MINISTRY OF HEALTH

URBAN IMMUNISATION COMMUNICATION PLAN 2021-2025

PROTECT YOUR CHILD, IMMUNISE NOW

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PROTECT YOUR CHILD
IMMUNISE
NOW

Acronyms

ANC.....Antenatal Care
BCG…….Bacillus Calmette Guerin (TB vaccine)
BDM……...Behavioural Drivers Model
C4D……..Communication For Development
CHAI……...Clinton Health Access Initiative
CME ……...Continuing Medical Education
DPHE……..Department of Public Health and Environment
CSD…….Child Survival and Development
DPT…….Diphtheria Pertussis Tetanus
EPI……...Expanded Programme on Immunisation
FBOs……Faith Based Organisation
HPE&SC…….Health Promotion, Education and Strategic Communication
HPV…….Human Papilloma Virus
ICHD……...Integrated Child Health Days
ICCM……...Integrated Community Case Management
IDRC……....Infectious Diseases Research Collaboration
IPC……...Interpersonal Communication
IPV……...Inactivated Polio Vaccine
KCCA……..Kampala Capital City Authority
KFCP……...Key Family Care Practices
LC……Local Council
MOH……...Ministry of Health
NGOs……..Non-Governmental Organisations
PATH……..Program for Appropriate Technology in Health
PFP……..Private for Profit
PNFP……...Private Not for Profit
PTA…….Parents Teachers Association
RCC…….Resident City Commissioner
RDC…….Resident District Commissioner
RBF……..Results Based Financing
SACCOs……..Savings and Credit Cooperative Organisations
SBCC……...Social Behaviour Change Communication
SEM…….Social Ecological Model
SOPs……Standard Operating Procedures
SWOT……..Strengths Weaknesses Opportunities Threats
UDHS……Uganda Demographic and Health Survey
UNEPI……Uganda Expanded Program on Immunisation
UNICEF……..United Nations Children Emergency Fund
VPD…….Vaccine Preventable Diseases
VHT……Village Health Team
WASH……Water Sanitation and Hygiene
WHO……...World Health Organisation

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Foreword

Urbanization is a positive force for economic growth, poverty reduction and human development, but is closely linked to an increasing rate of urban dwellers residing in relatively informal small settlements. In these settlements, significant disparities exist in health services coverage, including immunisation, and health outcomes of people living in urban areas, especially between the rich and poor residents ((J.N Babirye et al, 2014)

Urban areas have a high rate of disease transmission perpetuated by high birth rate, crowded living conditions, extensive mobility, poor WASH conditions and high population density due to continuous influx of new susceptible people from rural areas, refugees, migrant communities and illegal informal settlements with varying anthropological conditions. (IDRC, 2020). These have contributed to the already bigger burden on Routine Immunisation services with big numbers of unimmunized children.
A high density of susceptible people means that a higher immunization coverage must be achieved in both urban and rural areas to control transmission of diseases spread by personal contact, particularly measles.

In the past, till of recent, equitable immunisation service delivery in Uganda was not prioritized to cater for the urban marginalized and unreached populations. Today, there is increased recognition of unique urban challenges and this has necessitated the need to refocus immunisation and communication efforts to urban settings.

The Ministry of Health, with support of UNICEF, has developed an urban immunisation communication plan to address the factors affecting demand for immunisation services in urban settings. The communication plan provides a framework for action, connects and mobilises partners and stakeholders in immunisation around a common cause of participating in demand generation activities.
All partners and stakeholders in the health sector and working with communities are encouraged to use this communication plan as a tool to guide systematic implementation of interventions geared to increasing demand for immunisatioin services in urban settings.

Dr. Henry G. Mwebesa
Director General,
Health Services

Acknowledgement
The Urban Immunisation Communication Plan is a result of concerted efforts of several individuals and stakeholders who contributed ideas to its development. The Ministry of Health wishes to acknowledge the contribution of all individuals and organisations that participated in the development of this communication plan.

Special thanks go to Health Promotion, Education and Communication department for leading and guiding the process of developing this communication plan.
The UNEPI technical team is acknowledged for providing technical guidance in reviewing several documents that informed development and shaped the content of the communication plan. These documents include; the desk review report, rapid assessment report and the urban immunisation communication plan.

The Ministry furthermore acknowledges the contribution of key partners, political and administrative leaders and stakeholders such as DHTs, Directors of Public Health and Environment Health departments, Medical Officers of Health, District Health Educators, EPI focal persons, Health Inspectors and VHTs in the urban authorities who provided the required information into the rapid assessment report that informed development of this communication plan.

The community participants especially mothers and men who were consulted during focus group discussions deserve thanks for highlighting their concerns that affect demand for immunisation services and suggesting appropriate interventions to address challenges to immunisation services uptake.
Finally, appreciation is extended to UNICEF for providing technical and financial support which facilitated the development of this urban immunisation communication plan.
We request UNEPI partners, stakeholders, public and private sector organizations, cities and municipalities to use this communication plan as a tool to guide implementation of behavior change communication interventions that will generate demand for immunisation services in urban settings.

Richard Kabanda
Ag. Commissioner
Department of Health Promotion, Education and Strategic Communication

1. BACKGROUND

The Ministry of Health with support from health partners established the Uganda National Expanded Program on Immunisation (UNEPI) nationwide to deliver safe and effective vaccines to the target population. UNEPI is located in the Department of National Communicable Disease Control within the Directorate of Clinical and Community Services and is headed by an Assistant Commissioner of Health Services also referred to as the Programme Manager. UNEPI is responsible for policy, standards and priority setting, capacity building, coordination of stakeholders and partners, resource mobilization, procurement of vaccines and program inputs – including supplies, surveillance, monitoring – evaluation and technical support supervision to the districts.

The health services in Uganda are decentralised, so is UNEPI health service delivery which is managed at the district and urban authority level with technical guidance, material and financial support from Ministry of Health and health partners. The scope of vaccine delivery has expanded over the years, and to date UNEPI schedule is comprised of a total of 9 vaccines to protect the population from 13 vaccine preventable diseases.

1.1 Vision, Mission and Goal of UNEPI

The **vision** of UNEPI is to ensure that the Ugandan population is free of vaccine-preventable diseases. The **mission** is to contribute to a reduction in morbidity, mortality and disability due to vaccine preventable diseases, so that they are no longer of public health importance.

The **goal** is to ensure that every child and high-risk groups (e.g. refugees, migrants, hard to reach) is fully vaccinated with high quality and effective vaccines against the target diseases and according to recommended strategies. The UNEPI goal is well aligned to the Health Sector Development Plan which is aimed at ***"accelerating movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life'. (MoH, 2015/16-2019/20)***

The immunisation program is guided by the cMYP 2016-2020 which articulates the program aspirations, strategies and activities prioritized for implementation in the 5

years. Currently UNEPI is in the process of developing a 5-year cMYP 2021-2025 to which the urban immunisation communication plan is aligned.

The current cMYP focuses on 4 major areas:

1. Strengthening Routine Immunisation (RI)
2. Conducting Supplemental Immunisation Activities (SIAs) to achieve global vaccination targets for polio eradication, maternal and neonatal tetanus elimination, and accelerated measles control
3. Sustaining a sensitive disease surveillance system within the integrated disease surveillance and response framework (IDSR)
4. Introduction of new vaccines in the routine schedule and also expanding vaccination beyond the traditional target group. This is articulated in the Immunisation Agenda 2030.

1.2 Immunisation status in urban settings

Globally, the proportion of the population living in urban areas including urban poor communities (slums) was predicted to reach 68% by 2050 from 54% in 2014.[1]

In Uganda, the proportion of the population living in urban areas increased from 18.38% in 2008 to 27% in 2021 (UBOS, June, 2021).

Urban areas have a high population density due to continuous influx of people from varied communities because of socio-economic and political reasons. This has exerted immense pressure on land and basic services including housing, water and sanitation, health, transport and education among others (Uganda National Urban Policy. 2017).

The influx comprises of new susceptible people from rural areas, illegal settlements, migrant communities, refugees and IDPs with varying anthropological conditions. The high population density is a source of disease transmission which is perpetuated by the high birth rate, crowded living conditions, extensive mobility and poor WASH conditions.

[1] Desa UN, 2014. World urbanization prospects, the 2011 revision. Population Division, Department of Economic and Social Affairs, United Nations Secretariat.

The continuous population influx has led to the growth of rapidly increasing urban poor in the peri-urban areas with widening socio-economic and health inequalities which have resulted in higher incidences of diseases caused by environmental pollution and unhygienic and sanitary conditions. Vaccine preventable diseases have a higher potential of transmission in urban areas than rural areas because of dense population, poor WASH conditions and poor socio-economic and health risks.

Recent publications have cited increasing disparities in immunisation service delivery in urban settings of Uganda as indicated in the statement that '*Complex health system barriers to childhood immunisation still exist in this urban setting; emphasizing that even in urban areas with great physical access, there are hard to reach people'*[2] In addition, a case study of Kampala Capital City Authority Immunisation services, revealed that the '*EPI model has not sufficiently adapted to the challenges of immunisation in an urban setting' (*IDRC, 2020).

Another publication adds that "t*he coverage of basic health services, including vaccination, is usually lower among urban poor communities, increasing their vulnerability to vaccine preventable diseases.' (UNICEF, 2016. A review of evidence).*

Until of recent, equitable immunisation service delivery was not prioritized to cater for the urban marginalized and unreached populations, more attention was focused on rural areas than urban settings. However, today, there is increased recognition of unique urban challenges that affect demand for immunisation services which necessitates the need to refocus immunisation and communication efforts to include urban settings.

The **Immunization Agenda 2030** (ia2030) has set a global vision and strategy for vaccines and immunization and aims to achieve the vision for the decade of: a *world where everyone, everywhere, at every age, fully benefits from vaccines for good health and well-being*.[3] The key approach to improve immunisation coverages is ensuring equitable immunisation service delivery with special focus on reaching the 'Zero dose' and 'under immunized' children to mitigate the increasing numbers of unimmunized children. The Ministry of

[2] N.J. Babirye et al, 2014. BMC Health Services Research. London

[3] Immunisation Agenda, 2030. A Global Strategy to leave no-one behind. IA2030

Health and Partners have included the ia2030 strategic guidance in planning and implementation of routine immunisation activities.

1.3 Urban Immunization in the context of COVID-19

The COVID-19 pandemic has caused social and economic disruption, negatively affecting health outcomes including the national immunization programme and putting the achieved gains at risk.

Characteristically, urban areas are dynamic socio-economic hubs with high mobility and heavy reliance on motorized transport. COVID-19 outbreak restrictions have affected health service delivery including immunisation through transport limitations and population movements. These have resulted in increased transport costs affecting travel of parents to health facilities. In addition, instances of stigma in the population, fear of infection while visiting health facilities and increased work load for concurrent routine immunisation and COVID-19 vaccination have negatively affected immunisation service delivery.

The effects of fear of contracting COVID-19 at health facilities and movement restrictions are highlighted in a statement by one of the journalists who said that "*as Uganda battles the devastating effects of the second wave of Covid-19 pandemic, some mothers, might be afraid to contract the disease in hospitals or unable to access health facilities due to movement restrictions, and they opt not to immunize their babies"* (New vision, June, 2021)

COVID-19 infections among health workers, absenteeism due to ill health and fear of infection are equally affecting service delivery. In this regard, the programme Manager-UNEPI said, *"in some districts, we have got information that some nurses are not turning up at work because they fear contracting Covid-19 and we are calling upon all mothers to make sure they go for routine immunisation for their children to avoid another pandemic,"*(Newvision,June,2021)

Globally, the immunisation programme is at risk of disruption because of COVID-19 vaccine hesitancy[4] due to vaccine misinformation and disinformation through anti-

[4] Vaccine hesitancy is the reluctance or refusal by communities to vaccinate children despite the availability of vaccines.

vaccine messaging by anti-vaccine lobby groups. The COVID-19 vaccine hesitancy can affect acceptability of routine immunisation vaccines. WHO states that vaccine hesitancy has a potential to undermine global efforts to eradicate polio, eliminate measles and contain cervical cancer.[5] WHO further points out that COVID-19 pandemic has triggered a social pandemic of misinformation called an "infodemic" that is spreading across social networks and the infodemic threatens to augment vaccine hesitancy, and in turn could impact routine immunization programs, complicate new vaccine introductions such as SARS-CoV-2 and nOPV2 vaccines and erode public trust in public health.[6]

According to UNICEF CRA data, 2020, only 12.1% of the Ugandan population would not take the vaccine if recommended to them, and 72.7% would take it. Although there is low COVID-19 vaccine hesitancy in the country, this should not be underestimated because it can indirectly affect demand for routine immunisation services as a result of anti-vaccine messaging by social media platforms on COVID-19 vaccine.

Besides the low uptake of routine immunisation services, there are high rates of mistrust in health workers by the population during the pandemic as a result of the negative attitude they have towards parents and caregivers resulting into poor working relationships that affect service delivery.

Despite the effects of COVID-19 on immunisation, World Health Organisation recommends that countries should support decision making that will sustain immunization services based on the local transmission dynamics of corona virus. This is because the health benefits of sustaining routine childhood immunization programme are greater than the COVID-19 risk associated with routine vaccination service delivery points, implying that childhood immunisation should continue while observing the Standard Operating Procedures (SOPs).

[5] UNICEF, 2020. Vaccine Misinformation Management Field Guide. Guidance for addressing a global infodemic and fostering demand for immunisation, New York.

[6] Ibid, 2020. New York

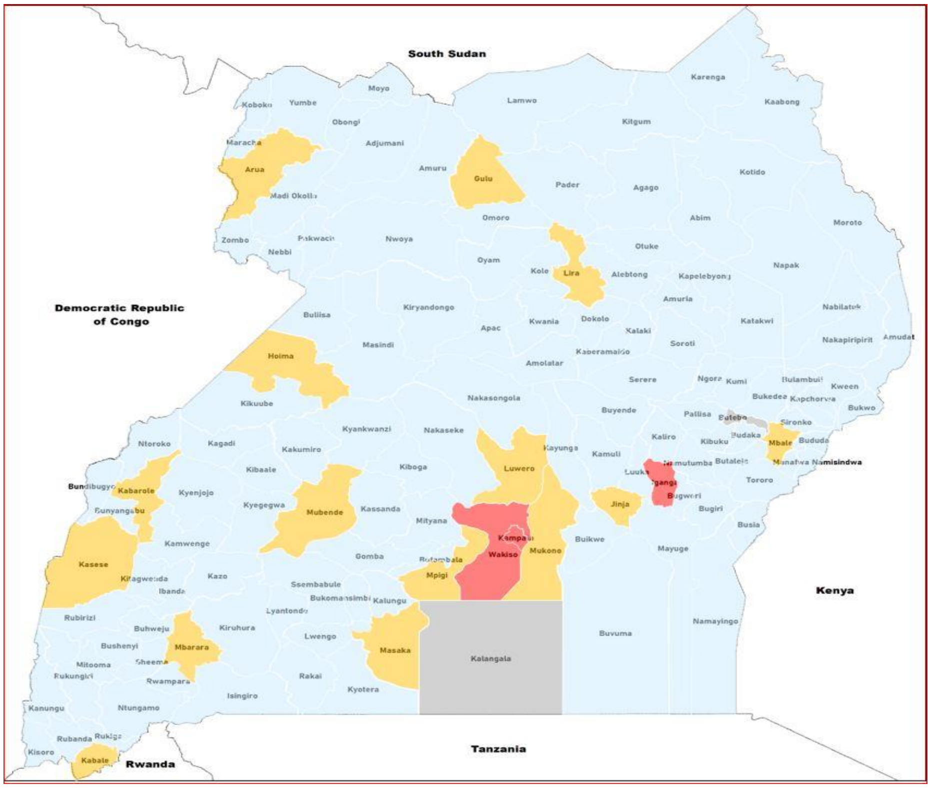
In 2020, the urban districts of Kampala and Wakiso accumulated a total of 68,442 unimmunised (zero dose and under immunised) children which is 34% of the national unimmunised (199,137) in the year (MoH, UNEPI -HMIS Report, 2020).

