Strengthening Immunization Service Experience

Global, Regional and Country Insight Gathering

Collected throughout 2020 to help frame and inform new directions for immunization programs

December 31, 2020

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ABBREVIATIONS

BeSD	behavioral and social drivers of vaccination
cIMCI	community integrated management of childhood illnesses
COP	community of practice
CSO	civil society organization
DTP3	diphtheria-tetanus-pertussis vaccine
FCHV	female community health volunteer
Gavi	Gavi, the Vaccine Alliance
iCCM	integrated community case management
INGO	international nongovernmental organization
IPC	interpersonal communication
EPI	Expanded Program on Immunization
JSI	John Snow Research & Training Institute, Inc.
KII	key informant interview
MOH	Ministry of Health
NGO	nongovernmental organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization

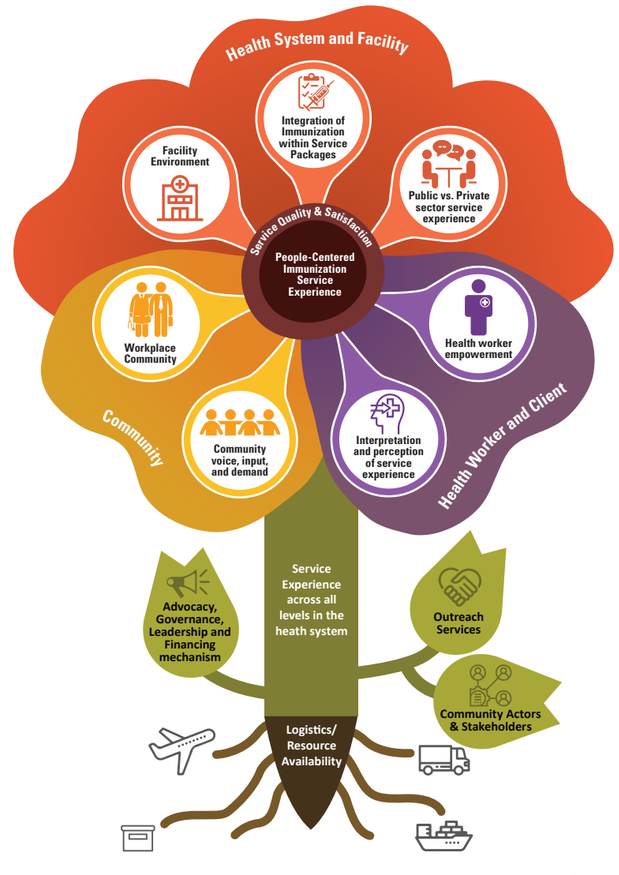
EXECUTIVE SUMMARY

Immunization services have historically focused on supply and delivery functions, with insufficient attention to the qualitative and socio-behavioral considerations that improve confidence, acceptance, use and demand. In recent years, inequities have highlighted the crucial component of demand generation and the need for a people-centered model for vaccination where services must be brought closer to people by enhancing service quality and accountability, considering health worker and client perspectives and needs, and bringing people to services with community engagement and development of a social norm. The glue between these two components is the immunization service experience.

Immunization programs have had relatively little investment and attention to date to 'service experience'. Consolidation of existing resources and learnings on user experience in and beyond the health sector—and implementation research to adapt these learnings to local immunization service contexts—are needed to empower countries to improve immunization and health service quality and reach. In order to move toward a more positive, people-centered immunization service experience, John Snow Research & Training Institute, Inc. (JSI), in collaboration with Gavi, the Vaccine Alliance, and members of the Demand Hub Service Experience Workstream consolidated existing knowledge and learning around immunization service experience at the global and regional levels (from January to April 2020) and in four countries (from April-July 2020)[1] using the following approaches:

1. Literature review of peer-reviewed and grey literature on service quality and delivery and its relationship with vaccination demand
2. Global and Regional KIIs
3. Rapid insight gathering (i.e., literature reviews and KIIs) in four countries: Ghana, Kenya, Mozambique, and Nepal.

Figure 1. Key components of a positive, people-centered immunization service experience



[1] Exercises at the global and regional levels began prior to COVID-19. Country level activities were set to begin in March 2020 but faced delays due to adjustments for COVID-19 restrictions and interruptions. The methodology for country insight gathering was adjusted accordingly, including updating the tools to include questions on COVID-19 and service experience and using virtual tools (i.e., Zoom) to conduct the key informant interviews.

Based on the literature review, various KIIs and insights, 13 key components of a positive, people-centered immunization service experience—which emerged during the global, regional, and country insight gathering exercises—are visualized in Figure 1 and detailed below.

KEY COMPONENTS OF A POSITIVE, PEOPLE-CENTERED IMMUNIZATION SERVICE EXPERIENCE

- **Service experience across all levels of the health system:** This component takes into account inputs and actions that can affect the immunization service experience at all levels, noting that while some interventions can be stand alone, others have ripple effects on the entire system and must be looked at holistically to ensure a movement toward more people-centered services.
- **Quality of the interaction and service provided:** Noting that quality must be at the center of immunization services, this component highlights the importance of defining immunization quality standards and the need for further exploration into context-specific issues of how service quality and service experience hinge on expectations of care.
- **Integration of immunization within a package of services:** This component explores if and how the integration of immunization into a package of services responds to the needs of health workers and communities; and highlights the need to examine the quality of care in integrated services and requirements necessary to support people-centered immunization service within a package of care.
- **Public vis-à-vis private sector experience:** Given increasing urbanization and the role of the private sector, this component explores why clients and caregivers may choose one type of facility over the other and how this links to the perception of the immunization service experience.
- **Facility environment:** This component explores if and how the facility environment can affect how people perceive service quality and their continued demand for immunization services, as well as the health workers' ability to provide services. Facility environment details to support client/caregiver and health worker needs are highlighted.
- **Interpretation and perception of service experience:** This component explores factors that influence client and health worker interpretation and perception of immunization service experience, highlighting that health workers consider both individual provider and facility/systemic factors; while clients consider the quality of interaction with the individuals within the system.
- **Health workers empowerment:** Health worker empowerment is key to ensuring a positive, people-centered immunization services. This component highlights different ways to empower health workers, including the availability of guidelines, training, supplies, and equipment; as well as strong management skills on the part of health managers.
- **Community voice, input, and demand:** This component speaks to involving the community in the design, delivery, and monitoring of services; the need for two-way feedback to foster accountability; and the importance of matching demand for services with the availability of services.
- **Workplace community:** This component explores what health workers may need to cultivate a stronger sense of community, noting that needs vary by location and individual needs, and that the health provider ecosystem can influence the experience of care.
- **Community actors and stakeholders:** This component highlights that different stakeholders—such as the private sector, academia, social influencers, and respected community leaders—can play a role in addressing key issues related to immunization service experience, depending on local contexts.
- **Outreach services:** This component highlights the importance of people-centeredness in outreach services, noting that the design and organization thereof according to community needs can fortify or decrease trust in the health system overall.
- **Advocacy, governance, leadership and financing mechanisms:** This component highlights that ongoing advocacy, strong governance and leadership, as well as sustainable financing support a positive, people-centered immunization service experience and demand for immunization services.
- **Logistics/Resource availability:** This component details how the availability of and access to a logistics and reliable supply of vaccines and commodities affects the experience for health workers, clients and caregivers—resulting in either continued or decreased demand for immunization services.

This document provides further details on these 13 components; and provides practical recommendations to improve the immunization service experience for clients, caregivers, and health workers across all levels—from the policy level to the point of interaction between the health worker and client or caregiver—as identified through country insight gathering and during a Demand Hub Service Experience Co-Creation Workshop carried out in July 2020. The document also highlights special consideration of the effects of COVID-19 on access to and provision of immunization services, and identifies key recommendations for any COVID-19-specific service experience related barriers. Information gathered is being used to develop a draft roadmap for technical support at the global level and for tailoring with regions and countries. More details on country-specific learning can be found in case studies for Ghana, Kenya, Mozambique, and Nepal.

INTRODUCTION

Immunization services have historically focused on supply and delivery functions, with insufficient attention to the qualitative and sociobehavioral considerations that improve confidence, acceptance, use and demand. Between 1990 and 2018, global vaccination coverage rates increased from 75% to 86% for diphtheria-tetanus-pertussis vaccine (DTP3). However, after increasing for more than two decades, routine immunization coverage rates began to stagnate again around 2010. While immunization programs are successfully covering the same proportion of a growing birth cohort, an estimated 19.4 million children under the age of one year of age did not receive basic vaccines in 2018. In recent years, inequities have highlighted the crucial component of demand generation and client-centered design needed to ensure uptake and encourage access, trust, and motivation to vaccinate and reach every child (and target populations for vaccination throughout the life course). In fact, the Immunization Agenda 2030: A Global Strategy to Leave No One Behind, includes Commitment & Demand as one of the six strategic priorities.[2]

In addition, published systematic reviews of the drivers of vaccine acceptance and hesitancy have concluded that two main factors in parental decision making on vaccination are: social norms and caregiver-provider interactions. These have a critical impact on caregivers' trust in and subsequent motivation and pursuit of vaccination for their children. In line with this evidence, the first pillar of the Gavi, the Vaccine Alliance (Gavi) demand framework is Service Quality and Accountability.[3] This is a critical piece in a people-centered model for vaccination where services must be brought closer to people by enhancing service quality and accountability, considering health worker and client perspectives and needs, and bringing people to services with community engagement and development of a social norm. The glue between these two components is **the immunization service experience.**

Immunization programs have had relatively little investment to date to 'service experience'. The top-down Information Education Communication campaign approach taken for immunization 'demand' historically shows varying degrees of impact and insufficient incorporation of social and behavioral insights, critical to addressing service experience. People-centered approaches have exhibited some success, including: interpersonal communication and interaction skills development, community participation and ownership, supportive supervision, group problem solving, and technical skill development.[4] Consolidation of existing learning on user experience in and beyond the health sector—and implementation research to adapt these learnings to local immunization service contexts—are needed to empower countries to improve immunization and health service quality and reach.
With the above in mind, the Demand Hub Service Experience Workstream developed an 18-month workplan (conceptualized in April 2019, see Figure 2) to assess needs and gather evidence across partners and countries to inform a new direction in people-centered immunization service provision towards strengthening service experience and demand. This entailed a landscape analysis across local, regional, and global contexts on need, appetite, practices, and measurement of providing positive service experience. The information and best practices collected have been distilled to inform the immunization system (within the broader health system), and plan for needed technical assistance with countries.[5]

2 World Health Organization (WHO). 2020. Immunization Agenda 2030: A Global Strategy To Leave No One Behind. Geneva, Switzerland: WHO. Available at: https://www.who.int/publications/m/item/immunization-agenda- 2030-a-global-strategy-to-leave-no-one-behind.

3 Gavi, the Vaccine Alliance (Gavi). 2019. Achieving immunisation outcomes through Gavi investments. Focus Area: Demand Generation. Geneva, Switzerland: Gavi. Available at: https://www.gavi.org/sites/ default/files/document/programming-guidance---demand-generationpdf.pdf.

4 Gavi. 2018. Resource Catalogue: Service Quality and Experience Literature and Tools. Geneva, Switzerland: Gavi. Available at: https://www.demandhub.org/wp-content/uploads/2020/06/Service-Experience-Resource-Catalogue.pdf.

5 Given the COVID-19 context, the mandate was further expanded and adapted in March 2020 to address service delivery and quality challenges due to the health system disruptions around the world.

Figure 2. Demand Hub Service Experience Workstream 18-month Workplan

3 MONTHS JUNE 2019	6 MONTHS SEPT 2019	12 MONTHS APR 2020	18 MONTHS JUNE 2020
• Lit review (Gavi) on service delivery including demand and community engagment strategies for immunization • Engage with "Quality Taskforce"	• Create draft-Workshop with field-based TA-in countries • Rapid assessment tool (for demand related barriers to service quality and community engagement) • Co-creation on people-centered service delivery model • 3-4 countries • Start research • Landscaping analysis on immunization services with PHC/Teriary care		• Apply lessons learned from the assessment in countries (sub-set) • Revise roadmap methodology • Workshop with countries • Finalize draft • Share final roadmap methodology via hub (or other fora)

John Snow Research & Training Institute, Inc. (JSI), in collaboration with Gavi, and members of the Demand Hub Service Experience Workstream consolidated existing knowledge and learning around immunization service experience at the global and regional levels (from January to April 2020)and in four countries through desk reviews and key informant interviews (KIIs) over 4-month timeframe (April-July 2020).[6] Results were then shared at a Service Experience Co-Creation Workshop to support

the identification of key components of a positive, people-centered immunization service experience strategy and draft roadmap for technical support at the global level and for tailoring with regions and countries.

This document summarizes the global, regional and country insight gathering, COVID-19 specific findings related to service experience, and key outputs from the Co-Creation Workshop, including a Demand Hub Service Experience Workstream draft workplan for 2020-2021.

6 Exercises at the global and regional levels began prior to COVID-19. Country level activities were set to begin in March 2020 but faced delays due to adjustments for COVID-19 restrictions and interruptions. The methodology for country insight gathering was adjusted accordingly, including updating the tools to include questions on COVID-19 and service experience and using virtual tools (i.e., Zoom) to conduct the key informant interviews.

METHODOLOGY

To inform a new direction in people-centered quality immunization service experience (including caregiver, client and health worker perspectives and needs), JSI and Gavi gathered evidence through the following approaches:

1. Literature review of peer-reviewed and grey literature on service quality and delivery and its relationship with vaccination demand
2. Global and Regional KIIs
3. Rapid insight gathering (i.e., literature reviews and KIIs) in four countries: Ghana, Kenya, Mozambique, and Nepal.

