance of their roles?

# Quality services

**Amenities versus clinical quality**. Clients may perceive that private providers have higher quality services over public clinics. Private providers may offer amenities such as convenience, time that provider spends with patient, shorter waiting times (or appointments). Offer vaccines not yet introduced in national schedule.

Both case studies and online survey identified concerns about quality in some private providers

- **Following national immunization schedule**
  - Private providers may not be up-to-date on recent guidelines and norms
  - Private providers more willing to deviate from schedule. This can result in incomplete vaccination.

- **Cold chain**
  - Insufficient guidance/training on cold chain
  - Not using recommended equipment
  - Transport of vaccines by caretakers from pharmacies to private pediatricians interrupts cold chain

# Quality services cont.

- **Consumers may take children to obtain vaccine from both public and private clinics**
  - No standard immunization card
  - More risks of duplication and drop out
  - Time consuming for caregivers

- **Reporting of doses** from private sector incomplete in some countries, compliance highest when vaccines supplied by government

- **Uneven reporting of AEFIs and VPDs**
  - Some providers indicated they report AEFIs to manufacturers and not to MOH

➢ How can government best use policies, formal agreements, training, norms, requirement to use standardized immunization cards, electronic reporting systems, EPI bulletins, supervision, other measures to improve these and other quality concerns?

# Efficiency issues

- Private providers, particularly not-for-profits, may be able to provide services where government facilities do not exist: governments can encourage this role
- Private providers may reduce burden on public facilities
- Private providers can improve awareness and acceptance of important new vaccines
- If government can purchase vaccines or cold chain cheaper than the private sector, they could sell to private providers at cost

➢ What efficiency issues and measures need to be considered?

# Conclusions

- Excellent examples of public-private collaboration in Middle East and North Africa Region, for example in Sudan and Jordan
- Even where national immunization program is high performing, there may be an important role for private sector, particularly not-for-profits, in reaching the vulnerable
- Study reveals many areas for improvement with recommended actions for government, partners, and professional associations
- Need to consider how to optimize existing arrangements but also how system should be shaped over longer term to achieve objectives

*Thank you to all our many collaborators and to UNICEF for organizing this study!*

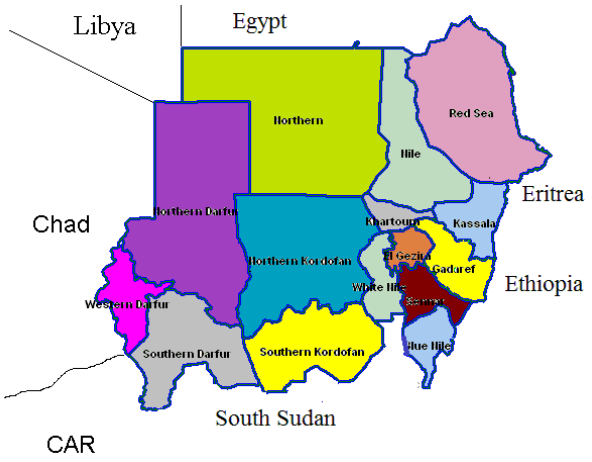
# Sudan Case Study: Increasing Immunization Coverage and Reducing Disparities