Similarly, a study conducted by IDRC (2020) in KCCA, revealed that all divisions of Kampala had large numbers of under immunised children for DPT3 and Measles in high risk communities. The high-risk communities identified were largely urban poor communities in all divisions of Kampala city including Muslim communities especially in Kawempe division, Somali Refugee communities in Rubaga and Kisenyi, parishes of Central division, and refugees from Ethiopia and South Sudan in Makindye division.[7]

Since the period 2019 to date, the Ministry of Health -UNEPI and partners have focused on supporting selected urban districts of Kampala, Wakiso, Iganga and Mbarara in order to ensure equitable immunisation service delivery. With increasing population and creation of new municipalities and cities, UNEPI in collaboration with DHTs, Urban Authorities and partners has been providing immunisation services to address the challenge of big numbers of unimmunized children in some of the emerging urban settings since 2019 to date as indicated in the map below.

[7] UNICEF, 2017. Equity Assessment Report

Figure 1: High population municipalities in Uganda[8]



[8] UNICEF, 2020. Presentation UCO. Promoting demand for immunization services in urban settings in Uganda

2. SITUATION ANALYSIS

Understanding the situation is the first necessary step in developing an urban immunisation communication plan. Hence a situation analysis is an essential element in laying a foundation for developing an evidence based communication plan.

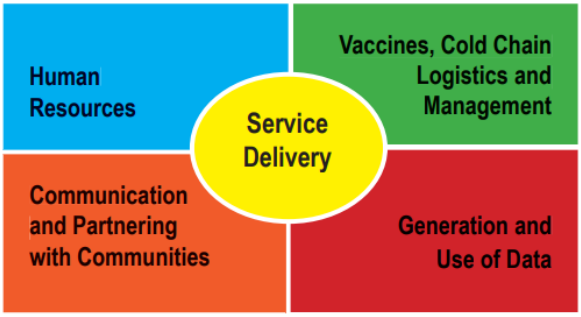
2.1 Immunisation Programme Environment

The Ministry of Health-UNEPI with support from partners is implementing immunisation activities with emphasis on the immunisation system components. These components include; service delivery, vaccine supply, quality, logistics, disease surveillance, monitoring and evaluation, advocacy, communication, and social mobilization.

Implementation of planned immunisation system activities is through a collaboration of MoH-UNEPI and partners who include: WHO, UNICEF, USAID-SBCA, CDC, GAVI, PATH, CHAI, AFENET, Red Cross, Living Goods, GOAL and World Vision.

UNEPI with support of partners works with the DHTs in facilitating health workers to conduct immunisation service delivery through static and outreach sessions. MoH has developed and disseminated immunisation standards, training manuals and guidelines to districts. Through National Medical Stores, vaccine supplies (gas, auto disabling syringes, safety boxes and vaccines) are routinely distributed to the district health facilities for use during immunisation sessions. MoH-Health Promotion department supports districts to create awareness and generate demand for immunisation services through community engagement, mass media and social media platforms.

Figure2: Components of Immunisation system



Source: MoH: *A Guide for National and District leaders to promote routine immunization*

At national level, HPE&C department is instrumental in coordinating development and implementation of social and behavior change communication interventions that include development and production of materials, messages and SBCC interventions; conducting orientation sessions of health workers and non-health stakeholders, development of communication guidelines and plans, public health education, and supporting community and house to house mobilization through VHTs.

Similar to the districts in the country, immunization services in urban settings are also delivered through a decentralized system of governance. Provision of equitable and quality immunization services to the target populations is a mandate of the DHT and urban health officers through the Department of Public Health and Environment (DPHE). Management and planning for immunization services at district and city level are mainly coordinated by the ADHO –MCH and division Medical Officers while within the municipality health facilities they are coordinated by the EPI focal persons.

Kampala Capital City Authority is responsible for planning and distribution of vaccines and other supplies to all health facilities in the city while the divisions are responsible for conducting immunization sessions, social mobilization, support supervision and monitoring.

In other Urban Authorities outside Kampala, the DHTs are responsible for planning and distribution of vaccines and other supplies while the urban health authorities together with DHTs are responsible for surveillance, social mobilization, supervision and monitoring of immunization activities. The health facilities provide immunization services and community linkage through Village Health Teams (VHT) that conduct community mobilization for immunization services with support of Health Inspectors and Health Assistants.

2.2 Policy environment

The goal of UNEPI is to ensure that all children and high-risk groups are fully vaccinated with high quality and effective vaccines against the target diseases according to recommended strategies.[9] The Urban Immunisation Communication Plan will contribute to the achievement of the vision, mission and goal of UNEPI and is aligned to the 'Roadmap towards universal health coverage in Uganda 2020/21 to 2029/30, the comprehensive Multi-Year Plan for UNEPI (cMYP 2021-2025) and the Uganda Immunisation Policy 2014. The Immunisation Policy states that advocacy and communication for UNEPI will be based on EPI Communication Strategy by addressing negative attitudes, myths and rumours on immunisation, enhance community involvement, community participation and improve attendance at immunisation service points[10] and the communication plan is in line with this policy mandate.

2.3 Understanding the problem

Despite the achievements made in implementation of immunisation activities, there has been little change in generating demand for immunisation services in urban settings. According to UDHS 2016, only 55% of children were fully immunized implying that 45% of children are not immunized (zero dose and under-immunised). This calls for increasing demand for immunisation services among other requirements to increase immunisation coverage.

Persistent challenges to communication affect demand for immunisation services by the target audiences and are classified into three categories namely; caregiver challenges, service provider challenges and structural challenges. Identifying and understanding these challenges and the audiences affected was done using the Root Cause Analysis technique which analyses and describes a problem to its root cause. The technique was used to analyse the barriers to caregivers' desired behaviours that contribute to low demand for immunisation services, service providers' barriers that affect health worker-

[9] Ministry of Health, 2021 : UNEPI comprehensive Multi Year Plan, 2021-2026
[10] Ministry of Health, 2014: Uganda Immunistion Policy. Kampala-Uganda

parent/caregiver relationships and structural barriers that affect the environment and lead to poor adoption of behaviours conducive to demand and uptake of immunization services.

For example, barriers affecting demand in respect to caregivers[11] include:

- inadequate knowledge on benefits of immunization
- lack of trust in safety of vaccines
- fear of side effects such as fever and pain after immunization
- fear of getting infected with COVID-19 at immunization centres
- fear of being abused by health workers after misplacing or losing child health card
- weak support by male partners
- long waiting time at health facilities

Ultimately, the inadequate information on the benefits of immunization was the primary reason caregivers did not fully vaccinate their children. The explanation for this reason was lack of an active program to provide context specific social mobilization on immunization in Kampala[12]. The same reason was advanced to explain low demand for immunisation services in other urban settings emphasizing lack of an active program to provide sufficient information about the need for immunisation through social mobilization or routine immunisation service delivery.

With regard to health workers, the barriers that lead to poor service delivery and affect demand for immunisation services include:

- inadequate knowledge on immunization
- inadequate communication skills
- poor customer care skills
- negative attitude towards mothers/care givers
- low motivation in immunization
- low prioritization of immunisation programme activities

[11] IDRC, 2020, Babirye et al, 2014. Evaluation of drivers of Urban Immunisation. Kampala-Uganda. Case study phase 1. BMC Health Services Research. London

[12] IDRC, 2020; Evaluation of drivers of Urban Immunisation. Kampala-Uganda. Case study phase 1.

In addition, there are health and social system challenges such as vaccine stock outs especially for Measles, TT, IPV and BCG in KCCA; transient populations and seasonal migration that complicate the estimation of target populations for routine immunisation services and tracking immunisation defaulters. These challenges coupled with low participation of the private sector in immunisation activities and inadequate budgetary provisions by government complicate achievement of desired immunisation outcomes in urban settings. The caregiver and health workers' barriers and system challenges call for application of SBCC interventions and system strengthening approaches by capacity building of health workers and providing logistics and supplies to achieve effective immunisation service delivery to urban communities.

2.4 SWOT Analysis on immunization

Table 1: SWOT Analysis

STRENGTHS Existing capabilities or resources within the community that this communication plan will build on	**WEAKNESSES** Internal negative factors that will hinder progress of the communication plan
• Some parents' have knowledge and understanding of the benefits of immunisation in terms of providing protection against vaccine preventable diseases • Some mothers complete immunisation because they appreciate benefits of immunisation to their children • Programme conducts outreaches that take services closer to parents and caregivers • The support of some male partners to the female partners motivates the latter to take children for immunisation • Parents' risk perception of not immunizing their children and being vulnerable to VPDs • Trust in immunisation services by some members of the community because it is a Ministry of Health programme	• Inadequate knowledge on benefits of immunisation by some parents/ caregivers • Community members' negative attitude towards immunisation and vaccines • Inadequate knowledge on immunisation by some health workers, VHT and policy makers • Lack of trust in safety of vaccines by parents/caregivers • Community members do not fully understand the risk of not immunizing their children • Negative attitude of health workers towards parents/caregivers • Low motivation of health workers and VHTs due to poor facilitation • High mobility by urban VHTs and giving little attention to their mobilization role • Low involvement of Environmental Health department in promotion of immunisation services

• The VHT strategy that is built on the house to house model used by the MoH to reach parents/caregivers with messages on immunisation • Existence of a package of child health interventions like Integrated Child Health Days (ICHD) (April and October) which are part of primary health care where immunization is well integrated with other child survival strategies. This leads to optimal utilization of the scarce resources to gain high impact of the interventions. During the ICHDs, immunisation catches up with defaulters and missed opportunities. • Child registration by VHTs which contributes to solving the denominator problem and allows child follow up while supporting creation of awareness for immunisation	• Inadequate number of champions and lack of role models to promote immunisation agenda • High dropout rates of more than 10% in most urban settings which contribute to a buildup of unimmunized children • Long waiting time at health facilities by parents and caregivers which discourages them from taking children for the remaining immunisation doses • Stock-out of logistics such as child health cards and vaccines • Old and faulty fridges • Hidden costs for immunisation[13] charged by some health workers to some caregivers for services which they should not have paid for • Weak community mobilisation by VHTs • Lack of a follow up system for immunization defaulters which makes it difficult to identify and trace defaulters • Poor documentation leading to poor follow-up
OPPORTUNITIES Positive factors external to Immunisation programme that will favourably contribute to its success	**THREATS** External factors that will affect successful implementation of the Communication Plan
• Evidence of documented best practices or promising approaches from elsewhere with potential for impact on urban immunisation • Existence of enabling and supportive policies and laws on health. For example the 1995 Uganda Constitution, the Immunisation Act-2017, Public Health Act and Children's Statute all of which provide for respect to the rights of	• High poverty levels especially among slum residents which drive their attention away from immunisation to economic profiting ventures • Competing priorities among urban residents; • Inadequate financial resources to support demand driven efforts for immunisation services

[13] IDRC, 2020. Evaluation of the Drivers of Urban Immunization in Uganda: A case study of Kampala city, Uganda

the child to access health services including immunization services • Supportive religious and cultural leaders in the community • Supportive district political and administrative structures which have networks to community level such as RDC/RCC structure, LCV structure and Chief Administrative Officer's/Mayor/town Clerk Structure • Supportive health development partners and stakeholders such as international and national NGOs and CBOs • Availability of supportive informal influential structures which have potential to promote immunisation services • Existence of a number of community structures that can be used to mobilise communities for immunisation e.g. migrant communities, IDPs, nomadic clan elders, refugee camp leaders, pre-primary school leadership, Health Unit Management Committees to strengthen community ownership of vaccination services	• Transient populations and seasonal migration that complicate the estimation of target populations for routine immunisation services • The elite populations are hard to reach and convince because they may choose not to use immunization services due to the perception that the health facility services are of sub-standard quality[14] • Community support and linkage structures are monetary driven-little can be done without paying for a service due to the socio-economic environments they are living in • Understaffing in health facilities such that there are a few health workers dedicated to immunisation services • Frequent staff turnover in private health facilities • Resistant and hostile communities opposed to immunisation • Religious sects/cults opposed to immunisation • Perceived marginalization of refugees and IDPs by health workers • Gender dynamics which involve power relations in a household that limits women's ability to seek immunisation services without permission from male partners • Influence of social media which has fuelled rumours and misinformation on safety of vaccines and eroded public trust in vaccines • Health and administrative system challenges arising out of structural problems that affect

[14] Ministry of Health, 2018. Desk review report on implementation of EPI communication and advocacy interventions

	collaboration between DHTs and City/Municipal health departments • Covid-19 pandemic which has caused travel restrictions, raised cost of transport and created stigma • Natural calamities like floods in Kasese and landslides in Bududa and other parts of Uganda which have disrupted immunisation programme activities

In addition to the SWOT analysis, a journey to health and immunisation framework will be applied to conduct a barrier analysis and provide an overview on the priority factors in the immunisation system that affect demand for immunisation and effective delivery of services. The barrier analysis will be done on caregiver, health care provider and system factors that affect demand for immunisation services. A holistic exploration of the journey to immunisation will help to provide a deep understanding of the strengths, opportunities; weaknesses and threats to the caregiver efforts while trying to access immunisation services for the child. Priority interventions will then be designed to address the barriers in a holistic manner. The caregiver journey to immunisation also helps to explore the range of diverse experiences and events that occur before, during and after accessing immunisation services.

2.5 Audience and Stakeholder Analysis

A desk review, rapid assessment of EPI interventions and stakeholder analysis highlighted several communication and non-communication barriers that impede successful implementation of demand generation activities in urban settings. Several categories of stakeholders who include political leaders, religious and cultural leaders, clan leaders, elders, health workers, VHTs, partners, parents and caregivers were

identified and tconsulted to provide information on factors affecting demand for immunisation services.

The social ecological model was used to describe how individuals are influenced by their peers, family, community and the overall enabling environment, and how their health behaviours are influenced by the information they receive, their motivation and ability to act.