LITERATURE REVIEW

At the global level, Gavi conducted a literature review of peer-reviewed and grey literature on service quality and delivery and its relationship with vaccination demand. Table 1 shows key search terms.

Table 1. Global Literature Review Search Strategy Terms

CONCEPTS	KEYWORDS
Vaccination and Immunization	Vaccination Immunization Vaccine
Service Quality (Health)	Service Quality Service Delivery Services
Low Income Setting	Low/Middle Income Countries Low Resource Settings Global
Demand	Demand Acceptance Hesitancy

The literature search yielded **40** eligible pieces, with **30** additional eligible pieces collected through Demand Hub consultation. Literature results were organized under the following 10 categories:

- Service Experience Definition
- Service Experience and Quality Assessment
- Problem Definition and Planning
- Service Quality Interventions: General
- Interpersonal Communications
- Community Participation / Engagement
- Supportive Supervision
- Group-Problem Solving
- Vaccine Administration Skills
- Health Service Quality Policy and Strategy

Literature review results can be found in the Service Experience Resource Catalogue on the Demand Hub Service Experience Workstream Site.

GLOBAL AND REGIONAL KEY INFORMANT INTERVIEWS

Results from the literature review were used to develop guiding questions for KIIs with global and regional level experts working in immunization, health system strengthening, and other technical domains on service experience (See Annex 1 for Global and Regional KII Questionnaire). The following themes were explored during the KIIs:

- Experience of care and service quality at different levels of the health system
- Integration and missed opportunities for vaccination
- Health care worker empowerment and capacity building
- Community engagement in service quality and delivery
- Measures and metrics for monitoring service experience

JSI conducted a total of 25 interviews across nine organizations,[7] interviewing contacts of contacts via snowball sampling (and utilizing Zoom or face-to-face for a select few). Based on the global and regional KIIs, JSI conceptualized a draft graphic to visualize the service experience components (see Annex 3) which was then shared as part of the Country KIIs for further insights and refinement.

RAPID INSIGHT GATHERING THROUGH KIIS AND LITERATURE REVIEW IN FOUR COUNTRIES

From April – July 2020, JSI utilized a similar methodology (incorporating results from the global and regional KIIs) to guide rapid insight gathering in Ghana, Kenya, Mozambique, and Nepal (see Table 2 below). The countries were determined based on geographic and language variance, JSI's presence and experience working with these countries (to facilitate rapid data collection in a short time period), Gavi Senior Country Manager input, and Ministry of Health/Expanded Program on Immunization (MOH/EPI) interest and agreement.

Table 2. Approach and Timeline for Service Experience Insight Gathering in Four Countries[8]

COUNTRY	APPROACH	TIMELINE[9]
Kenya	Literature review	April-May 2020
Nepal	KIIs	April-May 2020
Mozambique	KIIs	June 2020
Ghana	KIIs + literature review	June-July 2020

In Kenya and Ghana, JSI staff conducted a literature review of peer-reviewed and grey literature on service quality and delivery and its relationship with vaccination demand. Based on lessons learned from the global level literature review, findings from the global and regional level KIIs, and guidance from the Demand Hub Service Experience Workstream members, the literature review framework for countries was updated to include other health areas beyond immunization, terms such as 'people-centered' and 'client-centered' care, and organized in a way to reflect the service experience lens. Table 3 shows key search terms for the literature review.

Table 3. Country Literature Review Search Strategy Terms

CONCEPTS	KEY WORDS
Vaccination and Immunization	Vaccination Immunization Vaccine Missed opportunities for vaccination
MNCH, HIV/AIDS, and Family Planning	Maternal, Newborn, and Child Health HIV/AIDS Family Planning Integration
Service Experience	Service Experience People-centered Care Delivery Quality Integration
Demand	Demand Acceptance Hesitancy Community Engagement

The literature searches yielded **80 pieces** from Kenya and **43 pieces** from Ghana on service experience, quality and delivery and its relationship with vaccination demand.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7 Organizations include: American Academy of Pediatrics, Bill and Melinda Gates Foundation, Centers for Disease Control and Prevention, Gavi, International Federation of the Red Cross, John Snow, Inc., US Agency for International Development, WHO, and UNICEF. All respondents verbally agreed to participate in the interviews. All respondents who participated in the KII via Zoom agreed to have their interviews taped. JSI staff took notes during the interviews, which were then reviewed and updated with the recordings.

8 Approaches used in the four countries varied based on country context, timeline of the data collection (and COVID-19-related country situations), as well as input from Gavi personnel.

9 The timeframe for conducting the KIIs was originally anticipated to begin in March/April 2020. With the onset of the COVID-19 pandemic, and based on country-specific approval processes, the timeline for country insight gathering shifted into April-July 2020.

JSI used the global and regional insights to develop the Country KII Questionnaires (see Annex 2). The KIIs focused on the following themes: health care experience and the quality of the immunization experience; health care worker empowerment, skills and competencies, and motivation; community engagement in service quality and delivery; integration of services and missed opportunities for vaccination; service experience at public and private facilities (with specific concentration on the immunization service experience); what addressing experience of care and service quality looks like at the different levels of the health care system; and COVID-19 and service experience. Along with the Questionnaire, JSI developed a draft visual (see Annex 3) incorporating 9 key components of a positive, people-centered immunization service experience that emerged during the global and regional insight gathering. This visual was shared with country key informants for exploration and feedback, with a particular focus on whether or not (and to what extent) these key components resonate in their respective country contexts.

In Ghana, Mozambique, and Nepal, JSI carried out KIIs (via Zoom) with selected individuals —determined and finalized in collaboration with the Ministry of Health/Expanded Program on Immunization. Key stakeholders included immunization staff; maternal, newborn, and child health staff; representatives from civil society and community-based organizations; technical partners, such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF), and other bilateral and implementing partners; and donor partners who support immunization and related health services (see Table 4).[10]

Table 4. Key informant interviews conducted by trained JSI field staff and consultants in Ghana, Mozambique, Nepal combined

STAKEHOLDERS INTERVIEWED	TOTAL # OF INTERVIEWS IN THREE COUNTRIES
National and subnational EPI and MNCH staff	21
International Nongovernmental Organization (INGO)	12
UN agency (WHO, UNICEF)	6
National Nongovernmental Organization (NGO	6
Technical expert	3
Donor	3
Private organization	1
Humanitarian organization	1
Professional society	2
Total	**55**

10 All respondents gave permission for the interviews to be recorded. JSI staff took notes during the interviews, which were then reviewed and updated with the recordings.

FINDINGS FROM GLOBAL, REGIONAL AND COUNTRY LEVEL INSIGHT GATHERING

FINDINGS FROM GLOBAL, REGIONAL AND COUNTRY LEVEL INSIGHT GATHERING

Findings from global, regional, and country level insight gathering are organized below by the following five themes: 1) overarching, 2) health system and facility, 3) health workers and client, 4) community, and 5) emerging themes from country insight gathering. Themes 1-4, and their associated components, emerged after global and regional insight gathering and were shared with country key informants for exploration and feedback, with a particular focus on whether or not (and to what extent) these key components resonate in their respective country contexts. Table 5 summarizes the country reaction to themes 1-4, and their associated components. Theme 5 (i.e., emerging themes from country insight gathering) summarizes additional key components for consideration when addressing immunization service experience in countries gathered from the Ghana, Kenya, Mozambique, and Nepal insight gathering exercises.

Based on the literature review, various KIIs and insights, 13 key components of a positive, people-centered immunization service experience—as highlighted during the global, regional, and country insight gathering exercises—are visualized in Figure 1.

Table 5. Summary of Global and Regional Key Service Experience Components that Resonate with Countries

THEMES	GHANA	KENYA	MOZ	NEPAL
OVERARCHING THEMES				
Service experience across the levels of the health system	X	X	X	X
Quality of the interaction and service provided	X	X	X	X
HEALTH SYSTEM + FACILITY				
Integration of immunization within a package of services	X			X
Public vs. private sector experience	X	X	X	X
Facility environment	X	X	X	X
HEALTH WORKER + CLIENT				
Interpretation and perception of service experience	X	X		
Health worker empowerment	X	X	X	X
COMMUNITY				
Community voice, input, and demand	X	X	X	
Workplace community	X	X	X	X

OVERARCHING THEMES

SERVICE EXPERIENCE ACROSS ALL LEVELS OF THE HEALTH SYSTEM

This component takes into account inputs and actions that can affect the immunization service experience at all levels to ensure implementation. For example, for immunization service experience to be more people-centered, national policy and strategy work needs to include clients and health workers, not just immunization technical experts. Inclusion of a diverse set of stakeholders results in more holistic policies and strategies and addresses previously missing aspects of care and experience.

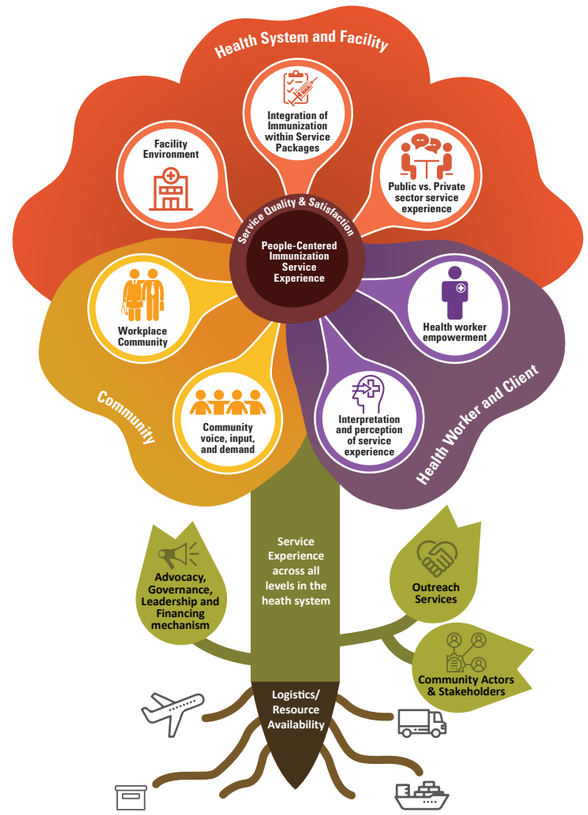
In Kenya, in an effort to increase access to and use of maternal health services, the government abolished the user fee for maternal health service delivery. However, this change was made without taking into account the additional human resources needed to care for the influx of patients. This policy change resulted in an increased workload for health staff; poor staff motivation; an inability to sustain quality of care; and the inability to fully adhere to the policy itself, particularly in rural, under-sourced, or marginalized areas. Similar efforts to address immunization service experience must take into account the effects at various levels of the health system, as these are intertwined and can have ripple effects if not considered holistically as part of the health system.

"The team that designs the system needs to have a combination of competencies because policies are predominantly technical and balance is necessary. Teams are missing gender experts, anthropologists, behavior scientists, and lawyers, for example."

– KII Respondent

Where policies on the experience of care and quality of care exist in countries, we asked whether or not and to what extent they emphasize or consider immunization. All four countries noted that neither immunization service experience nor quality care for immunization is examined in a formal way and that any existing policies on experience of care or services experience do not highlight immunization specifically. For example, in Ghana there exists a five-year (2017-2021) cross-sectoral strategic policy on quality care focuses on: improving client experience with child health; neonatal care, infant and under five services; an EPI policy directive on ensuring service quality through the provision of job-aids, supportive supervision and training of health workers; Regional Health Reviews and National Health Summit to improve experience of care for clients; as well as pregnancy schools that provide a peer support platform for pregnant women to share information about immunization service experience. Nonetheless, immunization service experience is not a specific focus nor is it systematically monitored. A next step in countries could include mapping their existing policies and strategies on experience of care and examining if and at what level(s) they take into account the immunization setting and service experience and the implementation progress.

Figure 1. Key components of a positive, people-centered immunization service experience



A next step in countries could include mapping their existing policies and strategies on experience of care and examining if and at what level(s) they take into account the immunization setting and service experience and the implementation progress.

QUALITY OF THE INTERACTION AND SERVICE PROVIDED

Across global, regional and country insight gathering, questions emerged on how immunization quality is defined and how it can be measured over time to track progress. All four countries noted that neither immunizations service experience nor quality care for immunization is examined in a formal way and that existing policies on service experience do not highlight immunization specificity. The WHO Quality of Care Standards—while not specific to immunization—can be a useful tool and starting point, noting that there are additional factors that impact service experience beyond service quality (such as the facility environment and accessibility). Other frameworks and initiatives that are investigating quality of care include the Quality of Care Network—which is considering how to bring these standards to the community level (as of now, it stops at the primary care level)—and the IHI Psychology of Change Framework, a white paper that provides valuable insights and concepts for quality improvement efforts to succeed in health systems. Countries noted that quality often suffers when vaccine availability and logistics barriers remain; but clear definitions and standards of quality immunization can provide a pathway for moving forward.

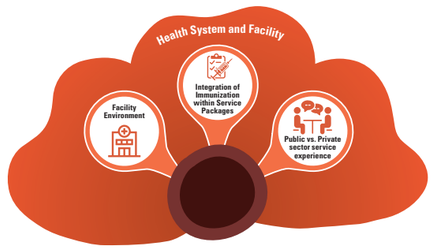
In all four countries, poor provider attitude and insufficient interpersonal communication (IPC) and counselling skills were noted as influences on the perception of the quality of care provided. In Kenya, literature review findings noted that some care givers do not ask questions due to poor provider attitude because they fear how providers will respond. Global KIIs noted that existing quality improvement indicators often teach to the hoped outcomes of the care provided and not around building health workers' confidence that they themselves can improve client interaction. Mentors and supervisors also need to be equipped to monitor, support and improve providers' skills in quality service experience.

