ASSESSMENT OF OUTREACH IMMUNIZATION SERVICES AS A STRATEGY TO INCREASE IMMUNIZATION COVERAGE TO REACH ZANZIBAR NATIONAL TARGET OF NINETY PERCENT

A CASE STUDY - NORTH "A" DISTRICT OF UNGUJA

ASSESSMENT OF OUTREACH IMMUNIZATION SERVICES AS A STRATEGY TO INCREASE IMMUNIZATION COVERAGE TO REACH ZANZIBAR NATIONAL TARGET OF NINETY PERCENT

A CASE STUDY - NORTH "A" DISTRICT OF UNGUJA

By

Mize Shah Abushir

A Dissertation Submitted to the School of Public Administration and Management in Partial Fulfilment for the Requirement of the Award for the Degree of Master of Science in Health Monitoring and Evaluation at Mzumbe University

2015

CERTIFICATION

The undersigned certify that they have read and hereby recommend for examination of thesis/dissertation entitled, ***Assessment of Outreach Immunization Services as a Strategy to Increase Immunization Coverage to Reach Zanzibar National Target of Ninety Percent. A Case Study - North "A" District of Unguja 2015***, in fulfilment of the requirements for the degree of Masters of Science in Health Monitoring and Evaluation of Mzumbe University

_____

Major Supervisor

_____

Internal Examiner

_____

External Examiner

Accepted for the Board of the Faculty of Public Administration and Management

.....

DEAN, SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

DECLARATION

I **Mize Shah Abushir**, declare that the information in this report is original. It has never been submitted to any institution for any award. It is a result of my hard work and no duplication has been made, however, where necessary recognition has been dully made.

Signature ……

Date ……

COPY RIGHT

ACKNOWLEDGEMENT

First of all, I would like to thank Allah for giving me strength to finish the survey exercises and final evaluation report successfully.

I would like also to extend my gratitude to my employer, Zanzibar Ministry of Health for allowing me to pursue this course and Zanzibar High Education Loan Board and CDC for providing financial support.

In addition I would like to express my grateful thanks to the School of Public Administration and Management (SOPAM- MU), My MU Academic Advisor: Dr. Salvius J. Mbano, Host Organization Advisor: Mr. Abdulhamid A. Saleh, of IRCH/ EPI – Zanzibar, Mr Ali O Ali (Community Health Coodinator- Joining Hands Initiative (JHI), Aga Khan Health Services), DHMTs (North "A") District of Unguja and all service providers and respondents from community who participated in my research for their support and patience during data collection**.**

Furthermore, special gratitude and thanks goes to my lovely husband, Mr. Juma Salum, my lovely sister Mrs. Fatma Shah Abushir, mother in law, Madam Salma Abdullah and all my family for their support, encouragement and for taking care of my lovely daughter Sumaiyya during the time of my course

Also, I would like to extend my sincere gratitude to my colleagues MU (first cohort Msc,HME 2013-14) and Mr Raymond MU M&E Resource person for their support, hospitality, ideas, and warm welcoming attitude accorded to me during the whole period of the study.

Finally I would like to mention Dr Ali Omar Ali – IRCHP Manager and Dr Mtumwa Ibrahim Kombo - Program coordinator (MOH-DPS) for inspiring me to join to this course

May Almighty Allah reward them abundantly, Amen.

DEDICATION

I dedicate this report to my lovely daughter Sumaiyya -dadamaya and in memory of my late beloved dad, Mr. Shah Abushir and my late beloved mum, Maryam Khamis for giving me the foundation of education in my life .

May Allah, rest their souls in eternal peace. Amen

ACRONOMYS

AFP	-	Acute Flaccid Paralysis
c MYP	-	Comprehensive multiyear planning
DPS	-	Directorate of Preventive Services
EPI	-	Expanded Program of Immunization
GAVI	-	Global Alliance for Vaccines and Immunizations
GIVS	-	Global Immunization Vision and Strategy
IDSR	-	Integrated Disease Surveillance and Response
IRCHP	-	Integrated Reproductive and Child Health Program
MDGs	-	Millennium Development Goals
MOH	-	Ministry of Health
MOHSW	-	Ministry of Health and Social Welfare
MU	-	Mzumbe University
Msc HME	-	Master of Science in Health Monitoring and Evaluation
REC	-	Reach Every Community
RED	-	Reach Every District
UNICEF	-	United Nations Children's Fund
WHA	-	World Health Assembly
WHO	-	World Health Organization
ZSGRPII	-	Zanzibar Strategy for Growth and Reduction of Poverty II