The social ecological model highlights the importance of social change communication which facilitates behavior change and recognizes people ***as agents of change, rather than as objects of change.***[15] Social change communication values dialogue and supports behavior change by addressing social norms, cultural practices and policies that may constrain health-enabling practices and are addressed in this communication plan.

2.6 Audience segmentation

The segmentation of audiences provides definition and description of stakeholders and their profiles based on the demographic and psychographic characteristics which in turn facilitates design of target specific interventions and messages to address the barriers to desired behaviors.

The target audiences in the communication plan are categorized into primary, secondary and tertiary audiences. The primary audiences include parents/caregivers, and men who provide care for children; the secondary audiences include, health workers who plan and immunize children, community health workers (VHTs) and non-health stakeholders who mobilise communities for immunisation, and tertiary audiences who include political and civic leaders and advocate for immunisation services. The target audiences are described as indicated in the table below:

[15] Ministry of Public Health and Sanitation and Ministry of Medical Services (2010): Injection Safety and Safe Disposal of Medical Waste: National Communication Strategy. Nairobi-Kenya

Table 2: Audience Segmentation and influences at different levels

Audience category	Type of audience and description	Where do audiences spend their time?	Who can influence the behavior of target audiences?
Primary audience These are people concerned about immunisation of children and whose behavior we need to change so they can take children for immunisation	***Parents, mothers, men and caregivers in the community***. These are people on whom communication efforts will be directed to increase their knowledge, change attitudes, beliefs, practices, and enable them to develop skills to facilitate change of behavior. They get affected when children fall sick from vaccine preventable diseases and have the power to decide whether children should be immunized or not. They live in informal and high end social class urban settings. They are highly mobile and most of them leave their homes early morning and return late due to demands of the jobs they are engaged in.	-Homes, offices -Informal settlements/slums -community --super markets, - health facilities - trading centres, - shopping malls, saloons, places of worship, factories, farms	-Family members, mothers in-laws, nurses, mid-wives, VHTs, caregivers, religious and cultural leaders, -community leaders, -elders, peer groups, -Clan leaders, -leaders of women groups, -Women leaders at LC1, -SACCOs, -neighborhood watch groups, - traders associations, -Leaders of market vendors, leaders of bodaboda,(motorcycle riders) associations, leaders of refugees and IDPs, Police, -Media houses & Social media platforms as well as mobile phone companies.
Secondary audience (influencers) These are people who directly influence the behaviour of primary audiences.	Secondary influencers are those people who directly influence the behavior of primary audiences and include: health workers such as EPI Focal Persons, health facility in-charges, VHTs, health inspectors, health assistants, health educators, community outreach workers, who include peer educators, teachers to help in demanding for Immunization cards at the time of enrolling children in pre-primary and primary school and mobilise girls for HPV vaccination, para-social workers, neighbourhood watch groups, SACCOs, Women groups, cultural and opinion leaders as well as clan leaders and elders They can influence the primary audiences because they can inform, educate, motivate, and support the primary audiences to take children for immunisation since they have knowledge and skills. They can also influence primary audiences	-Homes, offices, -health facilities -Community -Housing estates -Slums/informal settlements -Markets -Shopping malls -Places of worship -Factories	Health facility in-charges, HUMC, political and civic leaders at community level such as LCs, sub-county chiefs, religious leaders, cultural leaders, -head teachers -Mayors, Town Clerks, Town Agents, Health Inspectors, Health Assistants

	because of their relationships with them at home and community.		
Tertiary audience These are people in positions of authority who indirectly influence the behavior of primary audiences. They hold the key to the success of the immunisation programme at national, city/municipal, health facility and community level.	They provide an enabling environment for implementation of laws, social, economic and health policies related to immunisation and include: national, district, urban authority and community political and administrative leaders, development partners and programme managers. They also include MPs, RDCs/RCC, Mayors, town clerks and division councilors. They also include the media (print and electronic media) as well as social media. Other audiences that can play an advocacy and social mobilization role include: CSOs, private sector, professional associations such as; Uganda Medical and Dental Association, Uganda Paedriatric Association, Uganda Midwives and Nursing Council, Uganda Health and Allied Professionals Association; and Faith Based Organisations through their Catholic, Protestant and Muslim Medical Bureaus.	-Work places (Offices) -Media houses Social media platforms -Religious institutions	-MoH, -Health Development Partners -Leadership of Local Government -Parliamentary Forum on Health-Immunisation -Ministry of Information& National Guidance -Prime Minister's Office -President's Office -High level Religious and cultural institutions

2.7 Behavioral analysis

The behavioral analysis was done to assess the factors affecting the behaviours of individuals, groups and communities targeted for change that contribute to low demand for immunisation services. The analysis identified and categorized barriers under knowledge, attitude and practices domains and corresponding desired behaviours and provided guidance for development of target specific interventions and messages to address low demand for immunisation services.

Table 3: Behavioural analysis

Priority audience	Current Behaviour	Behaviours to promote	Barriers to desired behavior	Facilitating factors	Proposed actions
- Parents/caregivers -Teenage mothers -Mothers with disabilities with zero dose children in slum areas	-Some parents/ caregivers living in slum areas do not take their children for immunization at all -Some parents/ caregivers do not complete immunisation schedule -Some parents& caregivers lose or misplace child health cards and do not take them along with children to health facilities	-Take children for immunisation and complete the schedule -Keep child health cards safe and take them every time they go to health facility /outreach for immunisation -Send reminder messages to parents/caregivers to take children for immunisation -Get their children under 1 year registered for immunisation	**Knowledge:** Inadequate knowledge on: -benefits of immunisation - number of times a child should be taken for immunization -benefits of child registration to immunisation -lack of information on where immunisation services are offered -Lack of reminders to take child for immunisation **Attitude:** -Belief that immunisation harms and kills children -Belief that HPV vaccination is a family planning method intended to make young girls sterile -Poor health worker attitudes and abilities -Belief that a healthy child should not be immunized -Lack of trust in the vaccines and immunisation -Belief that vaccine preventable diseases do not exist anymore in their communities. E.g. "***there are no more polio cases so it is not necessary to vaccinate children now"*** FGD- Mother, Jinja district. -Fear of side effects such as fever and pain after immunisation -Fear of contracting COVID-19 at health facilities -The poor urban dwellers shun immunisation due to influence of rumours fuelled by social media platforms **Practice:** **-Some h**ealth workers make it a condition for parents/caregivers to produce child card in order for a child to be immunized -Some resistant people close their gates when they see VHTs going for home visits - Some mothers do not want to immunize their children because of experience from the previous reactions of Measles-Rubella campaign	-Availability of satisfied users who can act as role models -Availability of vaccines -Some mothers understand benefits of immunisation and complete childhood immunisation	-Increase health education during vaccination sessions, -Enhance IPC abilities of health workers to ensure they are able to respond to any query, -Put in place a reminder system so that caregivers are reminded of their next vaccination appointment through SMS messaging, - Put in place a mechanism for tracking and rapidly responding to rumours about vaccines before they circulate deep into the community

			- Private primary schools refuse to mobilise girls for HPV vaccination due to fear of reprisals from parents -Some public and private health facilities charge a fee on immunisation services -Some parents/caregivers drop out of immunisation schedule due to GBV that separates families		Increase health education on violence against children and women
Men	-Some men do not support their spouses to take children for immunisation -Some men refuse their spouses to take children for immunisation	-Accompany their spouses to immunisation centres -Provide support in form of funds for lunch and transport when mothers take children for immunisation	**Knowledge** Inadequate knowledge on benefits of immunisation and HPV vaccination for girls **Attitude** - Belief that taking a child for immunization is a woman's responsibility **Practice** -Men quarrel with spouses when a child experiences pain and fever after immunization and this affects the spouses' subsequent visits to immunisation centres -Some men fight their spouses which leads to separation of families	Some men understand the benefits of immunisation and provide the required support to their spouses	-Community dialogue on gender norms with men's groups -Advocate for men to provide funds to their spouses for transport and lunch at health facilities Establish mobile outreach centres where men congregate and discuss issues about immunisation
Health workers (EPI Focal Persons)	-Some health workers mistreat, abuse and rebuke parents/caregivers during immunisation sessions -Some health workers do not prioritise immunisation	-Interact well with parents and caregivers -Give priority to immunisation activities	**Knowledge** -Inadequate knowledge due to lack of basic training in immunisation or lack of refresher training. - Inadequate knowledge on the immunisation schedule - Inadequate interpersonal communication, customer care and basic counselling skills **Attitude** -Low health worker motivation stemming from challenges of high cost of living and poor remuneration -Poor customer care & communication skills leading to poor interaction with caregivers -Belief by some health workers that immunisation is a preserve of the EPI Focal Persons -Negative attitude towards mothers/caregivers manifested by ***'verbal abuse', poor communication, and customer care with the mothers/caregivers***	-In-charges of health facilities support immunisation and can influence other health workers to support immunisation -Supportive Health Unit Management Committees, -Knowledgeable EPI Focal Persons -Supportive IPs	-Training of health workers in immunisation, IPC skills and customer care -Provide job aids -Conduct CMEs -Increase health worker motivation through social recognition by posting pictures of best performer on HF noticeboards to appreciate and also provide certificates of recognition -Advocate for payment of health worker allowance in time

			Practice -Some health workers charge for services which parents/caregivers should not pay for e.g. payment for immunization cards at ***UGX 5,000*** on average in private and public health facilities[16] -Do not provide key messages on immunisation especially on benefits of completing the immunisation schedule and keeping child health card safe -Do not counsel mothers on side effects or reactions -Do not tell mothers and caregivers the return dates for the next immunisation dose		
Village Health Team (VHTs)	Some VHTs do not mobilise communities for child registration and immunisation but mobilise for other health programmes that facilitate them with allowances	-Mobilise urban communities on importance of child registration and immunisation -Register children for immunisation -Follow-up on defaulters -Distribute IEC materials	**Knowledge:** Inadequate knowledge on: ✓ benefits of immunization and new vaccines ✓ vaccine preventable diseases & immunization schedule. ✓ filling child registration form ✓ benefits of child registration **Attitude** - Low interest and motivation in immunisation due to poor facilitation **Practice** -VHTs are highly mobile and engaged in economic activities which interfere with mobilization -VHTs do not mobilize for immunization but mobilize for other health programmes that pay them well -Make mistakes while filling child registration forms	-Willingness of some HF in-charges to facilitate VHTs using PHC and RBF funds -Existence of on-going health programs such as ICCM which can be used by VHTs to mobilize for immunization -Support provided by some Implementing Partners to immunization services	Training in immunisation, child registration, communication and community mobilization -Provide incentives to VHTs to motivate them mobilise for immunisation services
Line departments (Schools and CDOs, chiefs/town agents	-Some private schools do not mobilize girls for HPV vaccination -Many non-health stakeholders do not mobilize communities for	-Orient non-health stakeholders (CDOs, teachers, town agents) on immunization, HPV vaccination -Mobilize communities for	**Knowledge** Inadequate knowledge on: -benefits of immunization and HPV vaccination -Poor access to information on immunization **Attitude** **-**Fear of reprisal from parents of girls -Lack of trust in safety of HPV vaccine and other vaccines	-Availability of Immunisation Act 2017 that supports immunization -Some schools are already mobilizing girls in	-Train non-health stakeholders in immunization and communication skills -Clarify their roles in working with health workers and VHTs to

[16] IDRC, 2020. Evaluation of the Drivers of Urban Immunization in Uganda: A case study of Kampala city, Uganda

	immunization services -Do not work closely with VHTs during community mobilization	immunization services - Ask for immunization cards from parents/caregivers on entry into pre- or primary school -Work with VHTs to strengthen linkages at community level	**Practice** -Allow children into pre-primary and primary schools without asking for immunization cards -Do not discuss immunization issues with parents during School Management Committee and PTA meetings -Weak linkages with VHTs at community level	school for HPV vaccination -Availability of supportive immunization policy -Availability of Parliamentary Forum on Health-Immunisation	mobilize for immunization

2.8 Theoretical basis for development of Urban Immunisation Communication Plan

The development of the urban immunisation communication plan is based on the recognition that social and behavior change communication can be effective when planned and implemented using a combination of communication approaches with appropriate behavior change models.

To this effect, three widely-accepted models were selected as appropriate and underpin the development of this communication plan. These models include the Social-Ecological Model, Behavioural Drivers' Model and the Journey to Health and Immunisation framework. These models provide guidance for systematic analysis of individual behavioural determinants along the behavior change continuum. They work in tandem with the Communication for Development strategies to promote positive individual behavior and social change communication that are crucial for social and health transformation.

The Social Ecological Model (SEM)

The Social Ecological Model (SEM) is a theory-based framework for understanding the multi-level and interactive effects of personal and environmental factors that determine people's behaviours. In the case of immunisation, it puts the individual at the center as a primary caregiver. The model recognizes and appreciates the interplay of factors between the individual and the environment and considers multi-level influences on an individual's behaviour. The individual is considered important but not sufficient in the

process of behavior change; other factors are important in influencing individual's behavior and must be addressed in their spheres of influence to change behavior.[17]

Thus the SEM facilitates analysis of behavioural determinants at each of the five levels of influence as follows:

Individual level- individual is influenced by intra-personal factors (psychographic) which include knowledge, attitudes, beliefs and practices. The individual needs these attributes to be able to develop values, communication skills, self-confidence and self-efficacy in relation to immunisation. They also include demographic factors such as literacy level, socio-economic status and gender dynamics which together with psychographic factors guide development of target specific interventions and messages to address barriers to desired behavior.

Inter-personal level- is characterized by relationship factors which include formal and informal relationships, social networks and social support systems among family members, peers, friends and relatives or colleagues who may positively influence the behavior of parents and caregivers in relation to immunization. This level further involves interactions with other people that can provide social support or create barriers to interpersonal growth that promotes healthy behavior.

Community level- involves community level participation, leadership, establishing and implementing bye-laws, norms, cultural beliefs, shared ownership and responsibility. They include organizational structures such as religious networks, women groups, village SACCOs, cultural/traditional institutions, informal groups, clan leaders and elders with underlying power relations.