"Because quality must be at the center of everything we do, immunization quality needs to be defined and the standards understood."

– KII Respondent

The correlation of service quality and experience is context-dependent and hinges on expectations of care. Additional focus is needed by programs to measure interpretation, perception and expectation of care.

HEALTH SYSTEM AND FACILITY THEMES



FACILITY ENVIRONMENT

Positive, people-centered immunization services are important for both clients/caregivers and health workers. The facility environment can affect how people perceive service quality and their continued demand for immunization services, as well as the health workers' ability to provide services. Table 6 below provides facility environment details to support client/caregiver and health worker needs for implementing this.

Table 6. Adjusting the health facility environment per client/caregiver and health worker needs

CLIENT/CARE GIVER NEEDS	HEALTH WORKER NEEDS
• Welcoming, calming, safe and friendly environment • Condition of the health facility: look, feel, cleanliness, and order • Management of the health facility: waiting room, health information table, useable toilet, drinking water • Set-up of the immunization session: minimize crowding and promote privacy during immunization sessions • Expanded facility hours, particularly in urban settings	• Adequate human resources: crowding and staff shortages can affect staff attitude and motivation • Strong health facility management • Set-up of the immunization session • Availability of equipment: vaccines, vaccine storage, data recording tools* • Safety and security of health workers

*See pp. 17-18 for more details on supply chain logistics and cold chain equipment.

"The environment in the health unit is very important. It can ensure mothers' adherence to vaccination and improve missed opportunities for vaccination."

– KII Respondent

INTEGRATION OF IMMUNIZATION WITHIN A PACKAGE OF SERVICES

Global and regional levels KIIs highlighted integrating immunization within a package of services to improve people-centered immunization service experience. An integrated package of services can more holistically help to meet community needs and leverage funding. Given that immunization is often one of the stronger public health programs in countries, integration of other services with immunization can facilitate uptake of these services, if well-monitored and funded by these other programs (and they do not compromise attention to immunization session needs). Similarly, integration of immunization into other clinical services—such as antenatal care (ANC) services—is convenient for clients, saving both cost and time. When well-coordinated and sufficiently monitored and funded by all linked programs, this can improve client/caregiver ability to maintain immunization schedules, reducing costs and time associated with accessing services multiple times. However, service provider interaction with clients can be compromised by integration due to increased pressure and staff time needed to deliver all services —combined with unmatched staffing and compensation—resulting in a stressful environment for providers.

"When we think about quality of care, we often overlook the quality of care in integration of services."

– KII Respondent

Putting integrated service delivery into practice requires changes across multiple levels of the health system. In Nepal, for example, key informants noted that because services are not integrated at the federal level, programmatic costs linked to reporting and management are high for health workers. Adjustments first need to take place at the federal level to support operationalization of integration (with training, monitoring and reporting) at the other levels.

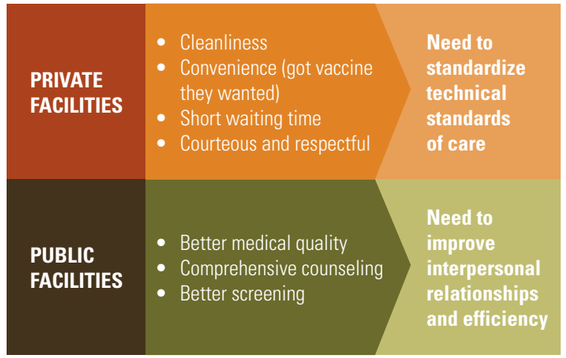
Integration can hinder the quality of the services, if human, financial and operational resources are insufficient or not assured long-term. In Mozambique, where integration takes place in outreach sessions, key informants noted that the quality of integrated outreach services has suffered at times due to a shortage of skilled human resources for the different areas of care—including staff qualified to administer vaccinations—and a shortage of supplies. Key informants noted that when health facilities face staffing constraints, a good health facility environment and referral system for immunization is more appropriate than integration, so as not to compromise vaccination and data quality.

Integration can also impact client perceptions of the quality of care provided. For example, in Ghana, the Growth Platform provides integrated childhood services, including growth monitoring, nutrition, immunization, and counseling up to 5 years. The absence of particular expected integrated services—as well as the absence of breast-feeding rooms and play grounds for toddlers—impacts the client's total experience of care. Client perception of quality of care can impact their care-seeking behavior and they may avoid accessing facility care if the

Integrating immunization into a package of services requires considerations to maintain quality of immunization.

perceptions are not met. Integrating immunization into a package of services requires considerations to maintain quality of immunization. Questions include: How are integrated services perceived by health workers, clients, and communities? How is this measured and routinely monitored by each health program vis-à-vis expectations/perceptions? Ultimately, whilst the integration of immunization into a package of services may better meet the needs of communities, further examination of the following is required to support more people-centered immunization service experience: changes in donor giving and resources for monitoring across interventions; revision of policies, strategies, and data collection tools; an exploration of immunization entry and convergence points that can affect the service experience; and health facility competency and ability to provide such services at fixed facilities and outreach/mobile sites.

Figure 3. Client perceptions of private and public health facility service experience



PUBLIC VIS-A-VIS PRIVATE SECTOR EXPERIENCE

Given increasing urbanization and the role of the private sector, it is important to learn from countries further along in private sector engagement with immunization. Questions comparing public and private sector experiences did not resonate across all countries. In Kenya, for example, it was difficult to compare private and public health facilities and service experience because the services differ, and not all facilities provide preventive services, like immunization.

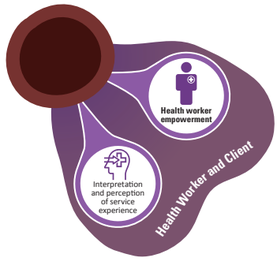
While private sector delivery of immunization varies in Kenya, Ghana, and Nepal, key informants highlighted reasons as to why some clients choose one type of facility (i.e., private or public) over the other (see Figure 3). In Ghana, for example, services and commodities (vaccines) are free at public facilities; yet, some clients prefer to pay for services at private facilities that they perceive as having the expertise to provide quality care.[11] They can also request—and pay for—additional vaccines (such as combined mumps, measles, rubella) not provided in the public sector; and they find it convenient to access vaccinations already integrated into clinical services at those facilities. A recommendation was made to establish 'centers of excellence' or model facilities within public sector to enhance client experience in Ghana.

Key informants in both Mozambique and Nepal noted that the limited provision of immunization services at private facilities results in missed opportunities for vaccination. Moving forward, technical standards of care and immunization service Standard Operating Procedures (SOPs) with private facilities are important to put in place to ensure the quality meets WHO standards. In addition, coordinating mechanisms and data share between public and private health facilities should be explored/ expanded (through which staff can discuss challenges and opportunities to improve the quality of the immunization program, their populations served, and including immunization service experience).

11 In Ghana, Mozambique, and Nepal, key informants noted that clients do not pay for the commodities (vaccines) rather the service. In Ghana, vaccines outside of the national immunization schedule, can be purchased and administered in private facilities.

Coordinating mechanisms and data share between public and private health facilities should be explored/ expanded (through which staff can discuss challenges and opportunities to improve the quality of the immunization program, their populations served, and including immunization service experience).

HEALTH WORKER AND CLIENT THEMES



INTERPRETATION AND PERCEPTION OF SERVICE EXPERIENCE

An emerging priority area is understanding whether interpretation and perception of immunization services is outcome-based vs. satisfaction with the experience itself—and how expectations affect both client and health worker perceptions. For example, in some situations, people experiencing poverty are less likely to report disrespect and abuse because they do not have a recourse or means to report. Initial findings from the KIIs in countries on what influences client and health worker interpretation and perception of immunization service experience is included in Table 7.

Table 7. Factors that influence client and health worker interpretation and perception of immunization service experience

CLIENTS	HEATH WORKERS
• Convenience • Respectful and dignified care • Provider attitude and communication • Higher levels of concordance of social characteristics (e.g., age, gender, education, and socioeconomic status) between patients and providers result in higher satisfaction with care.	• Staffing • Peer mentorship • Online repository • Support by the health system

As suggested in Table 7, health workers attribute poor people-centered care to both individual provider and facility/systemic factors; while clients consider the quality of interaction with the individuals within the system. Capacity building of health staff in interpersonal communication, health promotion and client engagement are highlighted as key to improving the interpretation or perceptions of service experience. This type of capacity building must be coupled with support from the health system to carry out their responsibilities (for health workers to feel supported by the system to do and enjoy their job and to embrace and value health education and engagement with clients).

The country KIIs noted that immunization service experience has not been sufficiently studied and merits further exploration within the countries. In Ghana, for example, feedback mechanisms to monitor or know when clients are satisfied with immunization services does not exist in a formal way. Some existing approaches to consider to better understand the community interpretation and perception of their immunization service experiences include: feedback forms for clients to fill, periodic surveys, and discussions during dialogue days/community dialogues to define and agree on the expected service quality and delivery. See pp. 19-20 for more details on existing mechanisms that can be used to monitor the interpretation and perception of immunization service experience.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HEALTH WORKER EMPOWERMENT

Global, regional, and country insight gathering noted the importance of health worker empowerment to provide positive, people-centered immunization services. Countries noted that simply the availability of guidelines, supplies, and equipment can empower health workers to provide immunization services in a positive, people-centered way. Capacity building approaches to empower health workers (used to varying degrees in the four countries) include: pre-service and in-service training and continuous education; online coaching and distance learning; interactive videos; national and subnational review and

Immunization service experience has not been sufficiently studied and merits further exploration within the countries.

planning meetings; new vaccine introduction activities; guidelines/ training in Mid-level Manager (MLM), Immunization in Practice (IIP), Adverse Events Following Immunization (AEFI), and Second Year of Life (2YL). All four countries noted that each of these approaches could be modified to incorporate skills building on areas such as interpersonal communication on immunization (IPC/I) and counseling. Also, health workers and managers could be further empowered to apply good management practices, ensure the accountability of staff, and provide feedback and motivation to health workers. The occasional morale boost can also go a long way.

Additional recommendations for health worker empowerment are included in Table 8 below.

In a study to assess health worker competence, many providers expressed great satisfaction at having received feedback and guidance from assessors. The few minutes of feedback provided by assessors, however, were not sufficient to constitute "training," but participant response to this feedback suggests that a minimal investment in training on specific technical aspects is appreciated and can improve the quality of care.

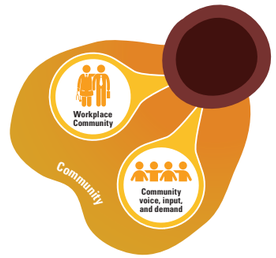
Source: Kenya: Assessment of health workforce competency and facility readiness to provide quality maternal health services.

Table 8. Recommended health worker capacity building and motivation interventions

CAPACITY BUILDING	MOTIVATION
• Use of pre-service, in-service, and blended learning approaches 12 to ensure health workers have the confidence in the clinical aspects of the work lead to more effective communication with the client and a more positive experience for them both • Feedback and supportive supervision • Investment (even minimal) in training on specific technical aspects is appreciated and can improve the quality of care. • Create learning environment, particularly for young health workers posted to remote areas (peer mentorship) • Training on IPC, specifically to communicate with people or organizations that are anti-vaccination	• Assign staff to the correct positions within the system and ensure that they have clear job descriptions and competencies1 • Clarify career options and guidance on promotions • Simple recognition of the performance of the best employees • Capacity building for health managers so they can provide good support to the health workers; service experience for health workers can improve if they feel well-supported • Respect the work and listen to their voice • Provide incentives, like free medical insurance • Provide transportation to conduct outreach sessions for immunization as well as a place to stay for people who are not from the area • Safety and security for health workers who must walk long distances

12 Opportunities for blended learning are explained in this document on "Building Routine Immunization Capacity Knowledge and Skills" (BRICKS) and on the BOOST website.
13 Developing immunization competencies: article and framework Developing immunization competencies: article and framework

COMMUNITY THEMES



COMMUNITY VOICE, INPUT, AND DEMAND

Community voice, input, and demand was highlighted at the global, regional, and country levels as a key component to ensuring positive, people-centered immunization service experience. Ensuring that the community is involved in how the services are designed and delivered—including through use of the Reaching Every District and Human-Centered Design approaches—can ensure they are aligned with the needs and expectations of community members. Health and co-management committees are an important platform through which community members can participate in the planning and monitoring of health programs, including immunization. All countries noted the importance of these committees but cited that in many situations, they are not functioning at scale (or without external support, in some cases). Kenya and Mozambique also noted that where they are functioning, some committees do not represent the community (e.g., committee members could be political appointees), which weakens their functioning and recognition by the community for their intended purpose. Community representatives should be from and be accepted by their communities.

"Creating community demand for health services must be matched with the availability of improved services within health facilities."

