



### ***Steps for strengthening Urban Immunisation***

Rapid growth, high population density and low immunization coverage with poor urban health infrastructure in urban slums calls for growing emphasis on immunization coverage for vulnerable urban poor where spread of infection is faster. Available data on immunization and related indicators for the urban poor highlights that state need to have policies and programs for routine immunization of urban slums. Presently urban immunisation is mostly managed through fixed clinics session in most urban areas. Urban immunisation should always be slum focused.

Following problems and challenges worsen routine immunisation coverage in urban slums.

- ❖ Inadequate and inappropriate urban health delivery system
- ❖ Left out slum population and pockets from Urban health planning
- ❖ Poor social access
- ❖ Inadequate demand for services among urban poor
- ❖ Low quality monitoring and tracking of urban slum related health services.
- ❖ Programme planning esp Health services Vs Development dilemma

#### **Urban immunisation coverage can be reached through :**

- (a) Effective outreach for underserved population and community empowerment to demand quality services;
- (b) Utilizing available resources by multistakeholder coordination;
- (c) Enhancing quality through improved supervision and joint problem solving; and
- (d) Strengthened monitoring of left outs and drop outs.

National Urban Health Mission has laid down emphasis on urban immunisation for taking immunization to the unreached population. This will lend the much needed political, civil society and media pressure and periodic uproar on the issue.

#### **Process 1: Identify all slums; use mapping and vulnerability assessment of slums as a planning tool.**

Mapping of all slums, beyond official lists with the help of “city knower” and slum assessment, enables identification of endemically weak areas of immunization coverage. Some urban slums are among the most difficult to reach areas during Pulse Polio campaign through recent experiences. Catchments of primary level facilities can be redefined based on city maps to ensure reach to left out pockets and equitable distribution of work. Where infrastructure is inadequate the need for new facilities will clearly emerge from the map. Collection of recognized and unrecognized slum lists from urban development authority and other agencies working in the urban areas is the first step for planning of urban immunisation. Local NPSP unit also have rich information on most of the slums with their population details and status of immunisation during pulse polio campaign.



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**Process 2: “Strengthened” and “Regular” immunization outreach, particularly for areas with poor access.**