# Engagement with the Private Sector to increase immunization coverage and reduce disparities

## Sudan case study

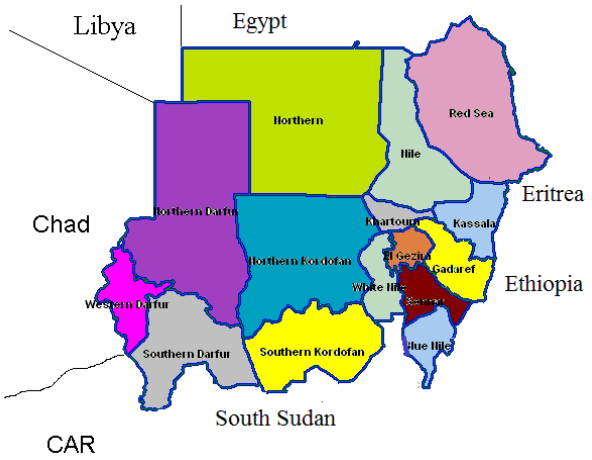
# Background

- 18 states, total population of 40.5 million
  - Birth cohort of 1.32 million
- One of three longstanding Gavi – eligible countries in Middle East and North Africa region
- Many economic and political challenges
  - Inflation, devaluation of currency, and fuel shortages
  - Secession of South Sudan➔loss of oil revenue
  - 2.2 million IDPs  as well as 2 million refugees (74% S. Sudanese)
  - COVID-19



# Background (continued)

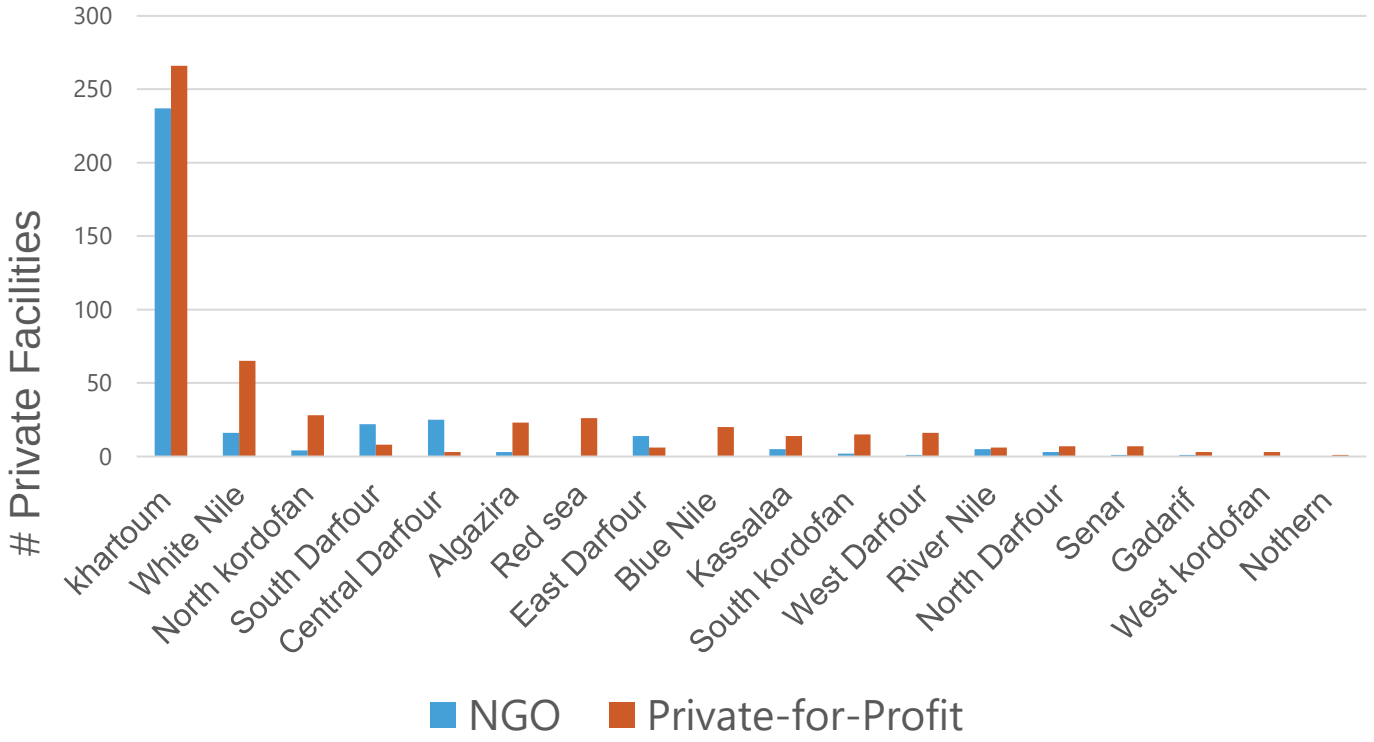
- Immunization program is performing well
  - Pentavalent coverage of 95% (WHO-UNICEF)
  - MCV coverage of 90%, 72% for first and second dos
- Challenges
  - High turnover for HR and reliance on volunteers
  - Hard to reach pops – pastoralists/nomads, IDPs, refugees, conflict areas