ABSTRACT

Reaching the whole target population is one among the five essential components of the WHO/RED Strategy, and an operational approach to achieve immunization coverage. Different approaches for reaching target population enhance delivering of the health services to a large proportion of the population, that is Outreach (fixed site or mobile), Mass campaign and Village Health Day and Nutrition,

The study was conducted to assess the outreach immunization service as a strategy to increase immunization coverage to reach Zanzibar national target of ninety percent. The study was carried out as quantitative and qualitative descriptive case study design involving 100 respondents including 80 community members from 5 selected Shehia in North "A "District of Unguja (Bandamaji, Kinyasini, Kandwi, Fukuchani and Kigongoni); 13 service providers from Chaani Kubwa, Kidoti and Pwani Mchangani health facilities and; 7 supervisors from the District Health Management Teams.

The information was obtained using guided interview questions, documentary review, and checklist/ observation. Data analysis was done by manual sorting, tallying, tabulation on master sheet through electronic software, and the results are presented in figures, tables and percentage (both qualitative and quantitative).

The study findings revealed that the majority 46.15% of service providers interviewed were unskilled personnel (auxiliary worker) who execute outreach immunization services, with no reliable transport to track and follow up the outreach services, (23.75) % of the respondents agreed that outreach settings were not conducive to perform outreach services, and (16.25%) respondents were not satisfied with the services they received at the outreach setting.

The study concluded that, factors limiting reaching unreached population include: weak supportive supervision (30%), weak male involvement (20%), and shortage of qualified staff (50%) to execute outreach immunization services and to reach all target population

.Moreover, community suggested that to increase the number of resources, outreach services should be comprehensive and integrated as well as construction of health facility at every outreach setting to be put into consideration.

The study recommended that the need to increase the demand for and supply of qualified staff so as to improve the utilization of health services and performance of the providers; to intensify community education on the use of the health services and to effectively provide supportive supervisions at regularly (at least monthly or quarterly) to improve staff performance.

TABLE OF CONTENTS

LIST OF TABLES

LISTS OF FIGURES

CHAPTER ONE

INTRODUCTION

1.1 Background

Immunization is one of the most powerful and cost-effective health interventions provided in many countries through the Immunization Vaccine Development (IVD) and as part of the primary health care approach. It is widely recognized as critical to achieve especially the number four and five Millennium Development Goals (MDGs)(National Development Plan, Vision 2020, ZSGRPII:2010 – 2015).

In 2012, immunizations saved two to three million lives (WHO, 2012). However, in the same year 22.6 million infants worldwide were not immunized, only 110.6million got 3 doses (DTP3) vaccine, and about 18.9 million of infants still missing out on basic vaccines.(WHO 2014) The international target for coverage of all antigens is 90% .

In Africa 2012, lots of children are not immunized, particularly those from peripheral, 14.3 million children under the age of one are reached routine immunization in all 21 Eastern Southern African countries, 13 per cent, or 1.8 million, were left unprotected. Most of these children were affected by civil war, and others their families and or communities refused to immunize their children. Almost 90 per cent of all un-immunized children lived in nine countries –Angola, Ethiopia, Kenya, Madagascar, Somalia, South Sudan, Tanzania, Uganda and Zambia(UNICEF, 2006).

In Tanzania the overall coverage at national level is about 90% following the implementation of the Reach Every District (RED) policy intervention (MOHSW Report, 2012).

Zanzibar has reached the global coverage of over 80% of district to have DTP- HepB – Hib – 3 coverage of 80% to sustain the national coverage of DTP – Hep B – Hib 3 from 92.4% in 2011 to 95% and above so as to meet the global set goals (WHO, 1989)

GAVI,2002 and UNGASS, 2002). The Penta 3 vaccine is used as proxy indicator to assess the performance of the immunization program. This is the third (last) dose of Pentavalent which comprises Diphtheria, Pertusis, Tetanus, Hepatitis-B and Haemophilus influenza type-B The population under one year used as the denominator to calculate immunization coverage is based on projections from the National Bureau of Statistics (NBS), 2002; and Tanzania Population and Housing Census - (TPHC, 2002). The coverage over 100% for BCG could be a result of under estimation of the population projections used as denominator. Regardless of the progresses in global vaccine coverage there are disparities in some of the districts both (Unguja and Pemba Island) immunization coverage