These structures provide settings within which social relationships take place and influence the behavior of an individual targeted for change. Some examples include: support from religious leaders, clan leaders, elders and community leaders by urging people to conform to positive norms and cultural practices. They can also establish bye-

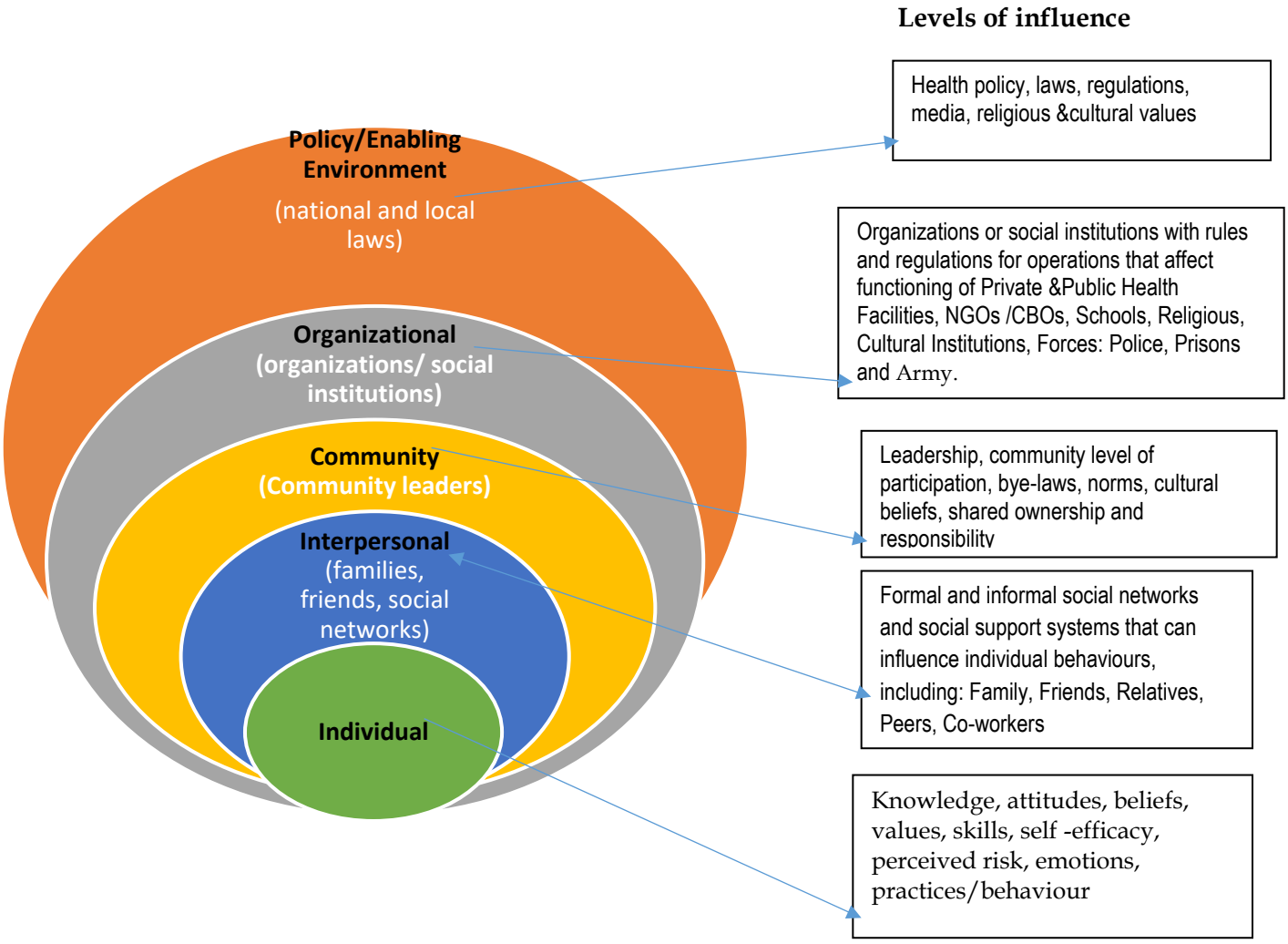
[17] OPM 2014: Advocacy and Communication Framework for the Uganda Nutrition Action Plan 2014-2018

laws to guide disciplining people who may refuse to take children for immunization. This level is cognizant of the importance of social change communication which values dialogue, and aims to support behavior change by addressing social norms, cultural practices, and policies that may constrain health-enabling practices.

Organisational Level- involves participation of organizations or social institutions which have formal rules and regulations that guide their operations. The organisations/institutions may include: urban public and private health facilities, and relevant departments like Community Development department, education, community leaders (LC III, II and I), division /ward administrators, town agents, Mayor, Town Clerk, and CSOs, NGOs/CBOs.

Policy level- consists of audiences at policy level who make decisions, public health policies, laws and legislation that regulate or support health actions and practices for disease prevention including immunisation services at various levels of service delivery. They advocate for immunisation services, control and allocate resources for planning, implementation, monitoring and supervision of immunisation activities. The leadership at this level provides an enabling environment in which urban authorities, implement laws, social, economic and health policies to promote immunization services in urban settings. The figure below illustrates how an individual's behavior is influenced by various factors at different levels:

Fig 2: Socio-Ecological Model to illustrate environmental influences on an individual's behavior



Behavioural Drivers Model (BDM)

The Behavioural Drivers Model was applied to provide a framework for analysisng behaviours and guide programming of social and behavioural change communication interventions. This model recognizes the importance of investigating a behavior to understand why it is being practised and figures out what may influence the drivers of its occurrence. For example, why do parents/caregivers not take their children for immunisation, why do they drop out of immunisation schedule? Likewise the BDM asks key questions such as ***"Why do people do what they do? How can we influence or change what they do?"*** These questions are part of the Root –Cause Analysis technique which studies and digs deep into the root cause of a problem. This

constitutes part of the problem-solving model that is key to developing evidence based communication interventions. These questions diagnose all possible psychological, cultural, social and structural factors along the levels of influence in the SEM that affect the behavior of an individual[18]. Thus, the BDM is part of a larger effort to promote evidence-based programming and complements the Socio-Ecological Model (SEM)[19].

The SEM and Behavioural Drivers Model are reinforced by the Journey to Health and Immunisation framework which analyses what a parent/caregiver experiences during the immunisation journey to be able to make decisions on whether to take a child for immunisation and complete the schedule or not. The journey to health and immunisation framework is a novel way to understand caregiver experiences in accessing and receiving immunisation services for children. It involves identifying barriers to immunisation and enablers to facilitate vaccination uptake by enhancing the overall caregiver journey in a systems-focused manner, using human-centred design approach.[20] Human-centred design (HCD) is ***an approach to problem-solving that puts the people at the heart of the process***[21]. The framework involves building a timeline that captures salient events which lead to the child getting vaccinated or not. It provides an understanding into the lived experiences of caregivers as they navigate immunization services for their children.[22]

The journey to health and immunization framework comprehensively captures psychological and social influences on vaccination decisions of a caregiver and provides a deep understanding of how caregivers navigate household dynamics; social network dynamics, community norms, processes and structures; and healthcare delivery systems to access immunisation services through a six stages behavior change continuum. The

[18] UNICEF, 2019. The Behavioural Drivers Model: A Conceptual Framework for Social and Behaviour Change Programming (Vincent Petit-The Communication Initiative Network. Middle East and North Africa (MENA)
[19] Ibid, 2019
[20] BM Journal, Open, 2014. The Journey to vaccination: a protocol for qualitative multinational study. Oxford, UK.
[21] www.Principles of Human Centred Design Approach.
[22] BMJ Open, 2014. Journey to vaccination: a protocol for multinational qualitative study. Oxford, UK.

framework has six stages and each of these stages highlights factors that affect a parent/caregiver decisions on whether to take or not to take a child for immunization. Thus, understanding the barriers at each of the six stages of the journey to immunisation requires identifying and addressing behavioural and system barriers that will enhance adoption of health behavior which will lead to essential immunization outcomes, such as completion of the recommended immunisation schedule, timeliness of immunisation visits and reduction in dropouts between vaccine doses. The journey to immunisation is illustrated in the framework which identifies the barriers to immunisation that pose obstacles to parents/caregivers' decision making process and affect demand for immunisation services.

The journey to immunisation is accomplished through a six stage continuum of behavior change and includes:

i. Awareness, knowledge, attitudes and perceptions of individuals and how they negatively affect demand for immunisation services. This stage emphasizes bevavioural factors that promote or prohibit demand for immunisation services.

ii. Intent: -entails parents/caregivers receiving information from diverse sources of communication, processing it and transforming it into positive attitudes, changed beliefs and forming intention to act positively.

iii.Preparation, cost and effort: as parents, caregivers put in effort to demonstrate desired behavior by taking children for immunisation, they need to be motivated by understanding and weighing the costs and benefits of embracing the proposed change. This stage can however, hit a snag from the immunisation system if for example, vaccines are not available, and the social media and mass media peddle rumours and misinformation on safety of vaccines thus eroding public trust in vaccines. This can pose a threat to the immunisation programme.

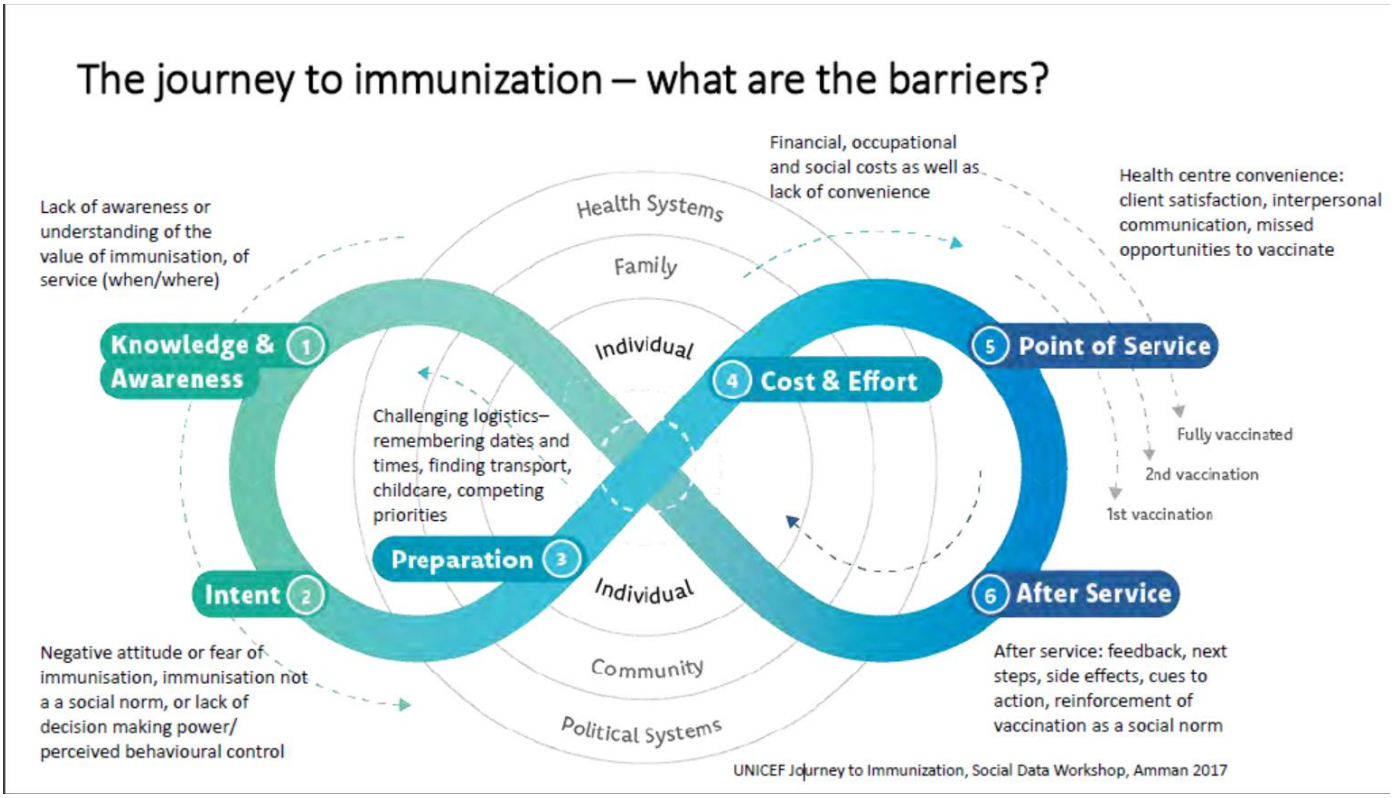
iv. **Point of service:** -this entails appropriateness and convenience of services being offered and how they affect demand for immunisation, e.g. distance to the immunisation

centre, waiting hours, availability of health workers to provide the services in time, availability of vaccines, practising SOPs in the era of COVID-19.

v. **Experience of care:** -this involves parents/caregivers' appreciation and satisfaction of services offered by health workers at that particular immunisation centre. For example, what is the quality of interpersonal communication between health workers and parents/caregivers?, how do the health workers relate with parents/caregivers,?; any evidence of customer care skills by health workers to parents/caregivers?, the level of trust by parents/caregivers in the vaccines being offered, and reaction of health workers to parents/caregivers when the latter do not present child health cards.

vi. **After service:** -this stage necessitates the need to utilize information from health workers so they can continue taking children for immunisation. For example, how do parents/caregivers manage AEFIs, do they know when and where to return for the next dose of immunisation, and do they share positive experience about immunisation with other members of the community that can act as positive reinforcement to take their children for immunisation. In the long run, the journey to immunisation framework anticipates that communities will consider immunisation as a norm where parents/caregivers develop self-efficacy and are able to take children for immunisation without being reminded to do so and can recommend the service to other members of the community.

Figure 3: The Journey to Immunisation Framework



Source: UNICEF Journey to Immunisation, Social data workshop. Amman, 2017

3. THE URBAN IMMUNISATION COMMUNIC ATION PLAN

The urban immunisation communication plan outlines a five-year communication agenda to guide implementation of demand generation activities for the period 2021-2025 and is expected to contribute to the vision, mission and goal of UNEPI. It identifies factors that affect demand for immunisation services and proposes strategic interventions for promotion of behavior change among parents and caregivers in urban settings.

3.1 Process of developing Urban Immunisation Communication Plan

The development of the communication plan followed the processes below:

- Desk review of relevant strategic documents with literature on immunization and communication interventions in urban settings. This review generated information which was used to compile a report that informed development of the communication plan
- Internet search for information about status of immunisation and communication interventions from relevant national and international health websites with best practices that can be replicated
- Rapid assessment of EPI activities in urban settings of seven districts that include: Kampala, Wakiso, Mukono, Jinja, Iganga, Gulu and Mbarara where consultative meetings were held with DHTs, City/Municipal Public Health and Environmental Health managers, Political leaders (RDC/RCC), health workers, health inspectors, community health workers (VHTs), non-health stakeholders such as CDOs, inspectors of schools, men and mothers/caregivers in the community to provide information on factors affecting demand for immunisation services.

  The rapid assessment applied the Human Centred Design (HCD) process –a problem solving approach that engaged parents and caregivers in identifying problems that affect demand for immunisation services in their communities. They also proposed local solutions that were tailored to address their needs. This approach facilitated the process of building consensus among target audiences by agreeing on the same solutions which contributed to the design of targeted interventions to address unique challenges in urban settings.

- Consultation with technical teams from UNICEF (CSD and C4D sections), UNEPI, HPE&C department, World Health Organisation and other national health partners who provided technical input that shaped the technical content and flow of ideas in the Urban Immunisation Communication Plan
- Meeting to review the draft Urban Immunisation Communication Plan-by Health Promotion department and partners to further provide technical input
- Consensus building meeting to validate the communication plan-by Health Promotion and Environmental Health Technical Working Group. This forum validated and approved the communication plan.