# Private providers are actively engaged in immunization service delivery

- 411 or 55% of private health facilities offer immunization services in 2017 (Ahmed et al. 2019)
  - 339 NGO facilities (69% of NGO facilities)
  - 517 private for-profit (40% of PFP facilities)

# Majority of private facilities are in Khartoum State




Source: EPI micro-plan 2020

# Regulation of private sector vaccination

- Sudanese government regulates the private sector through two agencies
    - Directorate of Private Care Facilities in states with large private sector presence
        - Agreements between providers and state governments
        - Must be licensed, follow national immunization policy, use national vaccines procured by government, provide vaccinations free-of-charge, and report monthly on their service volume
    - Humanitarian Aid Commission (HAC)
        - Regulates NGOs outside of Khartoum; requires NGOs to sign Memorandums of Understanding with state MoHs
- EPI provide regular supportive supervision from all levels (National, State and District) to private facility vaccination
    - Immunization officers conduct regular supervision on service delivery and to ensure that the cold chain is being maintained, review data and quality of services.

# Main characteristics of private providers

**Private for-profits**

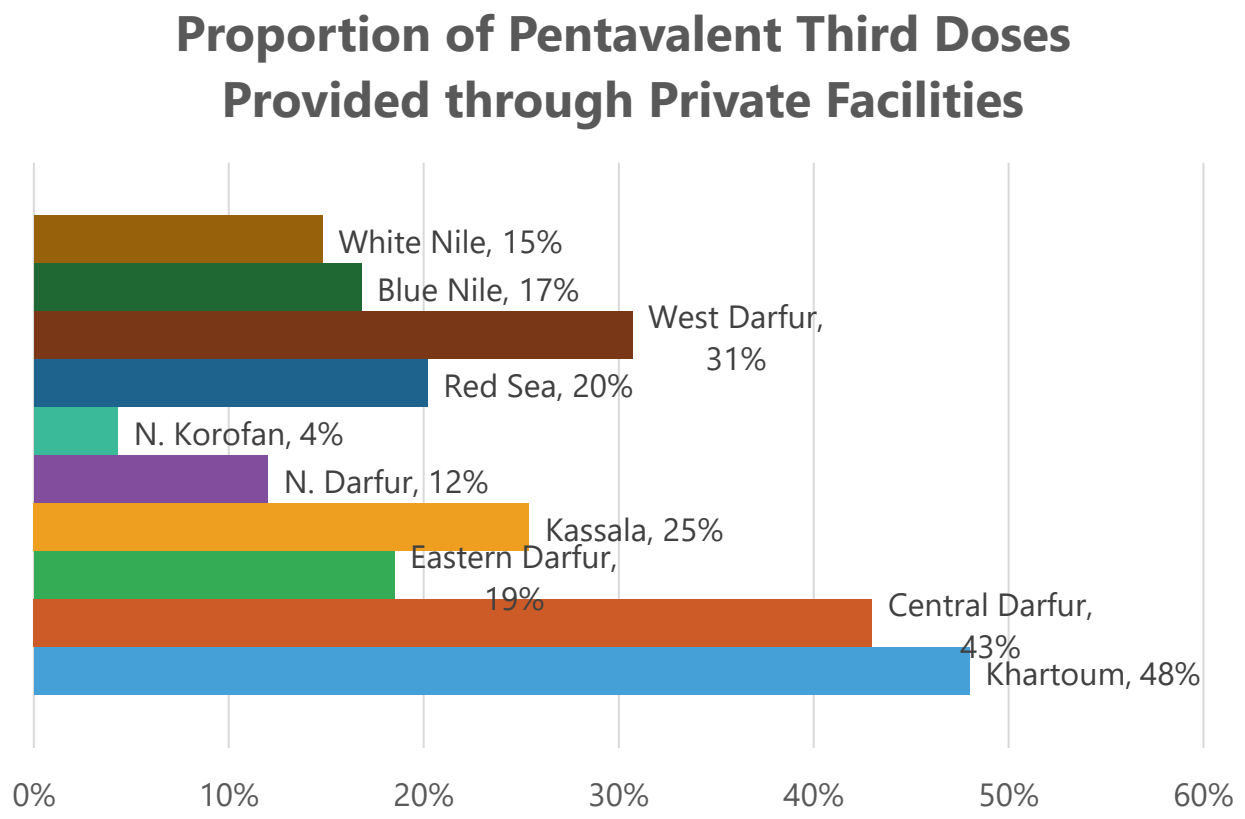
- Operate in urban areas
- Hospitals, clinics and private pediatricians
- Receive MoH vaccines at no charge from national immunization programme