### ❖ **Organizing an effective immunization outreach camp**

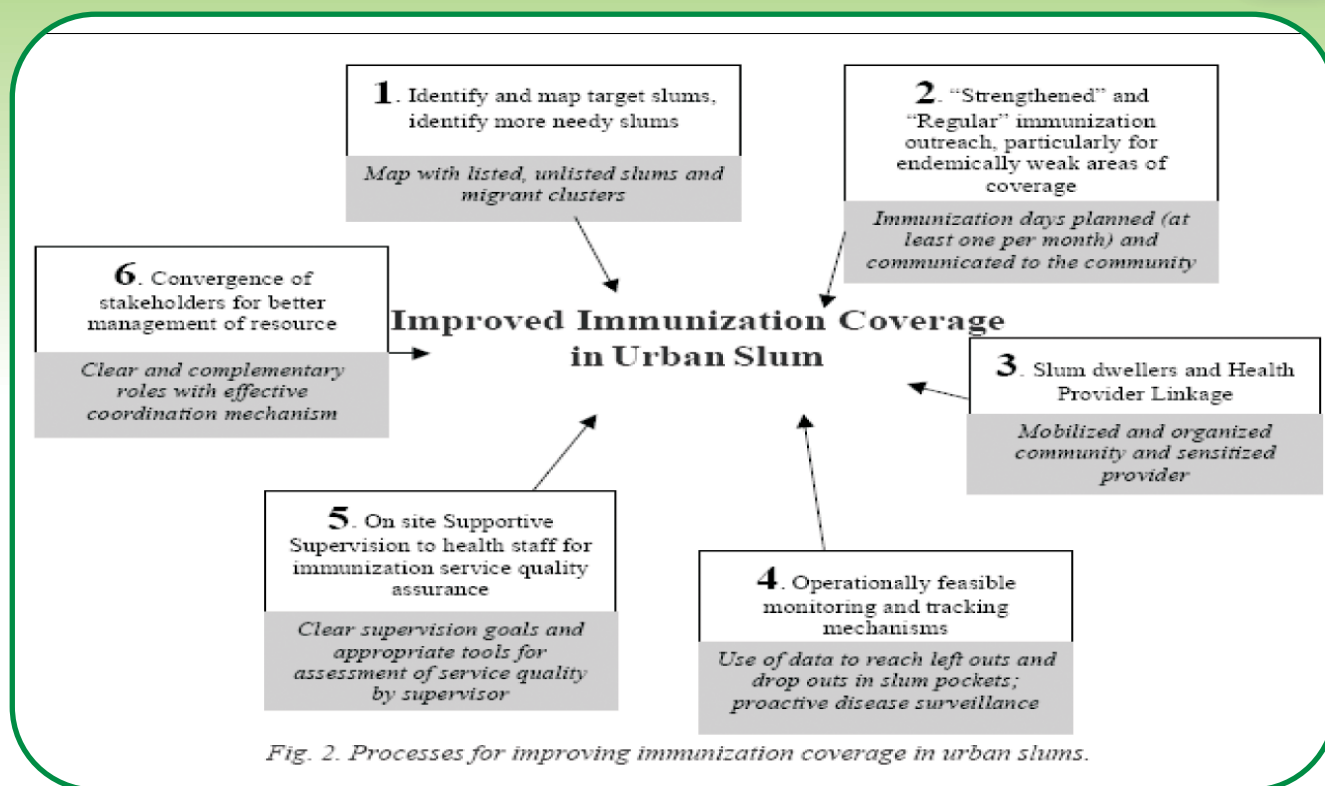
An immunization session is effective only if each child and woman attending it receives all vaccines s/he is eligible for, following necessary safety and efficacy procedures and returns timely for the next vaccine. Regular outreach camps at a convenient, well publicized, preferably fixed location and day, **for the preinformed time by health staffs which is convenient to the community**, with support from local stakeholders are essential in endemically low coverage urban areas. This requires micro planning with Ward or Urban Health Center (UHC) forming the unit for planning. A functional linkage between the ANM and AWW or community health volunteer like USHA with support from medical officer or Lady Health Visitor enables identification and registration of pregnant women, new births and children <5 years of age through a quick mapping of lanes and houses in the slum and its monthly updating. Caution should be observed in not limiting this list to the beneficiary list as per ICDS criteria. Urban local body can contribute Human resource, financial or in kind support (such as transport, camp logistics, publicity) for immunization activities through various schemes and programs namely Swarna Jayanti Shahri Rozgar Yojna (CDS and Development of Women and Children in Urban Areas - DWCUA) and National Slum Development Program (NSDP). Community Halls developed by DUDA, private/ government schools, private doctors' clinics, AWCs, community worship areas and other approachable venues may be used as site for immunization camps. Pediatricians in public and private sector can provide training for effective immunization outreach sessions and support monitoring of such camps.

### ❖ **Immunization focused publicity and social mobilization**

Mass media immunization drives where urban slums have better access to such media. Combined with community counseling and peer contact can enhance service utilization. Communication should be targeted to move caretakers from inertia *i.e.*, fear of vaccine and no fear of disease to action *i.e.*, no fear of vaccine and fear of disease. Community's concerns towards immunization should be addressed through involvement of decision makers like father, mother-in-law in addition to the mother and anti-vaccine rumors need to be countered. For areas predominantly occupied by migrating population announcement of immunization days and venue through loudspeakers is effective. Pediatricians and general medical practitioners could distribute pictorial cards or leaflets indicating appropriate age for different vaccines and reinforce significance of timely immunization when children visit for consultation. These will encourage families for getting children immunized even when they migrate to other areas.

### **Process 3: Slum dwellers and Health Provider Linkage**

Community participation improves vaccination coverage. However, more pressing issues of insecurity and disabling environment often undermine a slum dweller's motivation to ensure immunization for children. A 'link volunteer', essentially a resident slum woman trained on health issues and equipped with referral cards, has been proposed in Government of India's Urban Slum Health Guidelines for RCH II and recently introduction of USHA need to be engaged and involved for motivating parents to bring children for immunisation.