3.2 Goal and objectives of the Communication Plan

The goal and objectives of the urban immunisation communication plan are based on the social ecological model which analyses problems and behaviours of individuals targeted for change and provides strategic direction to operationalization of the communication plan.

Thus, the goal of the communication plan is to contribute to improvement in immunisation coverage through increasing demand for immunisation services in urban settings by end of 2025. This will further contribute to a reduction of zero dose children as highlighted in the immunisation agenda 2030.

Specific Objectives

1. Increase the proportion of parents and caregivers who demand for immunisation services
2. Increase the proportion of health workers who have adequate knowledge on immunisation and developed skills and attitudes needed to communicate and relate more effectively with parents and caregivers during immunization sessions
3. Increase the proportion of community health workers and non-health stakeholders who can mobilise communities to demand for immunisation services
4. Promote multisectoral collaboration and private sector engagement to increase alliances and partnerships for immunisation services

5. Establish a mechanism for identifying community concerns, tracking, monitoring and dealing with rumours on vaccines and immunisation

6. Strengthen mechanisms for evidence generation to guide development of targeted interventions for promotion of immunisation services

7. Promote media and policy advocacy for raising the profile of immunisation as a national priority health programme and mobilise resources to support demand generation activities

3.3 Strategies and interventions

The development of the communication plan is guided by four main strategies which include: behavior change communication, social change communication, social mobilization and advocacy.

3.3.1. Social and Behavior Change Communication

This strategy describes interventions aimed at creating awareness, increasing knowledge, changing beliefs, perceptions, attitudes and practices; developing self-efficacy and communication skills for adoption of health behavior. It also includes application of social change communication which involves processes that are meant to eliminate harmful beliefs and practices and change negative social norms that are a barrier to adoption of health behaviours. Thus, a number of interventions will be used to target behavioral and structural barriers at individual, household, health facility and community levels with focus on communication and non-communication factors to generate demand for immunisation services and they include:

- **Empowerment of families and communities to adopt healthy behaviours**

This intervention involves engaging households (mothers, men, family members) and communities in informal and gated communities in activities that facilitate transfer of knowledge, change beliefs, attitudes and develop skills and confidence to make informed and responsible decisions and choices about immunisation. Individuals and communities are at the centre of every public health intervention and empowering them with knowledge and skills in immunisation and communication builds their confidence and

facilitates development of self-efficacy in making right choices and decisions and demanding for immunisation services.

This intervention will apply the human centred design approach, by engaging members of the community to use indigenous knowledge and identify challenges affecting their socio-economic and health conditions. They will use the knowledge to collectively plan and agree on local solutions that can address their challenges. The human centred design approach guarantees ownership and sustainability of the interventions at household and community level and enables individuals and communities to perceive immunisation as a norm, beneficial and quality preventive service for their children.

- **Male involvement in immunisation services**

Male involvement is important for the success of the immunisation programme since men are traditionally heads of households and can influence decisions on matters concerning social, economic and health aspects of their families. The influence of male partners is illustrated in a statement by one of the mothers who said that, "***there is an incentive to immunisation; when you go to a health facility with a male partner for immunisation, health workers give you first priority and you go home early.***" Thus the support of male partners to their spouses adds value to the mobilization efforts for immunisation services.

- **Development of evidence-based targeted interventions, materials and messages**

Development of interventions, information tools and materials will be based on data collected on knowledge, beliefs, attitudes and practices ensuring mapping of the most vulnerable populations. Further data collection will be done to inform planning and design of interventions that are all inclusive and leave no one behind for immunisation services. It is important to strengthen communication research agenda with evidence and reduce reliance on assumptions. It is important to recognize that the population is dynamic and growing from one life stage to another and is developing different needs and aspirations. Communication research should therefore be conducted to target the different life stages so that interventions are target specific and informed by population dynamics. This

approach is one of the ways of contributing to evidence generation which will keep informing development of quality communication interventions, messages and materials on immunisation.

- **Engagement of champions and role models to promote immunisation**

The immunisation champions and role models are key influencers who should be identified in the community or at national level and be oriented on immunisation and communication skills. They will then be utilised to sensitise households and communities about benefits of immunisation, the need to register children under one year, and take them for immunisation and complete the schedule. The role models can be selected from satisfied users of immunisation services who appreciate the benefits of immunisation while champions can be selected from influential celebrities with good conduct at national level and be engaged by Ministry of Health to promote immunisation at various functions.

- **Embrace new technology using digital tools**

The adoption and use of new technologies can make immunisation services more easily accessible to the population. Currently, 74% of Ugandans in urban and rural areas use mobile phones (UBOS, 2021) and 90% of men and women in urban areas use mobile phones. This creates an opportunity to use social media platforms to deliver EPI messages to both informal and high end social class communities in urban settings. The high end social class communities include business people, politicians and technocrats who in most cases are organized into neighbourhood watch whatsapp groups that can be used to deliver messages to their fellow group members.

Social media can be a powerful tool to disseminate messages and dispel myths, rumours and misconceptions about immunisation; it can also deal with misinformation and disinformation around the safety of vaccines from anti-vaccination lobby groups.

Mobile phones can also be used by health workers to send reminder messages to mothers/caregivers as cues to trigger action for taking children for immunisation. This

will be accomplished through application of some of the digital tools such as m-health, U-Report, e-register and family connect communication technologies.

- **Use children's voices to promote immunization**

Children can act as advocates for immunization by giving testimony about the benefits of immunization. They can be used on various media platforms such as radio and TV to air messages through programmes, spots/jingles and testify to parents that immunization works. For example, **"we *are healthy because we were fully immunized and protected from vaccine preventable diseases."***

Children's voices can also be used when young people and adolescents in school are organized to promote child activism in immunization among their peers and parents/caregivers. Children can be equipped with knowledge on immunization and skills in communication and be engaged as champions to create awareness on benefits of immunization and influence their parents/caregivers on the need to protect their siblings against vaccine preventable diseases.

- **Provide signage in public spaces on location of health facilities**

Some public and private health facilities do not have signage to provide direction about the location of health facilities and the services offered there. There is a need to install sign posts with directions, services offered and hours of operation for vaccination on different days of the week (e.g. every working day starting at 9am) to address the information gap on location of immunisation services. The use of a familiar logo on the sign post can guide people to easily identify the services being offered in a particular health facility e.g. MoH court of arms and logos for private health facilities to direct members of the community to where immunisation services are offered.

- **Strengthen risk communication interventions to address rapid spread of rumours about vaccines, AEFIs and immunisation**

Communication interventions and messages on vaccines, immunisation and AEFIs can be affected by rapid spread of rumours on social media, mass media houses and the community. The rumours should be gathered, documented and tracked through

listening, reading and engaging communities. Rumour tracking can facilitate establishment of the source and how widespread it appears to be; how it spreads, type and when it happened and whether it demands immediate response or not. The Health Promotion and Communication department should train journalists, government spokespersons and public health professionals on how to track rumours and put mechanisms in place to rapidly respond to them through press releases, press statements and briefs in form of feedback to the community.

3.3.2. Social Mobilization Strategy

Social mobilization strategy involves uniting partners and stakeholders to work towards achieving a common purpose. It emphasizes efforts to unite partners, stakeholders and the private sector at national, city, municipal, health facility and community levels and continuously engage them to understand the benefits of immunization. It also promotes building of alliances and coalitions, strengthening stakeholder and partner participation and ownership of the immunization programme. The following interventions will be used to implement this strategy:

- **Building the capacity of health workers, community health workers and non-health stakeholders to improve their knowledge, skills and competence in immunization**

This intervention recognizes the importance of having a pool of trained service providers to implement the communication plan and these include; health workers, community health workers (Health Assistants and VHTs) and non-health stakeholders.

Service providers are the backbone of any health system and play a key role in generating and sustaining demand for immunization services at community and household level. The health workers include; health facility in-charges and EPI Focal Persons. They will be trained in immunization, interpersonal communication skills and customer care skills to enable them develop skills and positive attitudes which will improve their relationships with parents and caregivers and facilitate effective delivery of quality immunization services at health facilities and outreaches.

The community health workers include; VHTs, assistant health educators, peer educators, health inspectors and health assistants. These will also be equipped with

knowledge and skills in immunization and communication and work together to implement community mobilization and community based surveillance activities at health facility, community/ward and household level.

The non-health stakeholders include; religious leaders, teachers, community extension workers from Agriculture, animal industry, community development and town agents at community level. They interact with communities almost on daily basis during execution of their duties and are well positioned to mobilise for immunization. They will be equipped with the required information on immunization and communication skills and together with VHTs be engaged to mobilise communities for immunization services.

The teachers will play a dual role of mobilizing girls in primary schools for promotion of HPV vaccination and also participate in assessment of immunization uptake using child health cards during enrollment of children into pre-primary/primary school. They also include leaders of major religious allies who are influential opinion leaders in the community and can facilitate change of negative social norms and harmful cultural practices to promote behavior change. Leaders of major religious allies will be mapped, oriented and engaged to sensitise their followers and create awareness on immunization through sermons in their congregational settings which include; places of worship, community functions such as weddings, funerals and baptism parties. They can also use face-to face interaction to counsel the parents/caregivers about immunization from a spiritual perspective by reminding them to have faith and hope in dealing with health and family issues.

- **Engagement of formal and informal structures to mobilise communities for immunization**

Formal and informal influential structures and stakeholders will be identified and sensitized on immunization and community mobilization skills so they can apply indigenous knowledge to mobilise urban communities for health and immunization. The participation of informal structures in community health and immunization activities

facilitates development of community led solutions which contribute to appropriate community action.

The informal influential structures include women groups, traders' associations, bodaboda associations, market vendor associations, transport associations, neighbourhood watch and estate whatsapp groups.

The formal influential structures include teachers' associations, Alliance of Mayors and Municipal Council Authorities (AMICALL), and Parliamentary Forum of MPs. When these structures are organized and sensitized on immunization, they can provide the needed resources in terms of knowledge, skills, logistics and funds to facilitate mobilization of communities for immunization services.

- **Strengthen multi-sectoral collaboration with relevant partners and stakeholders**

This intervention entails working with relevant sectors to address issues that affect health and particularly immunization. The multi-sectoral collaboration approach creates opportunities for bringing partners and stakeholders together and promote urban immunization communication interventions as they utilize resources to improve access and health service delivery to individuals and communities. There are several partners and stakeholders working with urban authorities with potential that can be harnessed to increase demand for immunization.

It is important to engage partners beyond EPI, to incorporate immunization interventions in their work-plans and promote it in the workplace. For example, stakeholders from relevant ministries of Works, Education, Local Government, Gender and Social Development, Agriculture, Animal Industry and Fisheries, Water and Environment, and Trade and Industry and health development partners can join the discussion to promote immunization in the work place and contribute to achievement of Universal Health Coverage using the PHC approach.

- **Promote private sector engagement in immunization service delivery**

The private sector has Private for Profit (PFP) and Private Not for Profit (PNFP) health facilities that provide curative and preventive health services directly and/or support government to provide the necessary services. In Kampala district, private health practitioners constitute 98 %(PFP and PNFPs) and these can be mapped to ensure effective mobilisation, equitable coverage and geographical access to the hard to reach, marginalized and underserved communities where government cannot reach, e.g. ghettos, slum areas and gated communities. Some of the private health sector organizations include missionary health facilities, religious health organisations such as Catholic, Protestant and Muslim Medical Bureaus and private hospitals and clinics in urban settings.

The Ministry of Health needs to accredit willing private health facilities in Kampala and other urban settings to provide immunization services in hard to reach/serve urban communities. Ministry of Health also needs to engage with non-health private organisations such as mobile phone companies, oil companies, banks, and civil society organisations to use their social responsibility role and promote immunization in the work place and communities they serve. The involvement of the private sector can increase access to immunization services and reduce distance to the health facilities thus reaching the unimmunized children.

- **Advocate for establishment of outreach vaccination sites in high volume places**

The urban populations are highly mobile with little or no time to take children for immunization. It is important to map the most vulnerable communities and use data to inform planning for establishment of outreach vaccination sites that will target the most vulnerable children for immunization. The audiences to be mapped and targeted for vaccination of their children may include: women/caregivers, men, single parents, and adolescent mothers with zero dose and under-immunized children. Targeting these audiences should ensure acceptability of immunization services for both mothers and fathers. They can be located in high volume work places that include markets, trading centres, supermarkets, taxi/bus parks, congregational settings, shopping malls, saloons

and factories in informal and high class settlements. They can also be mobilized and served through weekend and evening vaccination sessions, extended and flexible vaccination hours. This approach will reduce physical distance between urban informal communities and immunisation services when accessing the services, and accommodate working hours and caregivers' responsibilities wherever they are working. Thus, using geographic proximity to immunization services, parents and caregivers will be motivated to take children for immunization.

With consideration of local dynamics, this intervention advocates for increasing the number of vaccinators and deployment of more community mobilizers to areas with big numbers of unimmunized children and low immunization coverage rates and, particularly in settings where facility-based health services are not easily accessible.

- **Mobilisation of leaders of religious sects, cults and resistant communities opposed to immunization**

There are religious sects and cults as well as resistant and hostile communities that oppose childhood immunization because they do not trust the safety of vaccines based on their inadequate knowledge and negative beliefs. This situation is aggravated by prevailing myths and misconceptions around the use of vaccines as a western tool for population control. The religious sects include Muslim tabliqs and sharafa and triple six (666) cult; they hide their children from health workers and refuse them to be immunized. There are also resistant communities which are hostile to health workers and VHTs because of experience from minor reactions on their children resulting from the Measles-Rubella campaign in 2019. The hostility of resistant communities to health workers is highlighted in a statement by one of the VHTs who said, "***at one time we went for an outreach, and the residents mobilized themselves and chased us from their area because they believed the vaccines we had taken could cause their children the same reactions like those of Measles-Rubella vaccine"(KII, VHT)***

The religious sects, cults and resistant communities will be mapped and oriented and be engaged to mobilise and influence their followers to take children for immunization.

- **Embrace the Life Course approach by integrating immunization and communication into other health services**

The life course approach aims at having all people benefit from recommended immunizations throughout the life-course, effectively integrated with other essential health services[23] as emphasized by the immunization agenda 2030. The Immunisation Agenda 2030 aims to achieve the vision for the decade of: a *world where everyone, everywhere, at every age, fully benefits from vaccines for good health and well-being.* Integration of immunization into other health programmes can provide a better opportunity for delivery of immunization services alongside other health services to the children in their first year of life and beyond early childhood, through adolescence and in priority adult groups such as pregnant women, health workers and older adults. E.g. vaccination of women of child bearing age with Td, hepatitis, HPV and COVID-19 vaccine for adults of different age groups.

This intervention can also take advantage of national and international health events and services as well as implementation of routine health and immunization activities which include; Integrated Child Health Days (ICHD), growth monitoring promotion, mass drug administration, sanitation and hygiene campaigns, African Vaccination Week, vitamin A supplementation and de-worming, distribution of bed nets and other maternal and child health services. These health events can be used as opportunities to bridge the gap for missed opportunities.