**Non-profits**

- Operate in urban and rural areas
- Work in urban areas where no government facilities located
- NGOs provide services in conflict areas and other hard-to-reach areas
- Provide services in internally displaced people camps
- Receive MoH vaccines at no charge from national immunization programme

# Government support to private facilities

| | For profit providers | NGOs |
|---|---|---|
| **Vaccines** | ✓ | ✓ |
| **AD Syringes and safety boxes** | ✓ | ✓ |
| **Tools/forms** | ✓ | ✓ |
| **Refrigerators and Freezes** | Most purchased by provider | Most purchased by NGO |
| **Thermometers and Fridge tags** | ✓ | ✓ |
| **Vaccinators** | Combination of government, private and volunteer | Combination of government, private and volunteer |




MoH data, Ahmed et al 2019

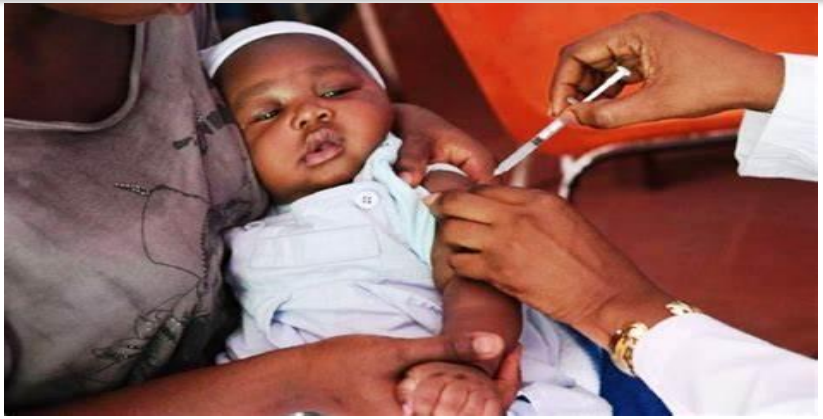
16% of pentavalent third doses provided through private facilities nationally!

