Leveraging Immunisation Programmes for better and equitable Health Outcomes in Urban areas

Godwin Mindra (UNICEF, New York) gmindra@unicef.org

Rachel Belt (Gavi, Geneva) rbelt@gavi.org
More people in urban areas compared to rural

56% in urban areas in 2018

Proportion of total population (%) vs. Year

Urban vs. Rural
Are programmes adapting to this changing context and demography?

• High population density and mobility
• Dominance by private sector in urban areas (with renown influencers)
• Lack of government recognition of urban slums and its commitment to provision of services
• Engagement with non-traditional partners such as local government, city authorities, city planners etc.
• People seek health services across different health facilities and service providers, instead of a single location
Global DTP3 containing vaccines coverage and number of un/under vaccinated infants by WHO regions (1980-2018)

Top 10 countries contributing highest number of infants who missed vaccines (2018)

Immunization Vaccines and Biologicals, (IVB), World Health Organization (WHO).
194 WHO Member States. Date of slide: 04 July 2019.
### Urban maternal health indicators, India (2005-2006)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Urban Poor</th>
<th>Urban Non Poor</th>
<th>Overall Urban</th>
<th>All India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers who had at least 3 antenatal care visits (%)</td>
<td>54.3</td>
<td>83.1</td>
<td>74.7</td>
<td>52.0</td>
</tr>
<tr>
<td>Mothers who consumed IFA for 90 days or more (%)</td>
<td>18.5</td>
<td>41.8</td>
<td>34.8</td>
<td>23.1</td>
</tr>
<tr>
<td>Mothers who received tetanus toxoid vaccines (minimum of 2) (%)</td>
<td>75.8</td>
<td>90.7</td>
<td>86.4</td>
<td>76.3</td>
</tr>
<tr>
<td>Mothers who received complete ANC (%)</td>
<td>11.0</td>
<td>29.5</td>
<td>23.7</td>
<td>15.0</td>
</tr>
<tr>
<td>Births in health facilities (%)</td>
<td>44.0</td>
<td>78.5</td>
<td>67.4</td>
<td>38.6</td>
</tr>
<tr>
<td>Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)</td>
<td>50.7</td>
<td>84.2</td>
<td>73.4</td>
<td>46.6</td>
</tr>
<tr>
<td>Women age 15-49 with anemia (%)</td>
<td>58.8</td>
<td>48.5</td>
<td>50.9</td>
<td>55.3</td>
</tr>
</tbody>
</table>
Why urban lens in programming?

• Growing urban population with concomitant growth of urban poor populations

• Existing services not on pace with rapid growth, leading to insufficient supply

• Widening disparities (urban rich vs urban poor) and growing vulnerabilities

• Use immunization as entry point for broader health platform as urban poor communities might miss other services (Health, WASH, Education)

• Learning from other programmes: polio, measles, nutrition, surveillance help prioritize high risk urban populations and tailor service delivery
Urban immunization toolkit

- Planning, Coordination, political will and Management of Resources
- Improve immunization coverage and equity in urban areas
- Reaching all Eligible Populations
- Supportive Supervision
- Monitoring and Using Data for Action
- Engaging with Communities

8
Urban immunization toolkit Application

• Advocacy, coordination and leadership
• Tailored service delivery approaches
• Private-public partnership
• Data systems to aid advocacy and service delivery
• Community engagement and participation
• Monitoring and mentorship
• Implementation research

Link to toolkit
Progress: urban immunization agenda

- Improved recognition of urban poor communities
- **Uptake of the urban toolkit** and similar guidance has led to the completion of more than;
  - 13 urban immunization evaluations and diagnostics during 2017-2019
  - Costed urban specific strategies to improve PHC delivery
- **Investments:** approximately $25 million in urban specific programming across Gavi-eligible countries
Planning for Urban Immunization/health Investments

- Country engagement
- Creation of evidence (Qualitative and Quantitative)
- Development of innovative approaches to tailor demand and service delivery interventions
- Development of monitoring tools and concurrent evaluation of progress/lessons learned
Evidence for Action: Kenya

• Urban “Diagnostic” reviewed supply and demand barriers such as:
  • Caregiver wait time
  • Health worker knowledge
  • Locations, status and opening times of facilities (via GIS mapping)
  • Vaccine stock availability

• Findings of the diagnostics showed long wait times in urban poor areas, issues of stock outs and low human resource availability.

“Sometimes you may come and the health worker is busy doing her own things, you will have to wait until one feels like leaving without getting services.” (Caregiver, Kibera Community HC).
Implementation and Process: Madagascar

- Daily fixed session at community level
- Funded monthly outreach sessions at less than 2 Km from any community
- Maintain “reactive“ outreach to reduce drop out rate
- Community register all newborns
- Communication targeting Grandmothers and vulnerable pops
- Meetings with religious leaders and City admin staff
Interventions:

- Identified and targeted high risk communities in urban areas
- Engaged private providers in vaccinations and allocated cold chain equipment and trained frontline cadres
- Increased outreaches in slums, vaccine distribution, VHT mobilization, revised micro plans, and frequently reviewed progress

Gains: 1/3 reduction in under immunized for Jan-July 2018 compared to the same period previous year
Key messages

• Health and immunization systems are inadequate in urban areas and highly rural focused
• Urban poor are far underserved by immunization, health, and nutrition services
• Average urban immunization and health indicators mask the inequities
• A multitude of factors affect vulnerability of slum populations requiring mixed methods research
Thank you