– KII Respondent

Providing communities with a forum to express their demands and hold the health system accountable for what has been promised can help to ensure immunization services are people-centered. Engaging the community in monitoring the quality of service delivery (and providing a forum or mechanism through which to do that) encourages feedback and feed-in loops, builds trust, and allows the community and health system to manage expectations together. As noted above, this can be done through health committees. Community score cards and client satisfaction cards are effective and appreciated approaches raised by key informants in Ghana, Mozambique, and Nepal; however, these interventions are often reliant on donors. Mechanisms need to be institutionalized by health systems for community feedback to be regularly provided (and not just conducted periodically by NGOs or civil society organizations [CSOs]) and can improve community ownership, inputs and monitoring of immunization service delivery. Verbal feedback through mother's groups, father's groups, and to trusted community leaders are all valuable mechanisms through which feedback on immunization service experience can be received; however all four countries noted that two-way feedback is necessary to build trust in the system. Feedback is received but not often responded to in a transparent manner; this is a key area for improvement highlighted in all four countries and important to ensure accountability.

WORKPLACE COMMUNITY

For the health worker, the health provider ecosystem—the workplace community—was highlighted as a key component for positive service experience. In rural areas, or in other situations where health workers may be isolated, supportive supervision was identified across all four countries as a key intervention to support exchange between health workers and to increase their capacity. At the global level, some key informants highlighted community structures through which peer-learning and interactive/collaborative learning take place. For example, in regular immunization review meetings, health workers from several health facilities are able to engage with and learn from each other.[14] In larger urban hospitals and facilities, health workers may have a built in opportunity through staff meetings to exchange ideas and learn from each other to cultivate a sense of community and support. Across several countries, health workers based in different facilities have leveraged WhatsApp to exchange ideas, share information, engage in informal peer mentorship, and discuss work issues. More formal structures, such as Communities of Practice (CoP) are not the norm across the four countries, except for in Kenya, where a CoP for eye care, COECSA Public Eye Care Community of Practice, recently formed.

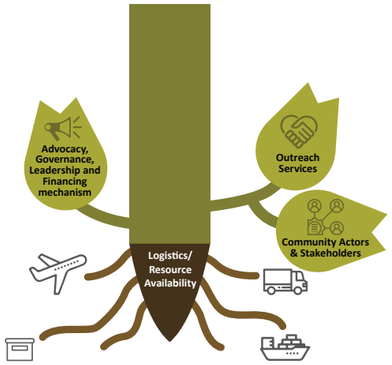
"There is something intangible and intrinsic about a physician who is volunteering to work with health facility workers that we found has been an incentive. It is not just someone is paying attention to them as an individual but it is also the idea that an expert wants to support me, work through these issues with me, and treat me as a peer. We are all health providers and we are going to work together to solve how we can make this better."

– KII Respondent

Further investigation into existing mechanisms and structures to cultivate a stronger sense of community – along with skills building and attention to fostering this – can support a positive, people-centered immunization service experience.

14 An example of review meetings as a platform for learning and exchange can be found here: Immunization review meetings: "Low Hanging Fruit" for capacity building and data quality improvement?

Feedback is received but not often responded to in a transparent manner; this is a key area for improvement highlighted in all four countries and important to ensure accountability.



EMERGING THEMES FROM COUNTRY INSIGHT GATHERING

The following insights were provided from the country KIIs and included as additional components to expand the service experience visual (see Annex 3 for original visual and Figure 1 for the updated version, which incorporates the components below).

COMMUNITY ACTORS & STAKEHOLDERS

In addition to clients, caregivers, and community members, other community actors and stakeholders can play a role in cultivating a positive, people-centered immunization service experience. For example, corporate actors involved in social investment can contribute to sustainable financing for immunization. In Ghana and Mozambique, leveraging private sector resources—such as transportation (i.e., motorcycle or vehicles) to support immunization service delivery—involves and empowers the community to engage in the health system. Academia as a 'community' must be involved in research on trends/emergence of socio-behavioral factors and solutions as well as program developments and improvements. Influencers also drive positive or sometimes controversial conversations on immunization and public health, including promoting use of traditional medicines or alternative medicines to treat vaccine preventable diseases. Engaging respected community leaders—i.e., chiefs, queen mothers—can help to influence anti-vaccination groups and social media campaigners to provide up-to-date and accurate information. A mapping of these stakeholders—particularly nonhealth stakeholders—in communities can unveil potential partners for the immunization program and can play a role in addressing key issues related to immunization service experience, as needed and according to local contexts.

OUTREACH SERVICES

The Country KII Questionnaire (Annex 2) included questions on public and private health facilities, but not specific to outreach immunization services (a key component to immunization service delivery in many low and middle income countries). Key informants noted that outreach services are seen as an extension of health facility services. If the outreach sessions are poorly organized (i.e., in a place or at a time not convenient for community members) or cancelled, trust in the health system can start to fray, resulting in decreased utilization of services—both outreach and fixed. In Nepal, for example, most of the 16,000 immunization outreach clinics in Nepal do not have a fixed place to provide services. When the weather is bad, outreach services are often cancelled. In recognition of the importance of immunization outreach services in Nepal, the government is providing funding for construction of houses for outreach clinics in community-approved locations, and the community is providing the land and labor to build the houses. As of 2020, 7,000 EPI fixed immunization outreach clinics in community-approved locations are available. Nepal is planning to make all 16,000 EPI outreach clinics a home within five years. By taking into consideration community needs to have services provided closer to where they live, the immunization service experience is improved.

ADVOCACY, GOVERNANCE, LEADERSHIP AND FINANCING MECHANISM

Key informants in Nepal highlighted the need for advocacy, governance, leadership and financing to support immunization service experience and demand for immunization services. The recent decentralization of the government in Nepal requires continuous advocacy and capacity building of those in charge at the local level, given that newer leaders may have limited knowledge or skills to plan, finance, or manage the immunization program. Mobilization of local resources based on local priorities is an opportunity to design immunization services to respond to community needs; however, budget for demand generation activities—including immunization service experience—is not currently available. In Nepal, as well as other countries, frequent turn over in leadership is common due government instability, so continued advocacy is necessary to ensure attention to immunization. Sustainable financing for immunization services, including for service experience and demand, is necessary. In Ghana, the need for a clear roadmap for immunization program funding after Ghana's graduation from Gavi was emphasized, including for operational costs that would help to address service experience.

Sustainable financing for immunization services, including for service experience and demand, is necessary.

"All of the service experience components included in this figure only make sense if vaccines and a functional cold chain exist."

– KII Respondent

LOGISTICS/RESOURCE AVAILABILITY

Availability of and access to reliable supply of vaccines and commodities is fundamental for the immunization service experience. If a client goes to a health facility and is turned away due to lack of vaccine, this can result in a negative service experience and a potential decrease in demand. The client may therefore not return for the next scheduled vaccination or for other essential health services. Likewise, the unavailability of cold chain equipment at the local level and inconvenient locations impact timely delivery of care, resulting in a negative experience for the health worker.

For example, in Ghana, a key informant highlighted that service providers sometimes ride about 3km from their service delivery sites to obtain vaccines from cold storage. They do so often in their own vehicles and at their own expense; sometimes arriving to a crowded health facility to pick up the vaccines and therefore delaying the start of their own sessions. In Nepal, inadequate cold chain results in challenges getting supplies to the local ward level, impeding health workers' ability to do their jobs and resulting in frustration for health workers and clients.

Some country KII suggestions on how to address supply chain and logistics challenges include: ensure health facilities have WHO pre-qualified refrigerators and that there is an adequate number of vaccines and vaccine carriers available at the community level; establish a power backup system/solar power to maintain cold chain at municipal level; and ensure timely procurement and uninterrupted supply of the vaccine and the logistics throughout the year. For additional information on how logistics and resource availability can influence immunization service experience and demand for immunization, please see this presentation, delivered at the 2020 TechNet Conference: Service Experience: Interlinking supply and demand for immunization services. This session explains service delivery models using case studies to highlight how service-side decisions (including resource management and supply) impact the everyday tasks of health workers, and, in turn, the experience of clients seeking immunization. The below Figures 4 and 5 are highlighted in the presentation as visual references and examples for the health worker journey.

Figure 4 shows a human centered tool, *The Journey to Health and Immunization*, which can help program planners identify and address social and behavioral barriers in service delivery and uptake of vaccines at the caregiver/individual level.

Figure 5 highlights the lengths an urban health worker must go to in order to vaccinate children, including traveling to and from the district hospital to collect and return vaccines every day due to inadequate cold chain capacity at her health facility.

Figure 4. The Journey to Health & Immunization[15]

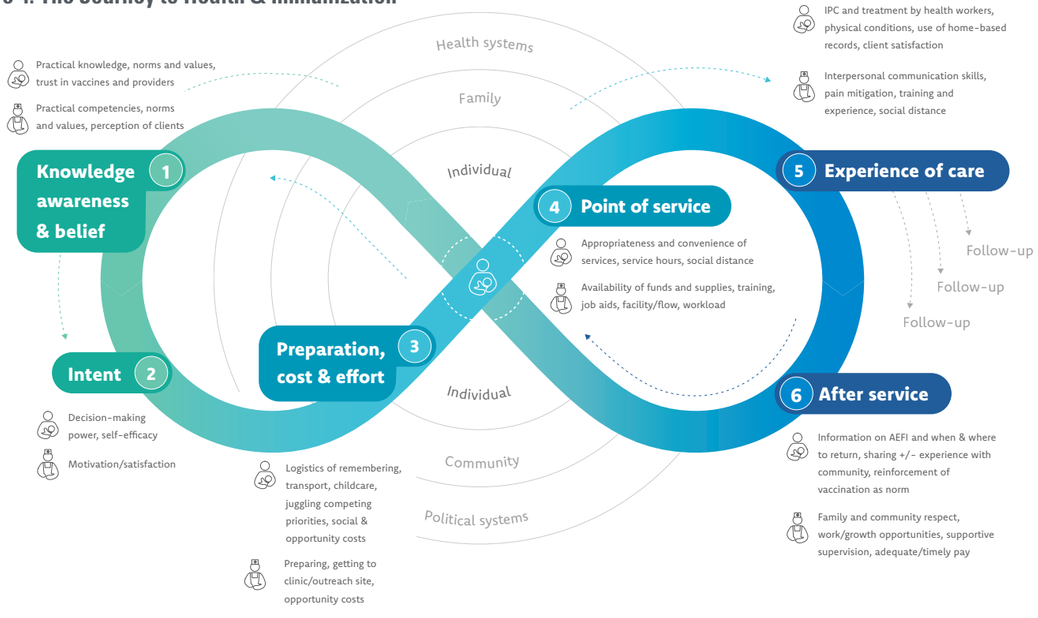
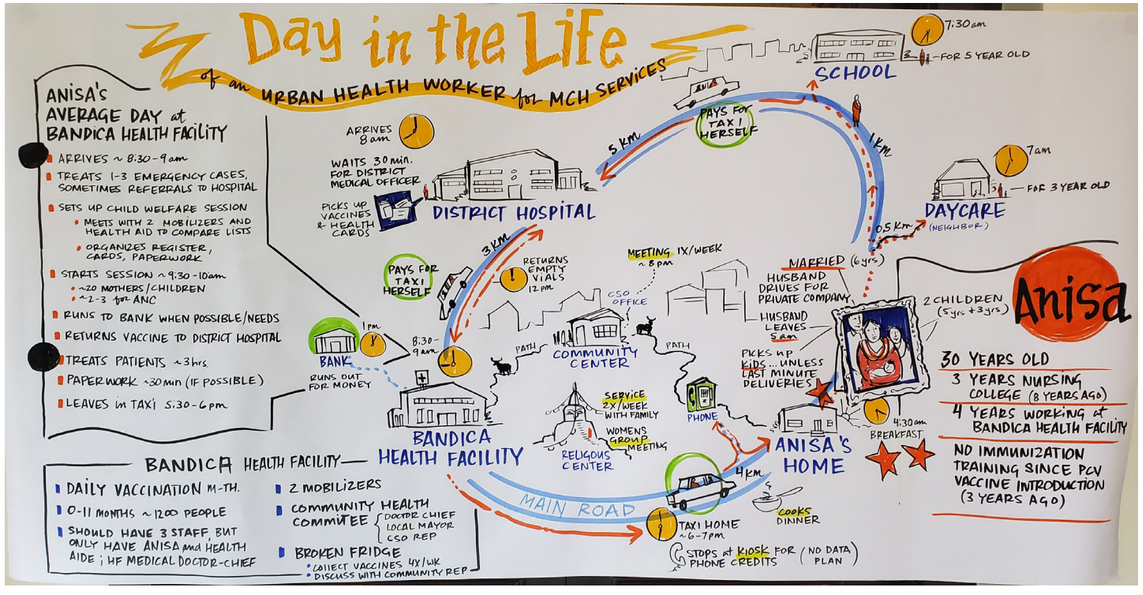


Figure 5. Day in the Life of an Urban Health Worker for MCH Services[16]



15 United Nations Children's Fund (UNICEF). 2018. Demand for Health Services: A Human-Centred Field Guide for Investigating and Responding to Challenges. New York, New York: UNICEF. Available at: https://www.unicef.org/innovation/media/10051/file/Demand%20for%20Health%20Services:%20A%20Human-Centred%20Field%20Guide%20for%20Investigating%20and%20Responding%20to%20Challenges.pdf

16 Vaccination Demand Hub. "Nepal Demand Hub Design Forum."" Kathmandu, Nepal, September 25-27, 2019.

Given that immunization service experience is newer in concept, the global, regional and key informant interviews focused on the need to identify and agree on potential indicators. For example, in both Mozambique and Nepal, key informants indicated that there is no systematic measurement of service experience and quality or client satisfaction of services on a regular basis. Some suggestions include: indicators for respectful and compassionate care; waiting time for provision of services; availability, accessibility, and affordability of immunization services; leadership and management of facilities; cleanliness and safety of facility; information provided to clients on vaccines; and the attitude of both health workers and clients. Table 9 highlights existing mechanisms that can be further used and adapted to monitor immunization service experience indicators.