# Conclusions

- Sudan has a well-organized immunization program and is engaged with the private sector
- Private sector providers are contributing to increasing immunization coverage and equity by providing services in hard-to-reach areas, in conflict areas, to IDPs and refugees
- Very few AEFIs are reported by the private sector, need to strengthen training and monitoring.
- There is a need for development of a policy framework for public private engagement in immunization for both NGO and for-profit private providers

# Private Sector Engagement in Immunization in Cote d'Ivoire


# Private sector engagement in immunization in Ivory Coast



# Presentation plan

1. Context

2. EPI Performances: Immunization schedule, national coverage rate and introduction of new vaccines

3. What are the current contributions of the private sector?

- Private for-profit sector
- Private non-profit sector
- Private companies

4. Current limitations and issues

5. For a partnership with the private sector

# Context

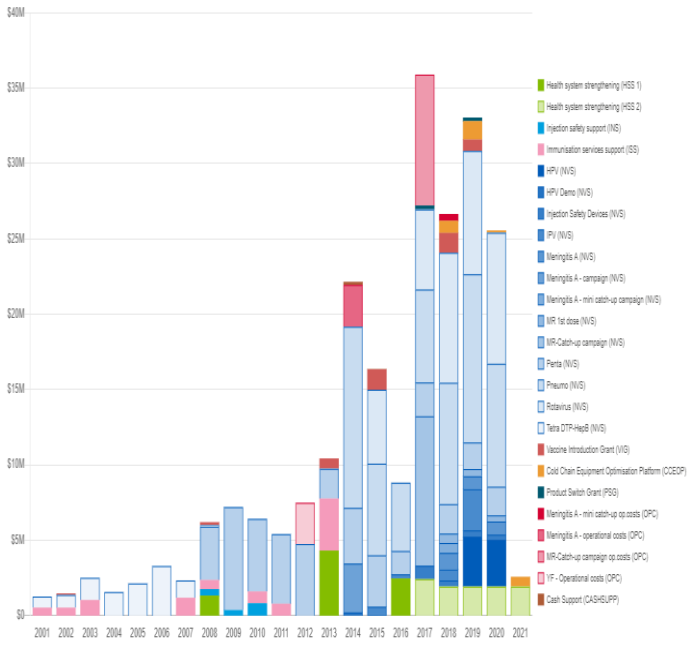
| | |
|---|---|
| Population 2019 | 25 million |
| Birth Cohort | 894.727 |
| Infant mortality rate | 67/1000 |
| GNI per capita USD | 1420 |

1. The Ivory Coast has had rapid economic growth in recent years. However, the country's GDP growth gradually declined from 10% in 2012 to less than 7% in 2019.

2. The country is faced with the double challenge of maintaining a rapid growth rate while reducing the poverty rate of the population (46.3%) and improving the social indicators which remain low and reveal great inequalities (education, nutrition, employment of young people, health, gender equality, ..)

3. Cote d'Ivoire enters transition preparation phase scheduled for 2022, with gradual reduction in Gavi support

**Gavi support**



# EPI Performances

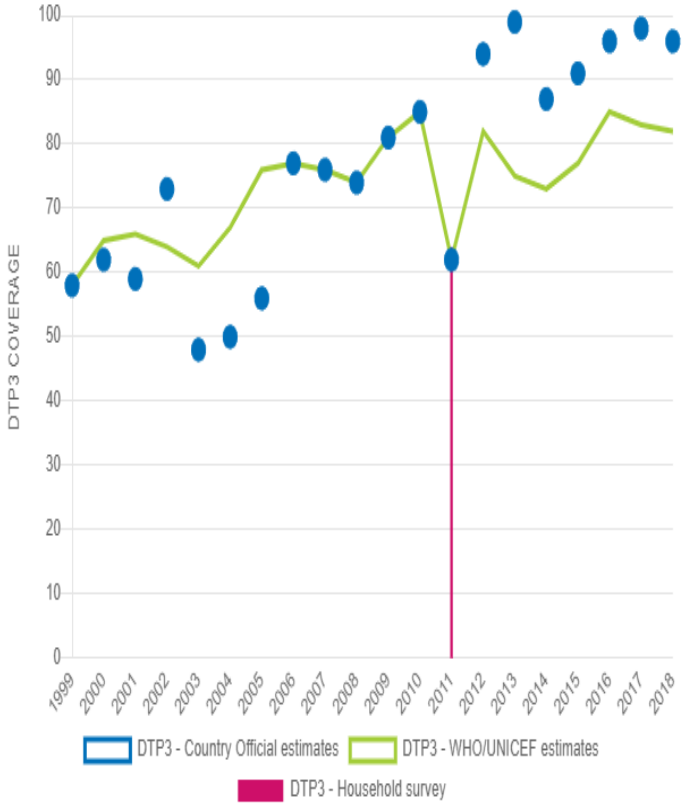
- Growing and high coverage rate….