## Process 4: Effective monitoring and tracking mechanisms

An effective monitoring and tracking mechanism enables identification of catchments areas of low reach, operational problems in improving coverage and corrective action to enhance service utilization. Both quality of immunization activities (*i.e.*, ensuring adequate supplies, vaccine Quality and cold chain, correct administration, post administration counseling, safe disposal of immunization wastes) and outcomes (immunization reach, identification and follow-up of left outs and drop outs need to be monitored. Impact assessment through disease surveillance is also necessary.

**Assessing quality of immunization services :** An observational checklist attached in Immunisation Handbook may be used for supportive supervision by Medical Officers or a trained supervisor through random visits to immunization outreach camps and fixed facilities. The ANM or trained Community health worker, having first hand understanding of field realities can effectively monitor outcomes, analyze problems and identify solutions.

**Periodic monitoring of immunization coverage and disease surveillance :** Developing graphs using monthly immunization coverage data by Medical Officer, LHV and ANMs is a vital tool for assessing effectiveness of immunization camps. Coverage monitoring chart and defaulter tracking bag need to be used as a self monitoring tool by the health workers and Supervisors.

**Disease Surveillance :** Monthly reporting of VPD cases by the ANM during outreach activities as well as at the fixed facility needs to be revitalized and regularly monitored. A decrease in the incidence of VPDs over time is important to ensure that immunization services are effective. Community Based Organizations (CBOs) can be involved for compiling information and distribute “family chits” providing name, date of birth, address and immunization eligibility of the child for the upcoming camp in selected slums. The counterfoil is retained by the CBO which helps in confirming timely immunization. Once the family is inducted the child’s attendant receives the chit for the next immunization at the preceding camp.



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### **Process 5: Supportive Supervision for immunization service quality assurance**

Low motivation of health staff due to unduly large catchment area, lack of recognition, Appropriate guidance and effective management systems contributes to the overall Inability to reach all eligible children. Supportive supervision with defined goals and tools, to ensure quality and optimum reach of immunization services at outreach camps and health centers, is vital. Supervisor should be trained in facilitative supervision that emphasizes two-way communication, coaching, mentor-ing and joint problem solving(49,50). Medical Professionals providing pediatric services should adapt such approaches to suit their operating context and enhance motivation and effectiveness of health workers.

### **Process 6: Convergence of stakeholders for better resource management**

Urban health stakeholders include

- ❖ Health and Family Welfare Department,
- ❖ Municipal Corporation,
- ❖ Urban Development Authority,
- ❖ ICDS,
- ❖ Education Department
- ❖ NGOs, CBOs
- ❖ Donor agencies
- ❖ Professional bodies (IMA, IAP),
- ❖ Private sectors and industry bodies,
- ❖ Railway, ESI corporation
- ❖ Medical colleges

### **Improved Immunization Coverage in Urban Slum**

Private providers (formal and informal, Corporate), Employees State Insurance, religious leaders, local resources such as schools and the slum people themselves. Multi-stakeholder coordination planning at city level can optimize use of such diverse resources and involves:

- Formation of a coordination forum with representation of all stakeholder groups and identifying complementary roles based on each stakeholder's capacity.
- Regular meetings of the coordination forum with defined plans and envisaged outcomes

A multi-stakeholder coordination approach and synchronized activities are preferred way.

### **State guidelines for urban immunisation under NRHM**

Each urban area with 10000 and above populations should have one vaccinator, who should conduct 4 outreach session every month .Urban areas with less number of health workers or vaccinators are entitled to hire one vaccinator\* for every 10000 population four times in a month for conducting immunisation session for underserved and under privileged population. For each day hiring Rs.300.00/day can be paid to the vaccinator and Rs. 50.00/day /session can be utilized for transportation of vaccine and other expenses. Total 289 Urban sub units have been approved by NRHM for all 30 districts. In addition to this provision for USHA has been made to do social mobilization for immunisation in urban slum. USHA to get Rs. 150/ immunisation session .Total 730 USHA has been approved by the state. Urban immunisation can be planned on any days not necessarily on Wednesday.