Table 9. Potential data collection methods

METHOD	DETAILS
EPI periodic cluster surveys, Multiple Indicator Cluster Surveys, and Democratic and Health Surveys	These survey-oriented measurement opportunities provide a platform through which immunization service experience indicators could be incorporated and systematically collected.
Supportive supervision tools	Immunization service experience indicators can be incorporated into supportive supervision tools. Capacity building is needed with supervisors/district management teams to identify, monitor, adjust and use indicators for immunization service experience
Mystery clients	Mystery clients can monitor immunization service experience. The mystery client approach is used by the Ghana Coalition of NGOs in Health and could be applied to NGOs in the Coalition working on immunization activities.
Client exit interviews	Client exit interviews and mini surveys can be conducted outside the heath facility immediately following outpatient consultation. Where client exit interviews have taken place, many are supported with external financial support Performed by immunization staff or students. Not done regularly due to lack of interest, accountability, time or skills.
Satisfaction cards	In Mozambique, caregiver satisfaction cards are already being used for other health interventions. Caregivers vote by placing cards (green, yellow or red) in a feedback box to express their satisfaction after attending the facility. Results are compiled at the end of each month and placed in the hospital window for public access. However, no formal feedback with the communities takes place. Moving forward, using information obtained from the satisfaction cards to engage with communities about their service experience creates opportunity for collaborative problem solving moving forward.

METHOD	DETAILS
Community score cards	Community score cards have been used as a participatory tool for communities to engage with health facilities to improve communication, participation, and accountability in community service delivery. Insight gathering in all four countries indicate that community score cards are an appropriate and effective way in which to gather information about community interpretation and perception of immunization services. In most cases, community score card interventions are supported by NGOs (e.g., CARE Community Score Card Toolkit). Adaptation of lessons learned through implementation of community score cards needs to be more systematic and independent of external financial support.
Health committees	Through health committees, the community participates in the planning of community health programs. Where they are operational, they can also be used as a platform to engage communities in a transparent manner to assist with evaluation and accountability of health professionals and service delivery. Quality assurance committees can be engaged to monitor the quality of immunization services provided by health facilities (Ghana).
Anecdotal evidence gathering through community actor	In countries with an established structure for community interface, reinforcement of this structure and capacity building of the implementing actors to support data collection at the community level can provide much needed insight to community interpretation and perceptions of the immunization service experience. In Nepal, the government-supported female community health volunteer (FCHV) structure could support this function. The 52,000 FCHV are a trusted source for immunization information within the community and bring the community voice to the health facility and operational committee meetings. They engage in data collection and their active qualitative evidence gathering can be used to adjust immunization service delivery.

A key finding from country insights is the importance of sharing results of any data collection, analysis, and monitoring activities with community members. Such a feedback mechanism allows community members to understand if and how the data collected is being translated into adjustments to immunization service delivery as well as the opportunity to co-create solutions through exchange. Robust feedback mechanisms are currently predominantly donor supported in the countries and need to be institutionalized. All four countries suggest that two-way, systematic, and ongoing feedback between the health system and communities can further build trust and demand for immunization moving forward.

Key next steps are to conduct a systematic review of existing indicators that could be used to measure immunization service experience and to collaborate with the Demand Hub Behavioral and Social Drivers of Vaccination (BeSD) group for further investigation into possible indicators.

INITIATIVES TO LEARN FROM FOR POTENTIAL APPLICATION TO IMMUNIZATION

As part of the global, regional and country insight gathering, participants were asked to identify other health initiatives or interventions that speak to service experience, service delivery and people-centered care and may be applicable to immunization. Table 10 below summarizes the suggested initiatives for further investigation by the Demand Hub Service Experience Workstream to understand the intervention itself, any challenges faced during implementation and identified solutions, as well as how these learnings can be applied and adapted to immunization service experience.

Table 10. Potential interventions to investigate for application to immunization service experience

GLOBAL, REGIONAL OR COUNTRY LEVEL	INTERVENTIONS OR APPROACHES	
Global + Regional	• Kangaroo Mothercare • Improvement collaborative approach • CenteringPregnancy • Birth Companionship • White Ribbon Alliance • IPC around Family Planning • Essential Care Package for Every Baby	• Integrated Community Case Management (iCCM) and community Integrated Management of Childhood Illnesses (cIMCI) • Protection from Sexual Exploitation and Abuse • Nurturing Care Model
Ghana	• Pregnancy Schools • Community Score Cards • 'Healthier, Happier Home' Project	• Ghana Red Cross Society Mothers Clubs • Father-to-Father Support Groups • Heart-to-Heart Campaign
Kenya	• Implementation of free maternity services • Peer Mentorship and WhatsApp in Kenya	• Change Package for Improving the Quality of Antenatal Care Services and Skilled Deliveries in Kwale, Kenya
Mozambique	• Iniciativa Maternidade Modelo • Baby Friendly Hospital Initiative • CARE's Community Score Card Toolkit	• N'WETI'S Community Scorecard Experience in Nampula
Nepal	• Community Health Score Board • Gender equality, female empowerment, and social inclusion	• Self-applying technique for quality of care through mobilizing health mother group

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COVID-19 SPECIFIC IMMUNIZATION SERVICE EXPERIENCE OBSERVATIONS

The global COVID-19 pandemic has emerged new issues in service experience. With severe disruptions to services, clear and consistent communication becomes challenging, notably on when and where to go when services are resumed. Caregivers may be unsure if they should continue to come for vaccination services, and be concerned about visiting health facilities during the pandemic. Front line health workers are also under considerable stress, and even where services are available there may be critical service quality issues that strain the relationships between health workers and clients. Understanding existing challenges for health workers (e.g., lack of personal protective equipment [PPE] and training in Infection Prevention Control, lack of vaccine, lack of capacity to adjust services, and vaccination services suspended due to COVID-19 risks)—as well as those that may emerge when the pandemic subsides—require thoughtful contemplation to shape the future of immunization service experience.

Country insight gathering for this work was set to being in countries in March 2020. With the emergence of COVID-19, the key informant interview guides were updated to include questions specific to COVID-19 and service experience. The questions added to the country key information interview guides (Annex 2) include:

- Has the [immunization program, or other relevant health program] faced any new or magnified service experience related issues in light of COVID-19?
- Since the emergence of the COVID-19 pandemic, have you found any changes in perception of immunization, broader health services and / or service experience?

The following results were collected across the four countries from April – July 2020, reflecting initial effects of COVID-19 on immunization service experience.

INADEQUATE SUPPLY OF COMMODITIES

COVID-19 had immediate impact on health personnel and their safety, as well as vaccine supply chain and stocks—all of which affected the maintenance of routine immunization services. For example, in all countries, immunization personnel were reassigned to support the COVID-19 response and insufficient PPE for health workers resulted in safety concerns for the health workers as well as the clients they serve. With vaccinators reassigned and those available to deliver services facing insufficient PPE, the health workforce was not able to deliver services as done prior to COVID-19. For example, in Ghana, service providers were instructed to suspend services due to absence of protocols and PPE. And in Nepal, the COVID-19 hotline received approximately 200 calls/day about the PPE and safety of health workers.

Some countries also faced interruptions in supply chain and stocks. For example, in **Kenya**, the cancellation of flights to the country affected the supply of three vaccines at the country level for several weeks. And in **Mozambique**, the transportation of supplies from the national to district level was delayed, resulting in insufficient supply of vaccines at health facilities and inability to vaccinate clients who came for services.

ACCESS TO IMMUNIZATION SERVICES LIMITED AT HEALTH FACILITIES

The closure of health facilities in some countries—like Ghana**,** where it was reported that some health facilities closed when health workers were infected with COVID-19—meant clients and caregivers could not receive services. In some countries, facilities designated as COVID-19 centers stopped immunizing, and faith-based/private facilities closed due to lack of clients (Kenya). In Ghana, Kenya and Nepal, transportation limited access to health facilities. In Kenya, public transport was restricted to 50% capacity; with less space available, fares for transport increased. And in Nepal, public and private transportation was suspended in urban areas. Once immunization was identified as essential, clients could show vaccination cards to authorities and use private transport for travel to health facilities.

In addition, concerns related to lockdown and fear of infection at facilities limited use of immunization services at health facilities (see Table 11 below).

Table 11. Concerns related to lockdown and fear of infection at facilities

LOCKDOWN	FEAR OF INFECTION AT FACILITIES
Communication is to stay home; people aren't coming to health facilities (all countries).	Fear of crowds at facilities and worry that social distance cannot be maintained (all countries).
Lockdown forced urban populations (especially marginalized populations like street sellers and head porters) to abandon services (Ghana).	Mothers reluctant to come to facilities because fear that babies and young children cannot wear masks (Mozambique).
	Stigma around visiting certain facilities: Where health workers were known to be infected (Ghana) Where COVID-19 cases are being treated

OUTREACH SERVICES PARTICULARLY DISRUPTED

Initial widespread disruption of outreach services occurred across all four countries in the early months of the COVID-19 pandemic, but their resumption was prioritized because outreach services target the most vulnerable and hard to reach. At the time of the Demand Hub Service Experience Co-Creation Workshop in July 2020, outreach resumed to some degree across all four countries, as shown in Table 12 below.

Table 12. State of outreach services in four countries during COVID-19, as of June 2020

COUNTRY	DESCRIPTION OF OUTREACH SERVICES
Ghana	Outreaches resumed to 2-3 times/month (1X/month at start of pandemic), targeting fewer clients.
Kenya	Suspension of outreach services; slow resumption after community mobilization.
Mozambique	Guidance to resume outreach in hard-to-reach areas prioritized at the start of the pandemic. Outreach resumed in areas selected based on review of data in early June.
Nepal	Communities demanded services closer to them. As of June, 50% of outreach is operating at capacity after initial full suspension.

NEW VACCINE INTRODUCTIONS AND SUPPLEMENTARY IMMUNIZATION ACTIVITIES DELAYED

In Nepal, the nationwide introduction of the rotavirus vaccine was postponed from May to July 2020 and MR campaigns were postponed by 3-4 months, resulting in a measles outbreak in 3 districts during that time. In Ghana, polio and yellow fever campaigns were postponed and responses to meningitis outbreaks in the Northern Regions were delayed. In Kenya, an MR campaign was suspended.

RUMORS AND MISINFORMATION

Rumors and misinformation began circulating in countries early on in the pandemic. Table 12 outlines the rumor topics across the four countries.

Table 13. COVID-19 rumor topics across four countries

RUMOR TOPICS	RUMORS
COVID-19 (Ghana, Kenya)	Created by scientists to depopulate Africa
COVID-19 + other vaccines (Kenya, Mozambique, Nepal)	BCG and measles vaccines will protect against COVID-19
Natural remedies (Ghana, Nepal)	• Turmeric and ginger can take the place/act as a vaccine for COVID-19 • Neem leaves and citric fruits boost the immune system and prevent COVID-19 • A popular vitamin supplement (COA FS) can prevent COVID-19 • Herbal medicine practitioners claiming cure for COVID-19 (See Corona Quacks: Exposing fake coronavirus cures in Ghana - BBC Africa Eye documentary)
COVID-19 vaccine	• Vaccines being created to depopulate Africa • Caregivers assume that infant vaccination is safe but adult vaccination is not, in light of a rumored 'plot' to eliminate Africans • Vaccines will be tested on Africans • COVID-19 vaccine already exists; pandemic was contrived to make it acceptable

EFFORTS TO RESTORE AND MAINTAIN IMMUNIZATION SERVICES

To restore and maintain immunization services, all four countries adapted or developed guidance and safety protocols to support the implementation of immunization services during COVID-19 and address the safety of health workers and community members. Guidance on where and when to access services is being updated repeatedly and is being used with the community and shared through local channels. Tailored messaging was developed and shared via local media and online fora as well as phone calls, SMS and WhatsApp. In Nepal, messaging was also shared via the COVID-19 hotline. In Mozambique, the country sought community input via a mini survey to understand reasons for not going for vaccination to assist with tailored messaging.

Additional actions are necessary to continue restoration and maintenance of immunization services. Table 13 below summarizes recommendations from the key informant, organized around three key themes: Research, guidelines, and planning; Capacity-building; and Organization and delivery of services.

Table 13: Recommendations for restoring and maintaining immunization services during COVID-19

RECOMMENDATIONS	GHA	KEN	MOZ	NEP
RESEARCH, GUIDELINES, PLANNING				
Use human-centered design to assess and address COVID-19 barriers	X			
Further adapt national guidelines to local level		X		
Adjust Human Resources plan to provide PPE for all health workers and assure facilities remain open				X
CAPACITY-BUILDING				
Build health worker capacity and confidence to provide essential services and communicate/address concerns about COVID-19 and routine immunization	X	X	X	X
Enhance capacity of local leaders to support routine immunization and COVID-19 response	X	X	X	X
Improve HW sensitivity to gender, caste, ethnicity, and other factors				X
ORGANIZATION AND DELIVERY OF SERVICES				
Community engagement and mobilization for outreach services	X	X	X	X
Focus outreach and communication efforts on urban poor communities	X			
Ensure safety of female health workers for outreach clinics in forested areas				X
Support in booking clients for services at health facilities		X		
Use SMS and email to provide messages and follow-up with due children			X	

"The immunization program was affected within 2-3 weeks after the national lockdown. But it was also the most resilient program, resuming services first. With strong demand from the community and support from partners, we are still not back to normal. It has had its impacts but the program was quick to resume."