| CV | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| BCG | 94% | 74% | 98% | 90% | 84% | 79% | 95% | 92% | 93% | 91% |
| **DTCHépB-Hib 3** | **87%** | **79%** | **99%** | **101%** | **87%** | **94%** | **101%** | **98%** | **98%** | **94%** |
| **VAR/RR** | **75%** | **77%** | **94%** | **85%** | **72%** | **82%** | **92%** | **96%** | **93%** | **92%** |

**..but with a significant difference from the UNICEF-WHO estimate and coverage surveys (over 10%). Regional disparities**

| CV | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| BCG | 91% | 74% | 93% | 90% | 84% | 79% | 95% | 93% | 98% | 91% |
| **DTCHépB-Hib 3** | **85%** | **62%** | **82%** | **75%** | **73%** | **77%** | **85%** | **83%** | **82%** | **82%** |
| **VAR/RR** | **70%** | **49%** | **74%** | **69%** | **59%** | **65%** | **71%** | **70%** | **71%** | **73%** |

WHO-UNICEF estimates



# The performance of the EPI in Ivory Coast: new vaccines introduced from 2010 to 2020 in the EPI

| Vaccines introduced | Date of introduction |
|---|---|
| **Pneumococcal vaccine (PCV13)** | **2014** |
| **Inactivated polio vaccine (IPV)** | **2015** |
| **The vaccine against rotavirus diarrhea (Rota)** | **2017** |
| **Meningitis A vaccine (Men A) and Measles-Rubella vaccine (MR)** | **2018** |
| **Hepatitis B birth dose and HPV vaccine** | **2019** |
| **Switch du** ROTATEQ (3 contacts) au ROTARIX (2 contacts) | **2019** |

DC PEV

# Place of the private sector in the health system (1)

- The private sector is important in the health sector
  - 1 in 3 doctors is in the private sector (for-profit and / or not-for-profit)
  - 2 out of 3 doctors work both in private health structures and in the public sector
- **Private sector for profit** has developed in recent years in the form of polyclinics, clinics, medical centers and offices, pharmacies, private infirmaries
- There were more than 2,036 private health facilities in 2011, many more in 2020 concentrated in cities and wealthy areas
- The import and distribution of pharmaceutical products of which more than 85% dominated by the private sector. There are one thousand one hundred (1100) private pharmacies

- **Private non-profit sector:** CSO/CBOs:
  - The denominational private sector, associations and community-based organizations are active in particular in the provision of primary care
  - Nonprofit health associations operate 50 health facilities on the outskirts of cities and in rural areas
  - They are financed by donations and by contributions from communities. They receive some public subsidies

# Place of the private sector in the health system (2)

- **Private health sector**

  - **In 2014,** the private pharmaceutical sector occupied a preponderant place in the health system and covered between 80 and 90% of the drug supply. This private pharmaceutical sector mainly comprises:

    - ✓ **four (4) wholesaler-distributors** (UBIPHARM, COPHARMED, DPCI and TEDIS PHARMA CI) who import more than 90% of their products;
    - ✓ **one thousand hundred (1100)** private pharmacies;
    - ✓ **eight (8) drug production unit**s, 4 of which are active, producing 6% of the national pharmaceutical market.