- **Advocate for institutionalization of e-registration of pregnant women at health facilities and registration of children under 1 year in the community**

Use digital tools such as smart paper technology to conduct electronic registration of pregnant women at health facilities during ANC sessions and follow them up to ensure they immunize their children. This intervention will facilitate longitudinal tracking of defaulters and unimmunized children, those without child health cards and follow up and remind their parents to take them for immunization.

[23] Immunisation Agenda, 2030. A Global Strategy to leave non-one behind. IA 2030

Village Health Teams are already registering children for immunisation; however, the numbers are low, and this necessitates intensification of their mobilization efforts to get more children registered. The health workers will check the child health cards to ensure whether registered children are immunized. If they are not, then the VHTs will physically visit the defaulting mothers/parents and remind them to take children for immunisation. Child registration by VHTs facilitates tracking of defaulters, increases turn up of unimmunised children at immunisation sites and identifies other health needs in homes and communities during mobilization such as Key Family Care Practices (KFCP) which can be addressed in an integrated approach.

Above all, village registration should be intensified to capture all household members, different age groups of children under one year receiving different antigens at different ages including MR2 at 18 months, HPV at 10 years and COVID at all recommended ages.

3.3.3 Advocacy strategy

This strategy seeks to develop or change laws, regulations and policies related to immunisation. It will be implemented through interventions which target people in positions of authority that can influence the success of the immunisation programme. Among the influential people to be targeted are the media for raising public awareness on immunisation and report immunisation information correctly and responsibly. Many people make decisions based on what they hear, see or read in the media and this makes the media a credible source of information on immunisation. The interventions to be implemented include:

- **Media advocacy to promote accurate and analytical coverage and reporting of immunisation activities**

Media advocacy is the strategic use of media to communicate with large numbers of people to advance a social or public policy objective or influence public attitudes on an important public matter.[24] The purpose of working with the media is to increase positive coverage and reporting about immunization issues on different media platforms. Thus

[24] UNICEF, 2017. The Multisectoral Communication for Development Strategy for Adolescent Girls. Kampala-Uganda.

representatives from media houses and public health spokespersons will be trained so they can play a key role in publicizing, reporting and advocating for immunization programme from an informed position. The media will identify areas of concern in informal communities where there are big numbers of unimmunized children and raise issues for the public, technocrats and leaders through mass media (newspapers, radio and TV) to take appropriate action.

- **Policy advocacy by decision makers to raise the profile of immunization**

This intervention aims at enlisting the support and commitment of policy makers, political and civic leaders to recognize immunization as a national priority health programme so they can allocate adequate financial resources and promote it at national district, urban and community level. Leaders need to be reminded to honour their commitments to the people they serve by providing the necessary support to immunization services. The political leaders include the members of Parliament, district and urban political leaders, LC system at district and urban authorities as well as community level. There is an existing parliamentary forum on immunization, however, to strengthen immunization services requires establishment of an EPI or health Parliamentary sub-forum focusing on cities and municipalities/urban settings.

3.4 Sustainability of interventions

Despite the challenges faced in generating demand for immunization services, some achievements have been made to increase coverage in immunization in urban and rural settings. These achievements need to be sustained by promoting the following interventions:

- Digitalise immunization services at all levels of health service delivery by capturing the biodata of parents/caregivers; and follow them up to find out whether they are immunizing their children on schedule. In addition, continuously track parents and caregivers who have not completed or dropped out of immunisation schedule and send them reminder messages from the health facilities where they immunize their children. For example, a reminder message

can read like ***"your child is due for immunization with DPT-HepB-Hib2, on Wednesday 28th July, 2021; please remember to take your child for immunization to get her scheduled dose."***

- Strengthen leadership, management and coordination of urban structures so they can support the immunisation programme. For example, when targeting leaders of bodaboda association or market vendors as allies in immunisation, we need to be cognizant of the fact that their social and economic welfare is driven by the survival instinct based on economic gains. This means that to get them commit themselves and mobilise for immunization requires providing them with social and economic support. One of the ways to win their support is to encourage them to form SACCOs which will earn them a living and motivate them to support immunization activities.
- Facilitate the VHT system to conduct home visits and community mobilization activities in the hard to reach and convince communities. When the VHTs are motivated, they can commit their time and mobilize communities for immunization by mapping the vulnerable communities and identifying zero dose and under immunized children and encourage their parents to take them for immunization.
- Also provide incentives[25] to parents/caregivers at immunization centres using primary health care funds by giving them tea as they wait for their children to be immunized. Some health facility in-charges are already doing it; this is a good practice that can be replicated in other health facilities throughout the country to motivate the parents/caregivers to take their children for immunisation. In addition, health workers can give the mothers insecticide treated bed nets as a way of rewarding them for completing immunization schedule.
- Continuous engagement of telephone companies to send messages to their clients or use immunization messages as automatic ring tones before the recipients

[25] UNICEF, 2016.Immunisation, Urbanisation and slums: A review of evidence. New York. USA

receive the call. This can SMS reminder messages can act as cues and trigger action by taking children for immunization.

- Continuous engagement of religious leaders in discussions and provide circulars with key messages on immunization in their congregational settings. This will reignite the immunization agenda in places of worship.
- Engagement of various influencers (opinion leaders, immunization champions and role models) on a face to face basis and discuss how they can play their role of working with different communities to promote immunization in urban settings
- Strengthen existing partnerships with the private health practitioners who provide health services to the elite and rich urban dwellers through neighbourhood watch and estate whatsapp groups
- Ensure that members of the community are involved in planning and their suggestions of what works for them comes from the community. The local solutions will be respected, owned and sustained by the community.
- Establish a system for rumour management and use community based structures like VHTs to monitor rumours and misinformation in the community and provide timely feedback to the leaders, technocrats and communities to take action. In addition, HPE&C department will conduct media monitoring to identify rumours and process the information to generate evidence that will inform planning of interventions to respond to the rumours.

Thus, in a bid to manage rumours, HPE&C department will assign VHTs to gather and record rumours in the community and submit to health facilities which will in turn submit to DHOs offices and finally to a central database at Ministry of Health. These will be reviewed by experts who will provide correct and scientific facts on immunization and disseminate the responses to the public through the Ministry of Health Call Centre, media houses and social media platforms to clear the rumours. Thus an important aspect of risk communication and community engagement in rumour management is to understand

the sources and types of rumours circulating in the community and address them timely through mass media, social media and community engagement platforms.

3.5 Communication channels, materials and messages

Various channels of communication will be used to deliver messages at different levels. However, as a first step, appropriate content will be developed, packaged, and delivered to audiences using different channels of communication. The channels of communication include; interpersonal communication, digital communication, folk media, mass media and social media platforms.

The development of messages and materials will be preceded by preparing a creative brief that will provide a strategic foundation as best practice to develop audience-driven strategic communication. A creative brief is a foundation for all message and materials design, concept development, and syntheses audience research that clearly identifies target audience, knowledge, beliefs, and attitudes, barriers to desired behaviours, communication channels, and facilitating factors to desired behaviours[26].

The development of messages and materials will be spearheaded by Health Promotion and Communication department bringing on board relevant programmes like UNEPI, and stakeholders from line ministries as well as partners in immunization.

The development of messages and materials will take into account the characteristics of a good message/material which include; being simple and clear, attract attention, convey benefits, create trust, and touch the hearts and minds of the audiences targeted for change by appealing to their emotions and calling for action.

The messages should have a degree of credibility by indicating the authority from which they are coming such as Ministry of Health, UNICEF and WHO so that people can believe in them. Developing the message content should use the co-creation approach involving stakeholders, women groups and other community based groups. It should among other considerations utilize the social marketing principles of 4Ps (place, price, product and

[26] Kincaid. D. L., et al, (2007). A social ecology model for social and behavioural change communication. Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs.

promotion) that can make messages attractive, capture the audiences' attention and cause change among individuals and communities. The key messages to deliver to the parents and caregivers should focus on the following key areas:

- The vaccine given and disease immunised against
- Side effects after immunisation and how to manage them
- Benefits of immunisation
- Number of times a child should be taken for immunisation and complete the schedule
- The safety and effectiveness of vaccines -to build trust in vaccines and immunization
- When to return for the next immunization dose
- Parents/caregivers to always take the child health card every time they take a child for immunization
- Parents/caregivers to keep Child Health Card safe and take it along each time they visit the health facility for immunization

Channels of Communication

The channels of communication are informed by channel analysis and audience preferences. Communication interventions and messages are most effective when disseminated in a sustained manner using possible and available communication channels. The urban immunization communication plan will be implemented using a multiple channel approach that will ensure message penetration to the intended audiences. The channels are tailor made to suit the needs of target audiences and community engagement through interpersonal communication, mass media, print, social media, and new communication technology through mobile phones and folk media through music, dance and drama will be used.

The different channels of communication have varied strengths and weaknesses but when strategically used in a combination form, they can build on each other's comparative

advantage, increase synergy, maximize frequency and ensure message penetration to the parents and caregivers.

Table 4: Audience, channel and key messages

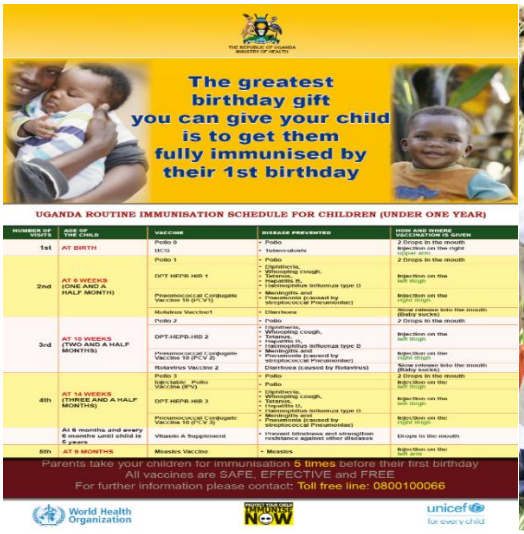
Audience	Channel &method of communication	Key messages	Outputs/outcomes
Mothers/caregivers and men	Interpersonal (one on one and Group) • One on one through home visits • IEC materials (posters, flyers, booklets) • Community radio to announce dates of immunization • Radio and TV programs o Radio drama skits o Radio and TV spots o Radio and TV talk shows o Radio DJ mentions •Group IPC- Parent Teacher Associations, School Management Committees • Community dialogue sessions by VHTs • MoH Call centre-hotline –education and counselling • Transit advertising through billboards and vehicles (taxis, buses) • Use of social net-works; Mothers and fathers unions • Social Media –Whatsapp, Face Book &twitter • Road shows/drives • SMS reminder messages on immunization-next date and dose,	• Take your child for immunization five times before first birthday to ensure the child is fully immunized and protected against VPDs • If child gets reactions after immunization and they persist, take the child to the nearest health facility for proper management[27] • Keep your Child Health Card safe and take it along each time you visit the health facility for immunization • The vaccines are safe, effective, and free and available at public and private health facilities and outreaches • Unimmunized children in urban settings are at higher risk of contracting VPDs which can then spread to other children including yours. Take your children for immunization to protect them against VPDs and avoid consequences of disability and death.	• Increased awareness and knowledge on benefits of immunization • Increased turn up at immunization centres • Parents/caregivers demanding for immunization services and taking children for immunization &completing the schedule
Health workers, VHTs and non-health stakeholders (religious leaders, teachers, CDOs)	• Training workshops • Review meetings • IEC materials (Booklets on Immunisation, brochures, immunisation schedule) • CME sessions for health workers • MTRack for health workers	• Mobilise parents/caregivers to take their children for immunisation and complete the schedule • Remind parents and caregivers to keep their Child Health Cards and take them each time they visit the health facility • Relate well with parents and caregivers to motivate them take their children for immunization	• increased knowledge on benefits of immunization • Increased communication skills • Improved interaction between health workers and parents/caregivers

[27] *Ministry of Health (UNEPI), 2018: Communication Aide for Health Workers on Routine Immunisation*

Community influencers; Religious and cultural leaders, informal groups (neighborhood watch groups, traders, market vendors associations), and head teachers	• Community dialogue sessions • Sensitisation meetings • Messages through networks -Inter religious Council • Cultural meetings • Messages through whatsapp estate groups • Messages through places of worship	• Unimmunized children in urban settings are at higher risk of contracting VPDs which can then spread to other children. Educate parents/caregivers to take their children for immunization to protect them against VPDs and avoid consequences of disability and death. • The vaccines are safe, effective and free and are available at public and private health facilities and outreaches	• increased knowledge on benefits of immunization • Increased communication and community mobilization skills • Increased participation in mobilization of communities for immunization services
Leaders of religious allies, religious sects and cults opposed to immunisation	• Messages through congregational settings such as places of worship • Community barazas/meetings • Mass media such as radio and TV • Social media platforms	• Unimmunized children in urban settings are at higher risk of contracting VPDs because of the crowded and poor hygiene and sanitation conditions. These diseases can spread to other children including yours. Educate parents/caregivers to take their children for immunization to protect them against VPDs and avoid consequences of disability and death. • Use the word of God to help parents and caregivers restore hope in life, health and immunization • The vaccines are safe, effective, and free and are available at public and private health facilities and outreaches	• Increased knowledge on immunization and skills in communication and community mobilization • Increased participation in mobilization of communities for immunization services
Media personnel	• Training workshops • Press-media briefings • Social media through whatsApp, Facebook and twitter	• Promote accurate and analytical coverage and reporting of immunisation issues • Promote immunization as a government health priority programme that can protect children against vaccine preventable diseases	• Increased knowledge on immunization • Increased positive reporting and coverage on immunization
District/City/Municipal authorities and Parliamentarians	• Advocacy meetings • Advocacy materials with support of advocacy & policy briefs and fact sheets	• Immunization is a government priority and every child has a right to be immunized	• Increased knowledge on immunization • Increased support and commitment by allocating adequate

	• Mass media through radio, TV and newspapers • Social media through whatsApp, Facebook and twitter	• Mobilise and allocate adequate financial resources to support immunization activities • Promote immunization as a government health priority programme that can protect children against vaccine preventable diseases	financial resources to immunization • Advocate for integration of immunization in work plans and budgets of relevant stakeholders such as Urban CDO and Education departments

Samples of IEC materials used to promote immunisation activities



Poster on Immunisation schedule

Community dialogue by VHT

Children's voices through radio programmes

4. IMPLEMENTATION MODALITIES AND TIMELINES

4.1 Implementation approaches

Several partners and stakeholders at national, district, urban authority and community level will be guided by this communication plan to implement demand generation activities. A mechanism for coordination, management, monitoring and evaluation is included in this communication plan to facilitate realization of desired results from implementation of SBCC interventions.

Activities will be implemented in a phased manner in consideration of what priority activities should precede others and gradually build momentum and synergy for subsequent activities over a period of five years. Special emphasis will be placed on high risk communities in informal settlements that are vulnerable to VPDs and hard to reach with big numbers of zero dose and under immunised children.