– KII Respondent

There are three recommendations that came up as high priority across all countries: 1) building health worker capacity and confidence to provide essential services and communicate/address concerns about COVID-19 and routine immunization; 2) enhancing capacity of local leaders to support RI and COVID-19 response; and 3) community engagement and mobilization for outreach services. For this third recommendations, implementation can play out in different contexts: outreach for urban poor communities in Ghana; and protecting lady community health volunteers conducting outreach in forested areas in Nepal. These approaches demonstrate how tailoring broad recommendations to different contexts is important, particularly in support of a people-centered immunization service experience.

VACCINATION DEMAND HUB SERVICE EXPERIENCE WORKSTREAM CO-CREATION VIRTUAL WORKSHOP SUMMARY

From 20-22 July 2020, the Demand Hub Service Experience Workstream hosted a virtual Co-Creation Workshop to assess service experience in the context of COVID-19 and review initial findings from the global, regional, and country level insight gathering; brainstorm opportunities for engagement and development in the service experience space, align on cross organizational roles priorities, and plan next steps as a workstream to support this developing programmatic area. Detailed objectives included:

OBJECTIVES

- Define role and scope of service experience in people-centered immunization service delivery.
- Identify priority needs for global support of people-centered service delivery.
- Map appropriate connections between service experience workstream priorities and other Hub workstreams and partners.
- Design roadmap Q3 2020- Q4 2021, outlining priority activities, products, and engagements to be undertaken by the Service Experience Workstream.
- Agree on co-ownership of the roadmap and associated activities amongst workstream.

Approximately 20 participants joined the co-creation workshop, representing the following organizations: American Academy of Pediatrics, Bill & Melinda Gates Foundation, Centers for Disease Control and Prevention, Civil Society and Institutional Development Programme, Gavi, International Federation of the Red Cross, JSI, UNICEF, US Agency for International Development, and WHO. JSI country representatives who conducted the country insight gathering also participated in the co-creation workshop. Please see Annex 4 for the workshop agenda.

KEY WORKSHOP LEARNINGS AND TAKEAWAYS

DEFINE ROLE AND SCOPE OF SERVICE EXPERIENCE IN PEOPLE-CENTERED IMMUNIZATION SERVICE DELIVERY

Workshop participants were asked to examine the relationship between quality healthcare and service experience, with the support of the following visuals from the WHO Service Quality Definition and the April 2019 Hub Meeting Definition (see Figure 6).

Key discussion points focused on expectation of care on the part of community members as well as health workers and the health system. First noted is the recognition that the correlation of Health Service Quality and Service Experience is context dependent and hinges on expectation of care. Understanding how one defines care increases understanding of their interpretation or perception of it. Participants noted that one of the most influential factors of service quality on service experience is people-centeredness, which is influenced at the health worker level. They also noted that the health worker experience is also impacted by factors in and beyond service quality. These factors need to be identified and addressed to ensure positive, people-centered experiences. Additionally, factors such as the facility environment and accessibility can influence the experience of care for both community members and health workers. Participants noted the importance of taking a systems approach that creates an environment that empowers health workers to provide a positive experience.

SERVICE EXPERIENCE AND COVID-19

After reviewing COVID-19 insights from the field (See pp. 22-24), attendees engaged in group discussions regarding the challenges highlighted and opportunities for potential support. Participants focused on brainstorming solutions for the following challenges:

Figure 6. Service Experience as a Perception of Quality

WHO Service Quality Definition

What is quality health care

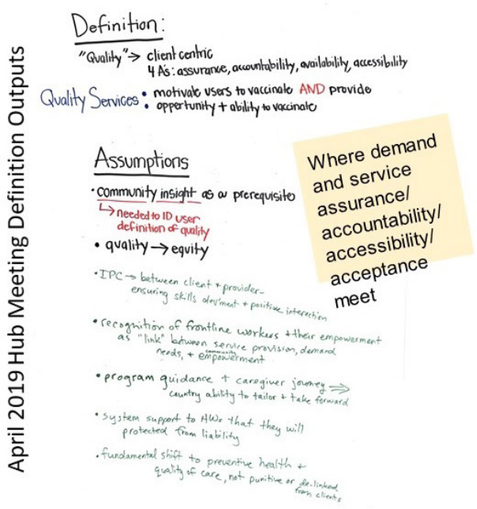
Quality health care can be defined in many ways but there is growing acknowledgment that quality health services should be:

- **Effective** – providing evidence-based healthcare services to those who need them;
- **Safe** – avoiding injuries to people for whom the care is intended; and
- **People-centred** – providing care that responds to individual preferences, needs and values.

To realize the benefits of quality helath care, health services must be:

- **Timely** – reducing waiting times and sometimes harmful delays;
- **Equitable** – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status;
- **Integrated** – providing care that makes available the full range of health services throughout the life course;
- **Efficient** – maximizing the benefit of available resources and avoiding waste.

April 2019 Hub Meeting Definition Outputs



- Lack of resources (financial, PPE, name-based tracking system) to identify those who have missed services due to COVID-19 interruptions (client and community perspective;
- Rumors/misinformation about prevention of and cures for COVID-19 and the COVID-19 vaccine itself;
- Confusion and fears related to if, when, and where services are taking place – fixed facilities and outreach (client and community perspective);
- Confusion and fears around if, when, and how to deliver services during pandemic (health worker perspective);
- Challenges with tailoring and implementing global/national guidance on 'essential services' like immunization at facility level (health workers); and,
- Lack of resources (financial, PPE, name-based tracking system) to identify those who have missed services due to COVID-19 interruptions (client and community perspective).

Solutions include: CSO engagement, building capacity of health workers to engage in data collection and information gathering (i.e., social listening for rumors and misinformation amongst community members), communication with community members around the COVID-19 disease and forthcoming vaccine introduction, and adaptive management for problem solving. COVID-19 provides an opportunity for CSOs to play a role both in providing information to the health system ono barriers to immunization during COVID-19 (e.g., *who* have been missed, *where* services are being disrupted and *why*) and in disseminating information about immunization on WhatsApp, text, online as it is updated and becomes available.

Health worker capacity building in adaptive management emerged as a key recommendation. Restoring and maintaining immunization in the COVID-19 setting is dynamic, and with the future introduction of COVID-19 vaccines to a new population not usually reached by national immunization programs, the ability to shift gears, adapt approaches, and communicate changes to community members will be an invaluable skillset.

In recognition that health workers are at risk for infection as a result of their job—and that the burden of treatment and health communication, as well as future vaccination hinge on them—Workstream participants also highlighted the importance of finding ways to support health workers at a time of great fatigue and stigmatization. A key step forward is to provide guidance on what is 'do-able' at the health facility level—that can be adapted and tailored with local support—to address immunization service experience during COVID-19.

UNDERSTANDING NEEDS AND ACTORS FOR PEOPLE-CENTERED IMMUNIZATION SERVICE EXPERIENCE

After reviewing information collected during the global, regional, and country level insight gathering on immunization service experience, participants brainstormed key needs at various levels of the health system. Participants also identified contexts in which immunization service experience should be prioritized. The priority contexts include fragile settings, remote/rural, urban poor areas (health worker and client), communities at risk, who are less educated/informed, and who have a low trust in authorities to understand their needs (community).

Table 14 below highlights key needs for global support of people-centered service delivery are evident across the health system and facility, at the point of interaction between the health worker and client, and down to the community level.

Table 15. Service experience needs at the health system and facility, heath worker and client, and community levels

LEVEL	NEEDS
Health system and facility	Within the health system and at the facility level, simple actions can create an environment that is welcoming and convenient to clients (i.e., beautification, cleanliness, clean toilets, and extended operating hours).
	In some countries, there is a perception of better quality services at private facilities (though costly). Supporting development of SOPs for private facilities and capacity building of health workers to adhere to quality standards is important.
Health worker and client	At the point of interaction between the health worker and client, strong managerial, technical and IPC skills on the part of the health worker are required. Blended learning approaches as well as peer learning and exchange can build such capacity.
	Understanding the key factors that impact perception will allow for them to be addressed in the name of better service experience.
Community	At the community level, improved communication across the facility-health worker-community spectrum, including though feedback mechanisms, is necessary.
	Improving capacity of community health workers in immunization specifically, and IPC/I to address fears/side effects and concerns with vaccination is a key point of possible support.
	In countries undergoing decentralization (or where leadership frequently changes), an advocacy mechanism to obtain support and funding for the immunization program, including demand-related issues, is necessary.
	Advocacy efforts to engage community actors and stakeholders in securing funding for immunization activities at the local level, like outreach services and proper supply chain and logistics support, can support access to and utilization of services.

A DRAFT ROADMAP FOR THE SERVICE EXPERIENCE WORKSTREAM AND PARTNER ENGAGEMENT

Based on the needs identified in the workshop (and Table 14), participants mapped connections between other Demand Hub Workstreams and partners to support moving efforts forward. Key actions and possible collaborations to move the Service Experience Workstream Workplan forward are outlined in Table 15 below.

Table 16. A way forward for the Service Experience Workstream and partner engagement

WITHIN THE SERVICE EXPERIENCE WORKSTREAM
Identifying existing best practices across different health sectors, developing guidance on measurement of service experience, and collating existing evidence and conducting operational research were identified as key areas of support.
Develop accountability tools, provide technical support to countries carrying out service experience related work (including civil society to be advocates), and SBCC for immunization service experience.
IN COLLABORATION WITH OTHER DEMAND HUB WORKSTREAMS
For overall guidance, link to the Behaviorally Informed Interventions Workstream and BeSD Workstream to ensure long-term, coordinated support. Collaboration with BeSD is particularly important in identifying service experience indicators and their monitoring and measurement.
Coordination around guidance for COVID-19 response, including adapting of guidelines to help countries/CSOs/partners to build capacity of HWs (emotional health also, given stress of C-19).
Resource advocacy with donor partners for Demand Hub Workstream funding and with in-country partners for local resourcing for Service Experience (needs local buy-in).
OTHER PARTNER ENGAGEMENT
Translate existing quality frameworks for use by local partners and government agencies, including a focus on quality improvement; as well as the adaptation of advocacy toolkits to the local level for partners to use in support of sustainable immunization financing and local resourcing for service experience.
Supporting the reprioritization of SE in countries and adapting of guidelines to help countries /CSOs/partners build capacity of HWs (including emotional health).

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NEXT STEPS

Following the workshop, a draft 2020-2021 Service Experience Workstream Workplan was developed and shared with Workstream members for review and input. Further refined based on emerging global priorities in December 2020, the updated Workplan can be viewed in Annex 5.

Key next steps to operationalize the Workstream include further establishing the Workstream governance; clarifying membership roles and responsibilities in moving Workplan activities forward; and sustainable financing for activity implementation.


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CONCLUSION

With stagnating routine immunization coverage rates and growing inequities, countries have shown increased interest in how to increase acceptance and uptake of immunization services. Rapid insight gathering at the global and regional levels and in country have indicated interest for additional support with people-centered immunization service delivery—evident across the health system and facility, at the point of interaction between the health worker and client, and down to the community level.

A number of key recommendations to move toward a more positive, people-centered immunization service experience include:

- Packaging the findings from the global, regional and country level insight gathering into practical guidance and a set of tools for country adaptation and implementation research.
- Conducting a systematic review of existing indicators that could be used to measure immunization service experience and collaborating with the Demand Hub BeSD Workstream for further investigation into possible indicators.
- Identifying existing best practices and evidence across different health sectors on people-centered care, including further investigation into existing mechanisms and structures to cultivate a stronger sense of community and examples of quality integrated service delivery that takes into account community need.
- Developing a menu of activities (short- and long-term) or checklist countries can implement to strengthen immunization service experience at the national, subnational, health facility, and community levels. Suggested activities can include mapping existing country policies and strategies on experience of care and examining if and at what level they take into account the immunization setting and service experience; health worker and manager capacity building in adaptive management, and interpersonal communication; and monitoring and evaluation approaches that include community (i.e., health worker and communities) feedback and needs and foster accountability.
- Conducting operational research in prioritized countries and documenting lessons learned to gain further insight into the immunization service experience and its link to demand and improved immunization coverage and equity.
- Examining system barriers—such as staffing, availability of supplies, and sustainable financing for immunization service experience and demand—must also be considered in the long run.

Key to moving these recommendations forward is commitment at the global, regional, and country levels and increased partner involvement and collaboration. Technical implementers' additional critical thinking and contributions result in a clearer understanding of opportunities, gaps, and critical needs where targeted investment will result in improved coverage and equity. Most importantly, improving the immunization service experience will strengthen trust in immunization programs, ultimately resulting in healthier and more productive lives for children and their families.

Rapid insight gathering at the global and regional levels and in country have indicated interest for additional support with people-centered immunization service delivery—evident across the health system and facility, at the point of interaction between the health worker and client, and down to the community level.

ANNEXES

Annex 1. Key Informant Interview Questionnaire (Global and Regional Level)

PURPOSE OF GLOBAL LEVEL KEY INFORMANT INTERVIEWS

The purpose of the global level key informant interviews (KIIs) is to gather evidence across partners and sectors to formulate best practices to shape the immunization system, within the broader health system, to focus on a positive experience. Part of this scoping exercise includes speaking with colleagues and experts who are working on client-centered services and learning more about what was done and how was it done; any specific country examples; how we know whether or not it is working (measurement); any successes, challenges, or lessons learned; and whether or not any of this can be applied to immunization.

Findings from the KIIs will feed into a scoping document that identifies opportunities for integrating immunization into guidance on people-centered health services.