  - **wholesaler-distributors**: have the vaccines present in the EPI and those available to the National Institute of Public Hygiene (INHP) and supply the pharmacies according to their needs
  - For vaccination, providers prescribe on a medical prescription the name of the vaccine to be administered to the client, who goes to a pharmacy to obtain it and then returns to the provider to have it administered.

# Role of the private sector in vaccinations

- The private sector is involved in vaccinations in the following forms:

  - ➢ Administration of vaccines in maternity wards, clinics and private hospitals
  - ➢ Informing families and patients about the importance of vaccinations
  - ➢ Vaccination services in NGOs and community-based health services
  - ➢ Financial support for vaccination campaigns

  - Partnership of Orange CI within the framework of the "M-Vaccin" project 29 Health Districts: reminder of the vaccination for 0 to 11 months to mothers and / or guardians by written or voice messages.
  - PP with the National Federation of Health Organizations of Côte d'Ivoire (FENOSCI): three hundred (300) organizationscontribute to the search and recovery of children 0 to 11 months lost to follow-up and not vaccinated.

- ➢ Help reduce drop-outs and sensitize communities to increase immunization coverage.

# Private for-profit sector and vaccinations

- **Some private health structures are involved in the EPI vaccination. About 10 to 15% of private health structures are active at the national level, this rate is higher than 60% in the city of Abidjan**
    - These structures are approved by the health districts
    - They are flaunched for the strategies put forward by the Ministry of Health
    - Theyadminister EPI but also non-EPI vaccines to their clients
    - EPI vaccines are provided by the Ministry of Health through the EPI Directorate
    - Non-EPI vaccines are supplied by private wholesalers-importers
    - These structures share their data with health districts
    - Services are payable for families

# Private non-profit sector and vaccinations

- NGOs and faith-based health associations are active in prevention, information, education and provision of basic health care in rural and disadvantaged areas
- They are involved in immunization campaigns
- They administer EPI vaccines in disadvantaged districts according to the national schedule. They administer EPI vaccines in disadvantaged districts according to the national schedule.
- Some associations have contracts with the Ministry of Health and have financial support to carry out vaccinations without charging families

# Public-private partnership (PP)

- Some private health structures are involved in the EPI vaccination. It is estimated that around 10 to 15% of private health structures:
  - these structures located in areas with little or no coverage by the Public Health Centers are chosen by the health districts;
  - Ministry of Health, through DCPEV, finances advanced strategies, provides vaccines and inputs free of charge;
  - administer vaccines free of charge to target populations according to the immunization schedule and share their data with health districts.
- PP with Orange CI for setting up the “M-Vaccin” project 29 Health Districts: reminder of vaccination for 0 to 11 months to mothers and / or guardians by written or voice messages.
- PP with the National Federation of Health Organizations of Ivory Coast (FENOSCI):
  - umbrella grouping together more than three hundred (300) organizations made up of NGOs, Foundations, Thematic Networks and Traditional Medicine Organizations;
  - contribute to the search and recovery of children 0 to 11 months lost to follow-up and not vaccinated. So it helps to reduce drop-outs and to raise awareness in communities which will help increase immunization coverage.

# Challenges and perspectives

## Challenges

- **Immunization coverage by the private sector is poorly documented and known**
- **The respect of the schedule and the quality of vaccinations are not always guaranteed**
- **Data and information sharing is weak. Fear of tax and taxes**
- **The private for-profit sector is mostly in large cities and targets the affluent and middle class**
- Associations lack skills and up-to-date training on vaccines and vaccinations
- **The state does not yet have a vision and a national policy of partnership with the private sector in the field of prevention and vaccinations in particular**

## Perspectives

- **The Ministry has initiated a dialogue with private sector associations to find out what is being done in vaccinations and the conditions to be met for a more important and quality commitment.**
- **Study underway in Abidjan, it will be extended to other cities and regions**
- **Preparation of a legislative framework to organize the contribution of the private sector to the national immunization program and reduce inequalities**
- **Identify programmatic and financial strategies for countrywide engagement of the private, for-profit and not-for-profit sector in EPI and basic health care**
- **Learn from current initiatives and mobilize more private companies to support vaccinations and reduce inequalities in coverage (initiative with Orange and with other companies**
- **Develop a national policy of sustainable partnership between the public sector and the private sector**