The Implementation plan will apply two key approaches namely the Year Round communication activities of routine nature which will be implemented throughout the year and the short term targeted campaigns that will intensify communication, social mobilization and advocacy activities during special health events such as Supplemental Immunisation Activities,(SIAs) African Vaccination Week and Integrated Child Health

Days. The short-term targeted campaigns will intensify community engagement activities using RED/REC approach to contribute to improved coverage and performance in immunization service delivery.

4.2 Levels of implementation

Implementation of the communication plan will be preceded by building the capacity of stakeholders at national, district, urban authority and community level to acquire knowledge and develop skills which they will use to mobilise households and communities to participate in activities that prevent diseases and improve the health and immunization status of children. Deliberate efforts will be made at national level to develop training materials and orient the Advocacy Communication and Social Mobilisation (ACSM) committee members on how to use and roll-out the communication plan to district and urban authority level. The oriented ACSM committee members will in turn be deployed to the districts to orient district and urban health and non-health stakeholders on immunization and how to implement the communication plan at different levels of service delivery in urban settings. The oriented urban health and non-health stakeholders will be expected to support community engagement activities by mobilizing communities to participate in immunization activities.

The key community based cadres in government structures that need to be oriented include; the district, city/municipal, division, ward and village level extension workers employed by government with a mandate of working with communities. The main sectors to be targeted include: Health, Community Development, Education, Administration and Security. The cadres of extension workers to be targeted for orientation will be selected from the following sectors:

Health –Health Inspectors, Health Assistants and health facility based workers such as in-charges and EPI Focal persons.

Community Based services – Community Development Officers, para social workers, Veterinary, Fisheries and Agricultural officers.

Administration – Divisional administrative heads, Town Clerks, Mayors and town agents

Security – RCCs, DISOs, Police, GISOs, PISOs and VISOs

Political-Chairpersons and councillors at LCV, LCIII, LCII and LCI and Secretary for Health

Education–Education officers, Inspectors of schools, teachers and prefect/student leaders.

The other social structures that are non-health stakeholders and need to be oriented on immunization and communication skills include:

- Divisional and ward /Parish VHT coordinators
- Religious and Cultural leaders
- Service Clubs such as Rotary, Lions, Scouts and Girl Guides
- Social Clubs – Youth and Women clubs and organizations
- Leaders of groups in informal settlements and high end social class communities

For sustainability of the immunization communication interventions, the non-health stakeholders will be requested to integrate immunization communication interventions into their day to day activities as they interact with communities. If these cadres of people are well oriented and coordinated, they can liaise, provide technical support and work with the existing community structures such as VHTs, religious, cultural and clan leaders to generate demand for improved immunization coverage in urban settings.

Table 6: Implementation plan for the urban immunization communication plan

Strategy	Interventions and key activities	Outputs/outcomes	Responsible Office(r)	Timeframe 2021-2025				
				Y 1	Y 2	Y3	Y4	Y5
Behaviour Change Communication	**Empowerment of families and communities to adopt health behaviours that promote immunisation**							
	i. Map the vulnerable poor communities in hard to reach and convince	Vulnerable poor communities including pre-primary, primary	-Health Inspectors, Health Assistants,					

	populations and identify unimmunized and under-immunised children-	schools mapped and identified	-VHTs -LCs					
	ii. Conduct health education talks on immunization in Out Patient Departments (OPD)	Increased awareness on benefits of immunization	-Health Educators, EPI Focal Persons					
	iii. Conduct community sensitization and dialogue meetings with mothers, men and caregivers to create awareness on immunization	Increased awareness on benefits of immunization	-VHTs, -CBOs, CDOs, Town Agents, Health Assistants					
	iv. Conduct home visits and educate households on importance of immunization	Increased awareness and knowledge on immunization	VHTs, para-social workers					
	v. Send bulk SMS messages to remind parents and caregivers to take children for immunisation and complete the schedule.	Increased awareness and knowledge on immunization	-Health workers					
	vi. Disseminate tailor made messages and materials to refugees, migrants and hard to reach communities through social media platforms such as WhatsApp, Twitter, Instagram, TikTok and Facebook	No. of audiences that receive messages through social media platforms -increased awareness on immunization	Health educators Health Assistants, social media firms					
	vii.Conduct awareness raising activities through mass media, (radio, TV, newspapers) Public Service Announcements, children's voices and transit advertising	Increased awareness on immunization	DHEs, Urban Health Educators, Radio &TV stations,					
	viii.Engage role models and champions to educate communities on benefits of immunization	No. of role models & champions mobilizing for immunization	Role models, Champions & VHTs					
	Development of evidence-based targeted interventions, materials and messages							
	i.Conduct formative research (desk review and community consultations) to gather evidence for developing SBCC materials and messages	Report on knowledge, attitudes, beliefs and practices (KABP) of urban residents on immunization	MoH, City/Municipal Health Authorities					
	ii.Develop target specific messages and materials for use through IPC, mass media, folk media and social media	Draft messages and materials	MoH, DHTs, City/Municipal Health Authorities IPs					

	iii.Pre-test the draft materials and messages with the urban communities	Field comments in the materials &messages	City/Municipal HEs,HI, EPI FPs					
	iv. Revise and refine the messages and materials.	Final messages and materials	City/municipal HE EPI FP					
	v. Mass production and distribution/dissemination of materials and messages to the target audiences	No. and types of materials/messages produced &distributed/disseminated	City/Municipal HE, MoH, EPI FP					
	vi. Conduct follow-up, monitoring and evaluation of communication activities	No. of urban residents that have received materials and heard messages on immunization	City/Municipal HE,HI, HA, VHTs,					
	Conduct registration of children under 1 year by VHTs							
	i.Conduct sensitization of communities to raise awareness about registration of pregnant women at health facilities and children under 1 year in the community	-Increased awareness and knowledge- -No. of pregnant women registered at HFs -No. of children registered in the community	Health workers, HAs, VHTs, CBOs					
	ii. Conduct home visits to carry out child registration	No. of children registered	VHTs, IPs, HAs					
	iii.Follow-up on mothers/caregivers to ensure registered children in the community are immunized	No. of mothers/caregivers continuing to take children for immunization	-VHTs, HAs, IPs					
	iv.Send SMS reminder messages to defaulting mothers to take children for immunization	No. of defaulting mothers reached with SMS messages	-Health workers -VHTs					
	vi. Conduct review meetings to share experiences and lessons learnt for re-planning and improved mobilization for child registration and immunization	No. of review meetings conducted -Availability of continuity plans	City/Municipal ADHO-MCH, DHE, EPI FP &VHTs, HIs, HAs.					
Social mobilization	**Building capacity of community health workers and non-health stakeholders to increase knowledge and skills in immunization and communication**							
	i.Identify VHTs and non-health stakeholders to be oriented on immunization and communication skills	No. of VHTs &non-health stakeholders identified for training	DHT, Municipal Public Health &Environmental departments					

	ii. Develop/adapt training materials and tools to support capacity building activities based on the needs of the audiences	Types of training materials &tools developed	MoH, DHT, City/Municipal Public Health &Environmental department					
	iii. Conduct training of VHTs and non-health stakeholders on immunization and communication	-No. of VHTs &non-health stakeholders trained -Increased knowledge on immunization	MoH, City/Municipal ADHOs-MCH,EH, HE, His, IPs					
	iv. Conduct supervision and follow–up of trained VHTs and non-health stakeholders	Increased knowledge on immunization and improved communication skills	DHT, Citymunicipal Medical Officer, DHE, HEs, HIs					
	v. Conduct review meetings with VHTs and non-health stakeholders to share experience, best practices and lessons learnt in implementation of demand generation activities	Lessons learnt and best practices shared	DHT, City/Municipal Medical Officer, DHE, HEs, His					
	Engagement of formal and informal influential structures to increase demand for immunization services							
	i.Identify leaders of formal and informal structures, train them on immunization and communication and engage them in community mobilization activities	No. of formal and informal groups identified and trained to conduct community mobilization activities in urban settings	ADHOs-MCH,EH, DHE,HE, Health Inspector, IPs					
	ii. Identify leaders of groups opposed to immunization in hard to reach/convince and engage them in dialogue meetings on immunization	No. of leaders opposed to immunization engaged in dialogue meetings & mobilizing for immunization	ADHO-MCH, EH, DHE, HE,Health Inspector, IPs					
	iii. Identify leaders of formal structures such as teachers' association, Alliance of Mayors and Municipal Authorities (AMICALL) orient and engage them in mobilising for immunization	No. of leaders of teachers Associations, Mayors and Municipal Authorities oriented	ADHO-MCH, EH, DHE, HE Health Inspector, IPs					

	iv. Identify leaders of informal structures in gated communities (neighbourhood watch whatsApp groups), orient them on immunization and engage them to conduct community engagement activities	No. of leaders of neighbourhood whatsApp groups oriented and mobilizing for immunization	ADHO-MCH, EH, DHE, HE, Health Inspector, IPs					
	v. Monitor and evaluate community engagement activities	No. of informal groups sensitized –Increased mobilization for immunization services	ADHO-MCH,EH, DHE, HE, Health Inspector, IPs					
	Strengthening multi-sectoral collaboration with relevant partners, stakeholders and private sector							
	i. Conduct joint planning meetings with partners and stakeholders, CSOs, FBOs on immunization	-Alliance formation -Joint social mobilisation and communication plans developed	ADHO-MCH, EH, DHE, HE, Health Inspector, IPs					
	ii. Conduct joint support supervision and review meetings on progress of mobilization for immunization activities	-Supervision reports -No. of review meetings held	ADHO-MCH, EH, DHE, HE, Health Inspector, IPs, CBOs					
	iii. Identify private sector organisations-private health facilities and orient them on immunisation and communication	No. of private health facilities identified	ADHO-MCH, EH, DHE, Health Inspector, IPs, CBOs					
	Iv Engage private sector organisations/health facilities to mobilise communities and provide immunisation services	No. of private sector health facilities mobilizing communities and providing immunization services	ADHO-MCH, EH, DHE, HE, Health Inspector, IPs, CBOs					
	Engagement of leaders of major religious allies and religious sects and cults to raise awareness on immunization							
	I. Conduct orientation meetings with leaders of major religious allies and sects/cults opposed to immunisation	Increased awareness on immunization	ADHO-MCH, EH, DHE, EPI Focal Person, HE, HA,IPs					
	ii.Develop and implement mobilization plans per religious institution by the trained religious denomination or sect/cult	Availability of mobilization plans for immunization by religious institutions	-DHE, Health Educator, Health					

			Inspector, IPs, FBOs					
	iii. Reactivate interfaith committees to address immunization challenges in urban settings	Revitalized interfaith committees	MoH, DHE, HI, Health Educator					
	iv. Conduct talk shows on religious FM radio stations to create awareness on immunization among urban residents	No. of talk shows on FM religious radio stations	- Medical Officer of Health, DHE,HE, HI, FBOs					
	v. Engage leaders of major religious allies to implement awareness raising activities in their places of worship and community functions (e.g. marriage ceremonies, baptism and funerals)	Increased participation of religious institutions in issues related to immunization No. of religious institutions involved in promotion of immunization	DHE, Municipal Medical Officer FBOs					
	vi. Engage leaders of religious sects and cults opposed to immunization to conduct awareness raising activities in their places of worship and community functions	-No. of religious sects/cults promoting immunization activities in their places of worship and community	DHE, HE, Municipal Medical Officer FBOs					
	Media advocacy to promote accurate and analytical coverage and reporting of immunization activities							
	i. Develop/adapt media kit and talking points on immunization	Availability of media kit and talking points	MoH, DHE, Partners					
	ii. Orient the media on immunization and provide a media kit	Increased knowledge on immunization	MoH, DHE, Partners					
	iii. Establish/reactivate and manage regular media forum for the media and stakeholders with a view to sharing challenges and best practices on immunization	Availability of functional media forum	-MoH, DHE ADHO-MCH, ---District Information Officer -Partners					
	iv. Conduct media coverage, briefings, press conferences and interviews with MoH, Urban Authorities, partners and stakeholders to update the public on the situation of immunisation in urban settings	Increased reporting about immunization situation in urban settings	MoH, DHE, ADHO-MCH, District Information Officer, Partners					

	v.Monitor implementation of media activities	Monitoring report	MoH, IPSOs, DHT, District Information Officer					
	Social media interventions							
	i. Develop social media content on immunisation	Types of media materials/messages developed	MoH, Partners					
	ii. Orient leaders of social media platforms on immunization	No. of leaders of social media platforms oriented	MoH, Partners,					
	iii. Engage leaders of social media platforms to disseminate messages on immunization	No. and types of social media platforms used No. of people reached with messages	MoH, Partners					
	iv. Monitor and evaluate media activities	Increased awareness on immunization	MoH, IPSOS, Partners					
	Policy advocacy to raise the profile of immunization as a national health priority programme and mobilize resources							
	i.Develop/adapt advocacy materials on immunization	No. &types of advocacy materials developed	MoH, Urban Health Authorities, DHTs &Partners					
	ii. Conduct advocacy meetings to sensitize new MPs and urban political leaders and policy makers on priority immunization issues, and provide advocacy materials	Increased awareness on immunization -Increased advocacy for immunization	MoH, Urban Health Authorities &Partners					
	Advocate for adequate financial resources to immunization programme in parliamentary forum and urban authority meetings and functions	-Inclusion of immunization in parliamentary and urban authority and community meetings -Increased budget for immunization programme	MPs, MoH, Min. Finance					
	iv. Monitor implementation of advocacy activities	Increased financial resources for immunization program	-MoH, Parliamentary Forum on Health/immuni					

			zation - Partners.					

5. MONITORING, EVALUATION AND DOCUMENTATION

Monitoring and evaluation of the urban immunization communication plan will be conducted to track progress and desired end results. It will consider the extent of engagement and participation of various actors in promotion of immunization activities at national, district, urban authority, health facility and community level.

Monitoring will track changes in program activities, outputs and outcomes over a period of five years, facilitate identification of successes and shortcomings which will be used to correct the wrongs and deviations from the set objectives and planned activities. Thus, monitoring provides regular feedback in form of early indications of progress or lack of progress[28] so that deviations from the objectives can be addressed early during programme implementation.

Evaluation will measure the outcomes and impact of the communication plan showing evidence of desired results among intended users e.g. mothers/caregivers benefiting from immunization of their children.