DRAFT KEY INFORMANT INTERVIEW QUESTIONS:

- Learning from other health areas that have refocuses on client-centered services, what did they do? How did they do it? Do you have any specific county examples? How do they know it is working (measurement)? Can any of this be applied to immunization?
- Do you know of examples where communities have been a part of the service delivery and quality decision-making? How did that work (or not)? Challenges? Successes? Key lessons learned?
- How to shape the immunization system – within the broader health system – to focus on a positive experience: policy, planning, training (pre-service and continuing), supervision?
- What are the measures and metrics (and how to help move this forward in/with countries)?
- How to re-institute an emphasis on care and meeting clients' needs and expectations?
- How will the people-centered service experience for immunization be integrated into health system strengthening?
- Do you have other suggestions on questions we should ask the countries? Or other people we should talk to (additional global/regional level KIIs)?

Annex 2. Key Informant Interview Questionnaires for Country Level Insight Gathering

KEY INFORMANT INTERVIEW GUIDE FOR EPI STAFF AND IMMUNIZATION TECHNICAL PARTNERS

Date: _____

Country: _____

Organization/Program: _____

Position of person interviewed: _____

Name of interviewer: _____

Interviewer to read the below to the key informant interviewee prior to conducting the key informant interview:

Good morning/afternoon.
My name is _____ and I work with John Snow Research & Training Institute, Inc., an NGO that is working with the Ministry of Health Expanded Program on Immunization [please adjust for country context].

We are talking to different stakeholders and partners to learn more about immunization service experience and how this links to satisfaction, uptake and demand for immunization.

I would like to ask you a few questions about how we can make immunization more people-centered. This should take about 45-60 minutes, and we will record the interview as long as you are comfortable. If you are not comfortable using a recorder, I will take notes on what we have discussed by hand.

What you say as an individual will be kept anonymous and will not be shared with anyone outside of this information gathering exercise. We will not alter the participants' wording but may paraphrase in consolidating the responses. Please answer all the questions to the best of your ability. We are interested in your honest answers, whether they are positive or negative. If you do not understand any question, feel free to ask me and I will clarify them accordingly.

If you are comfortable, would you be willing to answer these questions?

If the respondent says no	Thank the respondent for their time.
If the respondent says yes	If the respondent says yes, interviewer is to confirm that use of recorder is acceptable. Interviewer is to confirm that the recording will not be shared rather referred back to clarify any points missed during note taking. Notes can be taken instead of using the recorder, should the participant decline use of a recorder.
	Once the mode of documenting the conversation is accepted by the key informant, continue to the first question below.

1. What is your position?
2. How long have you been in this position?
3. What are your main responsibilities?

4. What does demand for routine immunization services mean to you?
   [Allow the participant to answer. If helpful, please let them know that what we mean by demand is "the action to seek, support, and/or to advocate for vaccines and immunization services" (as defined in the Gavi programming guidance).
5. What problems or needs do you see linked to demand for routine immunization services? Please feel free to share examples (studies, assessments, program reviews, others)
6. We are seeking insights and perspectives on how to address/improve the "immunization service experience" for health workers, caregivers and communities. How would you define or describe this?
7. How would you incorporate 'immunization service experience' as part of efforts to improve demand (and/or communications, knowledge/ attitudes/practices, acceptance, confidence, uptake) for routine immunization services? Please provide some examples.

Show your interviewee the figure. *Explain that these are some key themes that have emerged as considerations for addressing immunization service experience and refocusing to make immunization services more people-centered.*

8. Do these themes resonate with your country context and perspective? In what ways do they apply or not apply?
9. Which themes are the most applicable to your country context? Are there any that are already being done/implemented? If so, what are you doing in these areas?

   Please probe for each theme they identify. For example:
   - *Did they develop any new policies, guidelines, tools, processes or interventions to address these areas? Please ask them to describe how these were developed and who (or which organizations/donors/partners) helped to put them into place? What did they learn from the initial experience of developing, implementing, and/or testing the new or improved policy, guideline, or tool?*
   - *If the interviewee describes an intervention, please explore the following:*
     - *Was the intervention successful?*
       - *If yes, please proceed to the questions below.*
       - *If no, please probe and ask why?*
     - *How widely is this work being carried out now?*
     - *Can its implementation be expanded (This can be geographic expansion and/or expansion to other areas of work?*
     - *What makes it easy to expand? What are some challenges to expansion?*
     - *In what ways was this measured or monitored?*
   - If *there are <u>not</u> new policies, guidelines, tools, or processes, please have then describe some actions (simple and complex) that they think could help to address the theme(s).*
     - What may be needed to achieve those actions?
     - *Who needs to be involved?*
     - *What resources may be necessary?*
     - Do you have any suggestions as to how this could be monitored or measured?
10. Are there any themes missing from this visual that are important to address, when thinking about moving toward people-centered immunization service experience? If yes, please describe what is missing. Why do you think this is important?
11. Are there other pieces of work or health initiatives taking place in your country around 'quality care' and 'people-centered approaches' that you have heard about and that could potentially be adapted? *[**Please probe:** If yes, what is of most interest to you about these approaches and why? (If needed, probe for other health initiatives, such as reproductive health, IMCI, HIV/AIDS, MCH, ANC, WASH, etc.)*
12. What would it take to shape the immunization system – within the broader health system – to focus on a people-centered experience: e.g. policy, planning, training (pre-service and continuing), supervision? *[**Please probe:** What are some examples of where this has happened?]*

13. Do you/the system measure or monitor immunization service experience and the interactions between the health worker and the caregiver and/or client?
    a. *If yes, **please probe** (How is this measured? What are the indicators? Alternatively, were more informal methods used to measure and monitor the work?).*
    b. *If not, **please ask** if they have any suggestions as to how to measure or monitor immunization service experience and the interactions between the health worker and the caregiver and/or client.*

If time permits, the following questions can also be asked:

14. Do you have examples in which the **health worker experience** was specifically addressed to help improve immunization delivery? Please describe how this was done, the results and challenges, and how it worked.
    a. What could the health system do to support health workers to deliver high quality immunization sessions?
    b. How can we ensure that these quality skills are being met by the health worker?

15. What are some examples **where communities have been part of defining or monitoring the quality of service delivery**? [**Please probe:** How have they been involved in decision-making? What worked/did not work?]

16. Does the immunization or overall health system have **feedback mechanisms to monitor or know when clients are satisfied** with the services they are receiving?
    a. If yes, please explain how this works.
    b. If not, how could this potentially be incorporated?

17. Are there other entry or convergence points for immunization where the quality of integration is being explored (like ANC, IMCI, Family Planning, HIV screening)?
    a. How are these measured and tracked in terms of the service experience?
    b. How is equal attention to all services ensured – to maximize benefits and minimize any potential negative affects?

18. Are there any national level initiatives underway to address 'experience of care' for clients and health workers? [Please probe: Do these include immunization? If not, how could they potentially be adapted? Have these helped to improve demand for services (and if so, how)?]

Before concluding the discussion, please pose the following questions around COVID-19 and service experience to the participant. Please allow 15-20 minutes on these questions.

19. Has the [immunization program, or other relevant health program] faced any new or magnified service experience related issues in light of COVID-19?
    a. If so, have you taken any measures to mitigate this? Have they been successful? [**Please probe** to understand what was done, who did it, and how they are determining whether it has been successful.]

20. Since the emergence of the COVID-19 pandemic, have you found any changes in perception of immunisation, broader health services and / or service experience? If so, please elaborate. [**Please probe:** what have they seen?

This concludes our discussion. Is there anything that we have not discussed that you would like to mention?

Thank you for your time and information!

KEY INFORMANT INTERVIEW QUESTIONNAIRE FOR NON-IMMUNIZATION GOVERNMENT STAFF, TECHNICAL PARTNERS, AND CIVIL SOCIETY ORGANIZATIONS

Date: _____

Country: _____

Organization/Program: _____

Position of person interviewed: _____

Name of interviewer: _____

Interviewer to read the below to the key informant interviewee prior to conducting the key informant interview:

Good morning/afternoon.
My name is _____ and I work with John Snow Research & Training Institute, Inc., an NGO that is working with the Ministry of Health Expanded Program on Immunization [please adjust for country context].

We are talking to different stakeholders and partners to learn more about immunization service experience and how this links to satisfaction, uptake and demand for immunization.

I would like to ask you a few questions about how we can make immunization more people-centered. This should take about 45-60 minutes, and we will record the interview as long as you are comfortable. If you are not comfortable using a recorder, I will take notes on what we have discussed by hand.

What you say as an individual will be kept anonymous and will not be shared with anyone outside of this information gathering exercise. We will not alter the participants' wording but may paraphrase in consolidating the responses. Please answer all the questions to the best of your ability. We are interested in your honest answers, whether they are positive or negative. If you do not understand any question, feel free to ask me and I will clarify them accordingly

If you are comfortable, would you be willing to answer these questions?

If the respondent says no	Thank the respondent for their time.
If the respondent says yes	If the respondent says yes, interviewer is to confirm that use of recorder is acceptable. Interviewer is to confirm that the recording will not be shared rather referred back to clarify any points missed during note taking. Notes can be taken instead of using the recorder, should the participant decline use of a recorder.
	Once the mode of documenting the conversation is accepted by the key informant, continue to the first question below.

1. What is your position?

2. How long have you been in this position?

3. What are your main responsibilities?

4. We are seeking insights and perspectives on how to address/improve the "immunization service experience" for health workers, caregivers, and communities. How would you define or describe this?

Show your interviewee the figure. Explain that these are some key themes that have emerged as considerations for addressing service experience related specifically to immunization and refocusing to make immunization services more people-centered.

5. Do these themes resonate with your country context and perspective? In what ways do they apply or not apply? [Please note: The respondent may not have knowledge about immunization. Please encourage them to respond with their own perspective based on their experience and expertise.]

6. Which themes are the most applicable to your country context? Are there any that are already being done/implemented? If so, what are you doing in these areas? **Please probe for each theme they identify. For example:**
   - D*id they develop any new policies, guidelines, tools, processes or interventions to address these areas? Please ask them to describe how these were developed and who (or which organizations/donors/partners) helped to put them into place? What did they learn from the initial experience of developing, implementing, and/or testing the new or improved policy, guideline, or tool?*
   - *If the interviewee describes an intervention, please explore the following:*
     - *Was the intervention successful?*
       - I*f yes, please proceed to the questions below.*
       - *If no, please probe and ask why?*
     - *How widely is this work being carried out now?*
     - *Can its implementation be expanded (This can be geographic expansion and/or expansion to other areas of work (i.e., immunization)?*
     - *What makes it easy to expand? What are some challenges to expansion?*
     - *In what ways was this measured or monitored?*

7. If there are not new policies, guidelines, tools, or processes, please have then describe some actions (simple and complex) that they think could help to address the theme(s). **Please probe:**
   - *What may be needed to achieve those actions? (Who needs to be involved? What resources may be necessary?)*
   - P*lease also clarify at what level of the health system changes could take place. At the policy level? Planning level? Training (pre-service and continuing)? Supervision and on-the-job mentoring?*
   - *Do you have any suggestions as to how this could be monitored or measured?*

8. Are there any themes missing from this visual that are important to address, when thinking about moving toward people-centered immunization service experience?
   - *If yes, please describe what is missing. Why do you think this is important?*

9. Are there other pieces of work or health initiatives taking place in your country around 'quality care' and 'people-centered approaches' that you have heard about and that could potentially be adapted to immunization?
   - If yes, what is of most interest to you about these approaches and why? (If needed, probe for other health initiatives, such as RH, IMCI, HIV/AIDS, MCH, ANC, WASH, etc.)

10. Do you have any suggestions or advice to give to the immunization program when considering how to adjust the immunization service delivery to focus on a people-centered care?

11. How would you/the system measure or monitor the immunization service experience and the interactions between the health worker and the caregiver and/or client?
    - If yes, please probe (How is this measured? What are the indicators? Or were more informal methods used to measure and monitor the work?).
    - If not, please ask if they have any suggestions as to how to measure or monitor immunization service experience and the interactions between the health worker and the caregiver and/or client. Please probe if they have suggestions from their own field about how to measure/monitor service experience.

If time permits, the following questions can also be asked:

12. Do you have examples in which the **health worker experience** was specifically addressed to help improve service experience and/or delivery? Please describe how this was done, the results and challenges, and how it worked.
    a. What could the health system do to support health workers to deliver high quality services?
    b. How can we ensure that these quality skills are being met by the health worker?

13. What are some examples **where communities have been part of defining or monitoring the quality of service delivery**? **Please probe:**
    - *How have they been involved in decision-making?*
    - *What worked/did not work?*

14. Does the immunization or overall health system have **feedback mechanisms to monitor or know when clients are satisfied** with the services they are receiving?
    - *If yes, please explain how this works.*
    - *If not, how could this potentially be incorporated?*

15. Are there other entry or convergence points for immunization where the quality of integration is being explored (like ANC, IMCI, Family Planning, HIV screening)? **Please probe:**
    - *How are these measured and tracked in terms of the service experience?*
    - *How is equal attention to all services ensured – to maximize benefits and minimize any potential negative affects?*

16. Are there any national level initiatives underway to address 'experience of care' for clients and health workers? **Please probe:**
    - *Do these include immunization? If not, how could they potentially be adapted?*
    - *Have these helped to improve demand for services (and if so, how)?*

Before concluding the discussion, please pose the following questions around COVID-19 and service experience to the participant.