# Day 2 Country Group Work

# Day 2: Country Group Work

- What is the challenge to be addressed by the private sector?
- What role could a private actor play to address the challenge, and who are the potential private sector actors?
- How is this private actor well-suited to address this challenge?
- How would you approach this actor? Who could facilitate this dialogue (others within the MOH, other immunization partners)?
- What must be worked out to bring about a collaboration (financing, convincing other stakeholders, etc)?
- Actions to pursue a collaboration

Review Day 1 for ideas or develop new ideas.

Challenges may be COVID-related

Focus on demand generation and service delivery

| 1) What is the current challenge to be addressed by the private sector? | 2) What role could a private actor play to address the challenge? Who are the potential private sector actors? | 3) How is this private actor well-suited to address this challenge? | 4) How would you approach this actor? Who could facilitate this dialogue? | 5) What must be worked out to bring about a collaboration (financing, convincing other stakeholders, etc)? | 6) Actions to pursue a collaboration |
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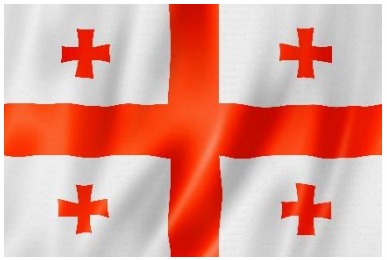
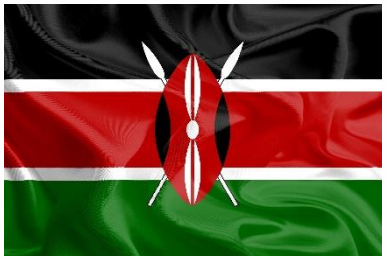
# Participant Reflections on Day 2

- In what ways do private actors having an advantage in demand generation and increasing access for under-immunized populations?



Georgia



Kenya

# Country Team Facilitators

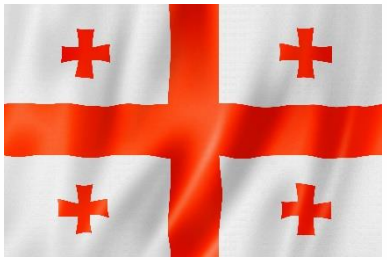
| Country | Facilitators |
|---|---|
| Congo | Edouard Ndinga (WHO)<br>Hermann Ngossaki (UNICEF)<br>Leah Ewald (LNCT) |
| Côte d'Ivoire | Miloud Kaddar (LNCT) |
| Georgia | Ivditi Chikovani (Curatio/LNCT)<br>Eka Paatashvili (Curatio/LNCT) |
| Kenya | Anthony Ngatia (CHAI)<br>Grace Chee (LNCT) |
| São Tomé and Príncipe | Cristiana Toscano (LNCT) |
| Sudan | Hanan Elhag Abdo Mukhtar (WHO)<br>Helen Saxenian (LNCT) |

# 10-minute break

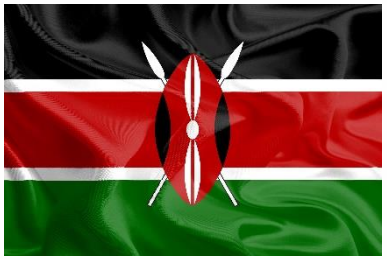
# Workshop Reflections & Closing

# Participant Reflections on Day 2

- In what ways do private actors having an advantage in demand generation and increasing access for under-immunized populations?



Georgia



Kenya

# Help us improve LNCT activities!

**Before you go, please fill out a short feedback survey!**

**We will use this to improve future LNCT activities.**

**The link is in the chat.**