Monitoring and evaluation will be done to measure progress and effects of interventions on the behaviour of individuals and communities based on the factors that affect parents and caregivers at each of the stages of the journey to health and immunization framework. Behavioural indicators will be developed to measure individual and community behaviours using Results Based Monitoring and Evaluation model at input, activity, output, outcome and impact levels and results will be used for informed decision making by implementers and policy makers. The levels of evaluation include:

Inputs-resources that go into the program, for example, personnel, time, funds, equipment and materials

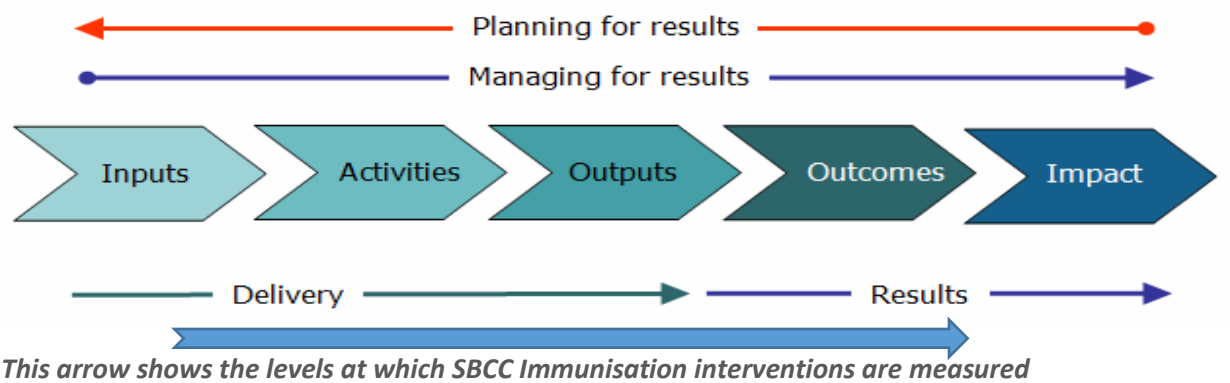
Outputs -products or services from implementation of activities (e.g. sensitization meetings, community dialogue sessions, home visits) that reach the intended audiences; and can be measured by for example, number of parents/caregivers reached with messages on immunization, number of VHTs trained on immunization and

[28] Ministry of Gender, Labour and Social Development, 2017: The Multi-Sectoral Communication For Development Strategy for Adolescent Girls.

communication skills, number of non-health stakeholders trained on immunization and communication.

Outcomes -short-term achievements to determine changes in the intended audiences such as changes in awareness, knowledge, attitudes, beliefs, self-efficacy and skills of the intended audiences while medium-term outcomes are the changes in behaviors, practices, decision-making processes, power relations, policies and social norms as a result of program activities.[29] E.g. proportion of parents who take children for immunisation and complete the schedule, proportion of health workers who educate parents and counsel them on side effects; proportion of VHTs who mobilise and educate parents, caregivers and communities on benefits of immunization.

Impact -the long-term change in the social, economic, policy, health and environmental conditions that occur as a result of the contribution of many factors such as implementation of UNEPI components, other health programmes, health development partners, national and urban political, cultural and religious leaders and ministries of Finance and Education. Impact can be measured in terms of improved health status of children as a result of the contribution of UNEPI, HPE&C department, other health programmes, and line departments such as Education and Community development. However, SBCC communication interventions will be measured at input, output, activity and outcome levels.



This arrow shows the levels at which SBCC Immunisation interventions are measured

[29] WHO: M&E Guide for C4D HPV Vaccination Programs: *Global HPV Communication*

Sources: Local Livelihoods: Results Based Monitoring and Evaluation Tool kit and **WHO: M&E Guide for C4D HPV Vaccination Programs:** *Global HPV Communication*

Table 7: Monitoring and evaluation Indicators

Proposed Indicators for Monitoring and Evaluation of SBCC interventions for immunization in urban settings
Outcome Indicators • Proportion of parents and caregivers in informal settlements who take children for immunization and complete the schedule • Proportion of parents and caregivers who accept to get their children registered and take them for immunization • Proportion of health workers who exhibit customer care to the parents and caregivers during immunization sessions • Proportion of non-health stakeholders who mobilise communities for immunization • Proportion of leaders of religious sects/cults that oppose immunization who mobilise their followers for immunization • Proportion of media houses at national and district level which conduct media briefings, coverage and interviews with MoH and city/municipal authorities to update them on the situation of immunization in urban settings • Proportion of social media platforms which disseminate positive messages and demystify rumours about immunization • Proportion of members of Parliamentary Forum on Health who advocate for immunization by allocating adequate financial resources • Proportion of political leaders and policy makers (councilors) at city/municipal level who advocate for and include mobilization activities for immunization in their work plans
Outputs and short term/interim Outcomes Indicators **Knowledge, Awareness, Perception of Risk, Acceptance and Trust** • Proportion of parents and caregivers in informal communities and high end social class communities who know the benefits of immunization • Proportion of parents and caregivers who perceive that their children are at risk of contracting vaccine preventable diseases if not immunized • Proportion of parents and caregivers who trust the safety of vaccines • Proportion of social media platforms that post messages on immunization to parents and caregivers • Proportion of non-health stakeholders who know and appreciate the benefits of immunization • Proportion of leaders of major religious allies who know and appreciate the benefits of immunization • Proportion of religious sects/cults who know and appreciate the benefits of immunization • Proportion of media houses with personnel who know and appreciate the benefits of immunization • Proportion of political and policy makers who appreciate that immunization is a government health programme

Table 8: Monitoring and evaluation Framework

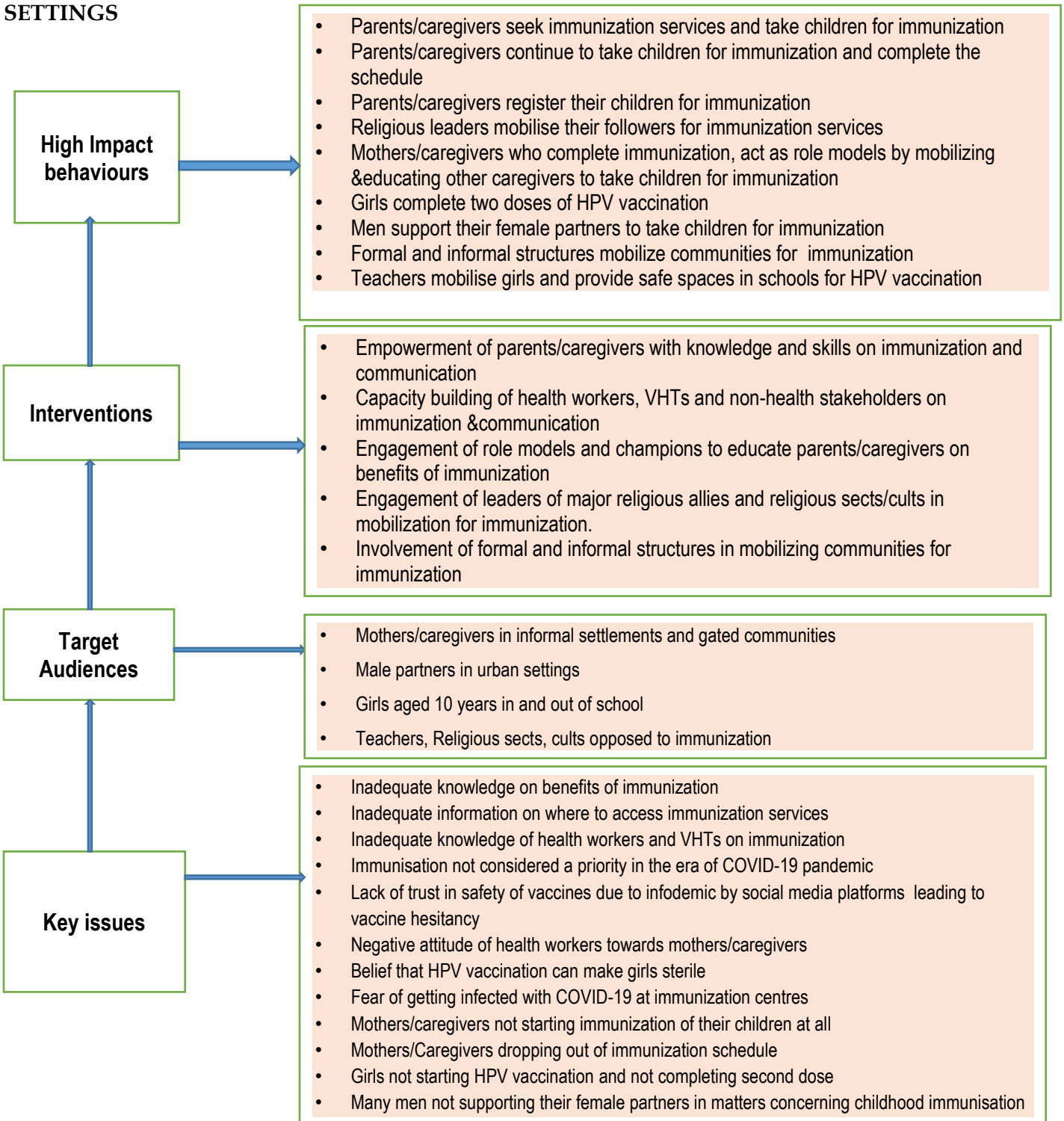
Strategy	Communication Objective	Key activities	Output indicator	Outcome indicator	Means of verification
Behaviour Change Communication	Increase the proportion of parents and caregivers who have knowledge about immunisation, seek immunisation services and complete immunisation schedule	• Map vulnerable poor communities in hard to reach and convince populations including schools and identify unimmunized and under-immunized children • Mobilise and register children under 1 year • Conduct health education talks in OPDs and community on child registration and immunization • Conduct community sensitization and dialogue meetings with mothers, men and caregivers to create awareness on immunization • Conduct home visits and educate households on importance of immunization • Send bulk SMS reminder messages to parents and caregivers to take children for immunisation and complete the schedule • Disseminate tailor made messages and materials to refugees, migrants and hard to reach communities through social media platforms such as WhatsApp, Twitter, Instagram, TikTok and Facebook • Engage role models and champions to educate communities on the benefits of immunization • Conduct awareness raising activities through mass media- (radio and TV talk shows, spots/jingles, DJ mentions) PSAs, children's voices and transit advertising	• No. of vulnerable communities with unimmunized children • No. of parents &caregivers with increased knowledge on immunization • No of children under 1 year registered in the community • No. of defaulting mothers who receive SMS reminder messages • No. of parents &caregivers with increased knowledge on immunization • No. of posts on social media platforms by HPE&C to mothers/caregivers	• Proportion of mothers/caregivers who take their children for immunization and complete the schedule • Proportion of role models who mobilise &educate communities on benefits of child registration and immunization • Proportion of mothers with registered children in the community who take their children for immunization and complete the schedule	• Activity implementation reports • Monitoring and supervision reports • Exit interviews at immunization centres • KAP survey • Lists of children registered
Social Mobilisation	Increase the proportion of community health workers and non-health stakeholders who mobilise communities	• Develop/adapt training materials and tools to support capacity building activities • Train VHTs and non-health stakeholders	• No. of VHTs and non-health stakeholders trained	-Proportion of VHTs and non-health stakeholders who mobilize communities for immunization	-Reports on training -Reports on supervision & monitoring

	for Immunisation services	• Conduct supervision and follow–up of trained VHTs and non-health stakeholders	• No. of VHTs with increased knowledge • No. of supervision visits conducted		
	Increase the proportion of leaders of formal and informal structures who apply community-led solutions for effective engagement of urban communities to demand for immunization services	• Identify leaders of formal and informal structures in urban settings and orient them on immunization and communication • Engage leaders of formal and informal structures to conduct community mobilization activities for immunization • Identify leaders of groups opposed to immunization in hard to reach/convince communities, orient them on immunization and engage them to conduct community dialogue meetings in their localities • Monitor and evaluate community engagement activities	• No. of leaders of formal and informal structures identified and oriented on immunization • No. of leaders of formal and informal structures with increased knowledge on immunization • No. of leaders of resistant communities oriented on immunization	• Proportion of leaders of formal and informal structures who mobilise communities for immunization • Proportion of leaders of resistant communities who mobilise communities for immunization	• Lists of resistant groups identified • Lists of formal and informal structures • Report on community mobilization activities
	Increase the proportion of leaders of major religious allies, sects and cults to mobilise their followers to demand for immunisation services	• Conduct orientation meetings with leaders of major religious allies and religious sects opposed to immunisation • Guide development and implementation of mobilization plans per religious institution /or religious sect/cult • Reactivate interfaith committees to address immunization challenges in urban settings • Conduct talk shows on religious FM radio and TV stations to address social norms and cultural practices that affect immunization • Engage leaders of major religious allies and religious sects/cults to conduct awareness raising activities in their congregational settings and	• No. of leaders of major religious allies and sects/cults oriented and have knowledge on immunization • Availability of community mobilization plans • Availability of functional interfaith committees • No. of religious FM radio stations disseminating messages on immunization	• Proportion of leaders of major religious allies who mobilise communities for immunization • Proportion of leaders of religious sects/cults who mobilise their followers for immunization	• Reports on awareness raising activities in places of worship • KAP survey

		community functions(e.g. prayers, marriage, baptism, and funerals)			
Advocacy	Increase the proportion of media personnel who report accurately on immunization issues	• Develop/adapt media kit and talking points • Orient the media on immunization and provide media kit. • Establish/reactivate and manage regular forum for the media and stakeholders for sharing challenges and best practices on immunization. • Conduct media coverage, reporting, briefings, press conferences and interviews with MoH and Urban Authority partners and stakeholders to update the public on the situation of immunization in urban settings • Monitor and evaluate media activities	• No. of media houses with personnel oriented and have knowledge on immunization • Availability of a functional media forum sharing challenges and best practices on immunization	Proportion of media houses at national and district level which conduct media briefings, coverage and interviews with MoH and city/municipal authorities to update them on the situation of immunization in urban settings	• Survey Reports • Supervision reports • IPSOS Media Reports • Evaluation Report • Observation
		Social media interventions			
		• Develop social media content on immunisation • Orient leaders of social media platforms on immunization • Engage leaders of social media platforms to deliver messages on immunization • Monitor and evaluate media activities	• No and types of social media platforms used to deliver messages to the public • No. of posts on social media platforms by HPE&SC to mothers/caregivers	Proportion of social media platforms disseminating positive messages on immunization	• IPSOS media Monitoring Reports • Survey Reports • Supervision reports
	Increase the proportion of political leaders and policy makers who advocate for immunization and mobilise resources to support demand generation activities	• Develop/adapt and provide advocacy kit • Conduct advocacy meetings to sensitise new MPs and urban political leaders and policy makers (councilors) on priority immunization issues • Advocate for adequate financial resources to immunization programme in Parliamentary Forum on health and urban authority meetings and functions • Monitor and evaluate implementation of advocacy activities	• No. of members of Parliamentary Forum on Health sensitised on immunization • No. of political leaders and policy makers at city/municipal level sensitized on immunization	• Proportion of members of Parliamentary Forum on Health who advocate for allocation of adequate financial resources to immunization • Proportion of political leaders and policy makers (councilors) at city/municipal	• Reports on meetings • Attendance list • Advocacy kit • Survey reports • City/municipal budgets for immunization • Monitoring Reports

			• No. of city/municipal meetings per quarter in which immunization is discussed	level who advocate for immunization to be included in their work plans	

6. EXPECTED RESULTS OF C4D INTERVENTIONS FOR IMMUNISATION IN URBAN SETTINGS



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