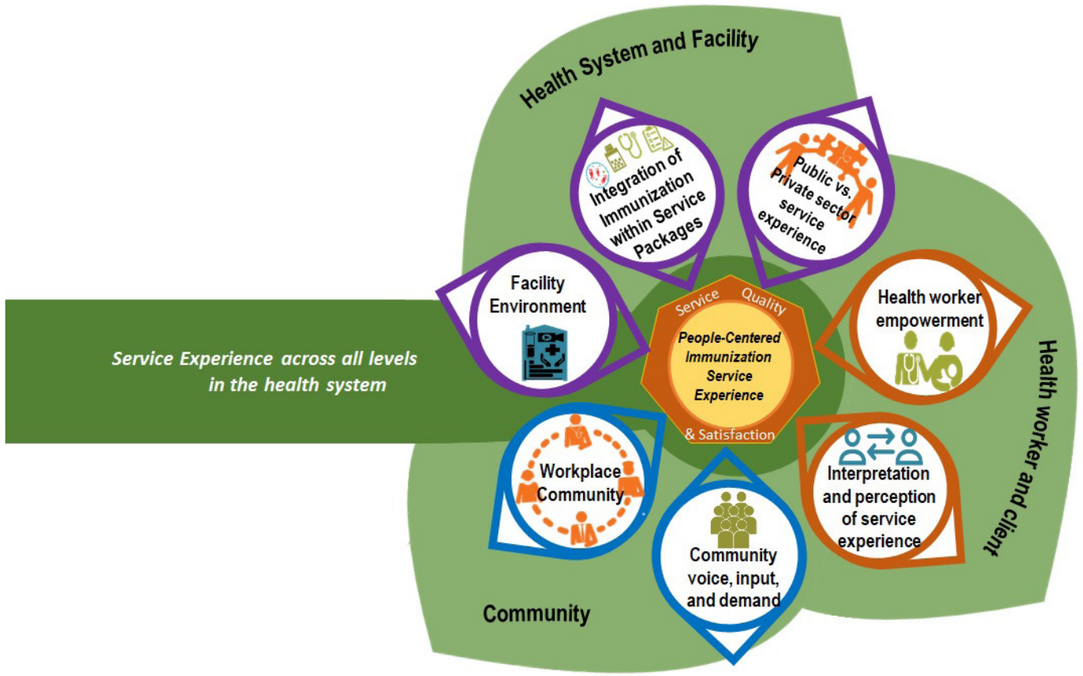
17. Has the [immunization program, or other relevant health program] faced any new or magnified service experience related issues in light of COVID-19?
    a. If so, have you taken any measures to mitigate this? Have they been successful? [**Please probe to understand what was done, who did it, and how they are determining whether or not it has been successful**.]

18. Since the emergence of the COVID-19 pandemic, have you found any changes in perception of health services and service experience? If so, please elaborate. [**Please probe: what have they seen?**]

This concludes our discussion. Is there anything that we have not discussed that you would like to mention?

Thank you for your time and information.

Annex 3. Draft Visual of Key Components of Immunization Service Experience



Annex 4. Demand Hub Service Experience Co-Creation Virtual Workshop Agenda

SESSION TITLE	
DAY 1: SERVICE EXPERIENCE AND COVID-19 MONDAY, 20 JULY 2020; 8:30-11:30 EST/14:30-17:30 GENEVA	
8:30-9:55	Session 1.0 Welcome, Introductions, Objectives
	Session 1.1 Defining Service Experience
9:55-10:00	Stretch break
10:00-11:10	Session 1.2 COVID-19 Insights from the field
	Session 1.3 COVID-19 and immunization service experience: challenges and opportunities
11:10-11:30	Session 1.5 Reflections and Close
DAY 2: UNDERSTANDING NEEDS AND ACTORS FOR PEOPLE-CENTERED IMMUNIZATION SERVICE EXPERIENCE TUESDAY, 21 JULY 2020; 8:30-11:30 EST/14:30-17:30 GENEVA	
8:30-9:25	Session 2.1 Review of previous day; preview of upcoming day
	Session 2.2 Scoping Results: Key informant perspectives on service experience
9:25-9:30	Stretch break
9:30-10:10	Session 2.3 Needs Mapping for Service Experience
10:10-10:05	Stretch break
10:05-11:30	Session 2.4 Service experience needs and actors: who? what? when?
	Session 2.5 Reflections and Close
DAY 3: A WAY FORWARD FOR THE SERVICE EXPERIENCE WORKSTREAM AND PARTNER ENGAGEMENT WEDNESDAY, 22 JULY 2020; 8:30-11:30 EST/14:30-17:30 GENEVA	
8:30-9:20	Session 3.1 Review of previous day; preview of upcoming day
	Session 3.2 2021 Vision for Service Experience Workstream
9:20-9:25	Stretch break
9:25-11:30	Session 3.3 Roadmap for Service Experience Workstream
	Session 3.4 Engaging beyond the Workstream
	Session 3.5 Workstream's Way of Work: Partnership engagement moving forward
	Session 3.6 Final reflections and agreements

Annex 5. Draft 2020-2021 Workplan for the Vaccination Demand Hub Service Experience Workstream (as of 17 December 2020)

The following chart and timeline were drafted during the Service Experience Workstream Co-Creation Virtual Workshop held on July 20-22, 2020 (see Annex 4). The "votes" column to the far left represents the number of Workshop participants who identified the activity as a priority for the Workstream in 2021. This is a live document being used by the Workstream members for 2021 Workstream planning. Activity 1 summarizes the work completed by JSI as part of its contract with Gavi to help frame and contextualize 'service experience' within the Demand Hub and for global, regional and country adaptation and incorporation into future immunization and communication/demand/service delivery and service quality planning. This workplan also provides space to link to activities taking place across the Demand Hub (e.g., see Activity 4) and for the various Workstream partners to link their organization-specific activities relevant for our Workstream to follow and support, as necessary (e.g., see Activity 8).

VOTES	ACTIVITIES	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	POTENTIAL PARTNERS*
3	**ACTIVITY 1: DEVELOPMENT AND FINALIZATION OF STRENGTHENING SERVICE EXPERIENCE TO IMPROVE IMMUNIZATION PRACTICAL RAPID ASSESSMENT TOOLS FOR ADAPTATION**						
	1.1: Refine Service Experience Assessment Tool ('flower' diagram) and four country case studies (i.e., Ghana, Kenya, Mozambique, and Nepal)						JSI
	1.2: Develop co-creation workshop summary document (2-3 pages)						JSI
	1.3: Scoping document incorporating service experience findings from the global literature review and insight gathering across global, regional, and country levels, with co-creation workshop inputs						JSI
	1.4: Update and finalize Service Experience literature review methodology and KII questionnaires/tools with insight from global, regional, and country levels, and the co-creation workshop						JSI
	1.5: Adapt and/or develop 'adaptive management' skills building tools (e.g., virtual, video) for incorporation into practical guidance for countries on service experience (See Activity 2)						M-RITE (to be confirmed)
	1.6: Develop checklists for positive, people-centered immunization service experience at the national and subnational levels, as well as at the health facility level						Workstream members
6	**ACTIVITY 2: PACKAGE SERVICE EXPERIENCE RAPID ASSESSMENT TOOLS (ALONG WITH OTHER EXISTING TOOLS) FOR IMPLEMENTATION RESEARCH WITH PRIORITIZED COUNTRIES**						
	2.1: Develop practical guidance for the adaptation of Service Experience Rapid Assessment Tools for countries, ensuring linkages to existing global and regional level guidance and frameworks (i.e., CEQ; Quality Immunization Planning Guide) and civil society organization (CSO) tools						JSI, WHO
	2.2: Develop COVID-19-specific practical guidance for the adaptation of Service Experience Rapid Assessment Tools to assist countries with operations research to understand the "levers" of positive service experience and adapt solutions to reach priority populations with the COVID-19 vaccine and increase COVID-19 vaccine uptake (link to WHO COVID-19 guidance) (link to Activity 8.1)						JSI, WHO
	2.3: Incorporate guidance for the adaptation of Service Experience Rapid Assessment Tools with Gavi Demand SFA programming guidance						Gavi, JSI
	2.4: Collate and conduct meta-analysis of existing service experience data and learning to-date (notably country tools, case study examples, other resources) to further inform practical tools for countries						Workstream members
	2.5: Create index list of existing tools and resources for country adaptation and use to address key components of immunization service experience (to be available via demandhub.org to external audiences; build also from interventions identified in the SE insight gathering [Activity 1], including non-immunization programs)						JSI can lead (with additional resources); UNICEF and partners for demandhub.org posting
3	**ACTIVITY 3: TECHNICAL SUPPORT TO COVAX FACILITY COUNTRY READINESS AND DELIVERY DEMAND WORKING GROUP**						
	Activity 3.1: Conduct literature review (peer-reviewed and grey literature) for health worker confidence in Ebola and H1N1 vaccines; summarize key findings and recommendations						JSI, UNICEF, BMGF
	Activity 3.2: Develop draft FAQ/Q&A documents with anticipated questions from HW/FLWs about the COVID-19 vaccine and anticipated questions HW/FLWs may receive from communities about the COVID-19 vaccine						JSI, UNICEF, BMGF
	Activity 3.3: Contribute sections to the COVID-19 vaccination training package for health workers (in collaboration with Demand colleagues and CRaD Training Group)						JSI, UNICEF, BMGF
	Activity 3.4: Develop/adapt FLW Decision Aids and tools, including: Job Aid: Flow diagram of potential scenarios with community members and how to approach each Job Aid: Effective Techniques for Interpersonal Communication on Immunization Job Aid: Strengthening Service Experience To Improve Immunization Demand Job Aid: Key Messages for COVID-19 vaccination (BI driven templates with messaging, adaptable visuals in different formats)						JSI, UNICEF, BMGF
	Activity 3.5: Work with ROs/volunteer countries to pretest tools and materials; refine and finalize materials						JSI, UNICEF, BMGF
	Activity 3.6: Adapt COVAX documents and tools to be more general for EPI						
2	**ACTIVITY 4: FOSTER CROSS-FERTILIZATION OF LEARNING ACROSS THE DEMAND HUB**						
	4.1: Sessions on harmonization and cross-learning of Demand Hub Workstreams						

VOTES	ACTIVITIES	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	POTENTIAL PARTNERS*
	4.2: Harmonize Behavioral and Social Drivers (BeSD) of Vaccination tools with service experience tools and work plans: Expand BeSD framework for adult vaccination and HCWs to support an understanding of drivers for vaccination across the life course and implementation of a new COVID-19 vaccine. Determine SE indicators are most important to increase uptake. BeSD user guidance to leverage SE tools and learnings to support use of data to implement interventions that increase uptake and improve SE.						WHO
	4.3: Digital Information Environment…						
	4.4: Engaging with Civil Society…						
	4.5: Behaviorally Informed Interventions…						
4	**ACTIVITY 5: SOCIALIZE THE LEARNING FROM THE STRENGTHENING SERVICE EXPERIENCE TO IMPROVE IMMUNIZATION INSIGHT GATHERING FOR FURTHER ADAPTATION BY OTHER COUNTRIES (WITH SPECIAL CONSIDERATION TO RESTORE ACTIVITIES, GIVEN C-19 RESTRICTIONS)**						
	5.1: Conduct mapping of key audiences and possible channels for dissemination (i.e., webinars, UNICEF regional workshops, EPI RWG meetings, etc.)						JSI and Workstream members
	5.2: Design PowerPoint presentation and online session on learning—such as a webinars—to be adapted per audience and dissemination channel						JSI—liaise with BOOST, others (resources needed)
	5.3: Conduct series of dissemination events with participants identified in collaboration with Service Experience Workstream Members (and in collaboration with other Workstreams, as appropriate)						
	5.4: Identification and alignment of support (with CSO workstream, others) to engage CSOs and professional societies with the service experience adaptation with prioritized countries						JSI, IFRC, AAP
5	**ACTIVITY 6: SUPPORT SERVICE EXPERIENCE IMPLEMENTATION RESEARCH WITH PRIORITY COUNTRIES (WITH SPECIAL CONSIDERATION TO RESTORE ACTIVITIES, GIVEN C-19 RESTRICTIONS)**						
	6.1: Provide technical support to priority countries for Service Experience implementation research						JSI (need additional resources)
	6.2: Facilitate country-to-country learning amongst early adopters and establish feedback loop with countries to influence guidance revision						JSI and other workstream and Demand Hub partners
	6.3: Document country experiences to support learning and continuous revision of global level guidance						JSI (additional resources needed), WHO, and Workstream partners
2	**ACTIVITY 7: WORKSTREAM FUNCTIONALITY**						
	7.1: Develop Terms of Reference for Workstream (to include information about frequency of meetings/calls; cadence of workstream member engagement and alignment; and establishing mechanism for engagement/feedback loop with countries)						JSI
	7.2: Develop plan for resourcing workstream management and overall coordination (within the workstream and across the Demand Hub)						JSI

VOTES	ACTIVITIES	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	POTENTIAL PARTNERS*
	ACTIVITY 8: PARTNER ACTIVITIES THAT LINK TO THE SE WORKSTREAM WORKPLAN**						
	8.1: Pilot the Quality Immunization Planning Guide in 4 countries alongside other quality and service experience strengthening tools, such as "TIP: a human centered approach" to support implementation of COVID-19 vaccines. Develop case studies to document learnings from pilots and finalize guide.						WHO
	8.2:						
	8.3:						
	8.4:						

*Resourcing requires further exploration.

** Activity 8 is being developed and populated by the Service Experience Workstream partners as they plan their 2021 activities and will be updated accordingly.