Table 1.1: Immunization coverage under one year by District, 2010 to 2012

District	BCG			Penta-3			Measles			Fully immunized		
	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012
Ch/chake	114.0	103.0	98.5	77.3	79.6	66.4	62.5	76.2	68.6	61.6	74.2	65.8
Micheweni	83.2	81.4	75.9	64.4	70.1	58.4	53.7	65.8	63.4	52.2	63.4	61.6
Mkoani	76.9	72.9	72.5	60.6	62.0	56.4	55.9	62.1	61.4	56.2	62.1	61.0
Wete	109.0	105.0	113.0	81.7	87.1	84.4	67.9	85.6	86.3	65.6	85.0	84.6
Pemba	95.4	89.8	89.3	70.9	74.2	66.5	60.0	71.9	69.9	58.9	70.7	68.3
Central	104.0	115.0	112.0	130.0	126.0	117.0	113.0	121.0	123.0	108.0	115.0	114.0
North A	86.6	87.7	108.0	85.7	74.6	71.4	74.5	77.0	73.7	74.5	76.8	71.6
North B	87.5	88.8	81.0	80.3	80.6	69.8	81.5	84.6	80.8	75.4	81.1	76.0
South	86.4	97.8	96.6	109.0	121.0	113.0	103.0	115.0	117.0	102.0	111.0	100.0
Urban	201.0	213.0	237.0	121.0	116.0	105.0	110.0	120.0	129.0	101.0	107.0	105.0
West	122.0	98.5	142.0	108.0	75.8	104.0	91.4	80.1	128.0	87.0	74.4	120.0
Zanzibar	114.0	110.0	120.0	89.0	84.0	81.0	77.7	84.6	90.8	74.6	80.4	84.2

Adopted from Zanzibar Annual Health Information Bulletin (2012)

Description of the program to be evaluated

1.2 Background

Zanzibar Expanded Immunization Program is the one among the unit within the Integrated Reproductive Child Health Program under the Directorate of Preventive Services and Health Education in the Ministry of Health Zanzibar. The main task of the program is to provide vaccination services to children and mothers in order to prevent vaccine preventable diseases. EPI services are provided free of charge to all eligible children and women of child bearing age in both public and private health facilities.

The implementation of immunization services in both Unguja and Pemba zones are coordinated and supervised by Health Management Teams. Unguja has six teams while Pemba has four. The National levels provide supplies, logistics and technical assistance for the zones and districts.

EPI has been contributing substantially to the achievement of the Millennium Development Goal 4 which aims at reducing childhood mortality with a target of reducing the under five mortality rate by two-thirds, by the year 2015.Zanzibar has about 158 Health facilities distributed by districts Out of 158 health facilities, 152 (96%) provide immunization services. In total, there are 68 outreach sessions conducted monthly in all districts of Zanzibar. These services are supported by either National or DHMTs. However health facilities conduct their own outreaches according to their needs by utilizing available resources such as bicycles etc. The minimum number of outreaches per district in a month is 3 while the maximum is 10.

EPI provides vaccination against the 10 targeted diseases from the support of The Republic Government of Zanzibar and United Republic of Tanzania in collaboration with foreign funded projects and programs. These diseases include; Pentavalent which comprises Diphtheria, Pertusis, Tetanus, Hepatitis-B and Haemophilus influenza type-B , rotavirus and Pneumococcal vaccines PCV , Measles, poliomyelitis (polio) and

tuberculosis (TB). Full immunization includes three doses of Pentavalent Vaccine, four doses of oral Polio Vaccine, Measles vaccination and BCG vaccination

VISION: To improve the health of children and women of child bearing age through the provision of immunization services and the control of vaccine preventable diseases.

GOAL: To contribute towards the reduction of under five and maternal morbidity and mortality through disease control initiatives.

OBJECTIVE: To achieve and maintain at least 90% vaccination coverage in Zanzibar, with each district achieving vaccination coverage of about 80%.

1.2.1 Expected programme effects/objectives

The plan is to maintain and sustain high immunization coverage of more than 90%. This can be achieved by supporting low performing districts (North A and North B in Unguja and Mkoani, Chake Chake and Micheweni in Pemba) increase outreach immunization services, improve data quality and eliminate MNT in the high risk districts.

1.2.2 Major strategies

The EPI program has the following strategies in order to ensure quality provision immunization services. These are, Service delivery, Surveillance, Vaccine supply, quality and logistics, Advocacy and communication, Injection safety, Sustainable financing, Human resource capacity, Program management and Accelerated disease control.

1.2.3 Programme activities and resources

In order to execute the quality provision of immunization services. EPI program has the following activities and resources: Vaccine cold chain management, safety injection,

social mobilization and communication, EPI logistic and provision of quality services. supportive supervision and routine immunization and outreach services

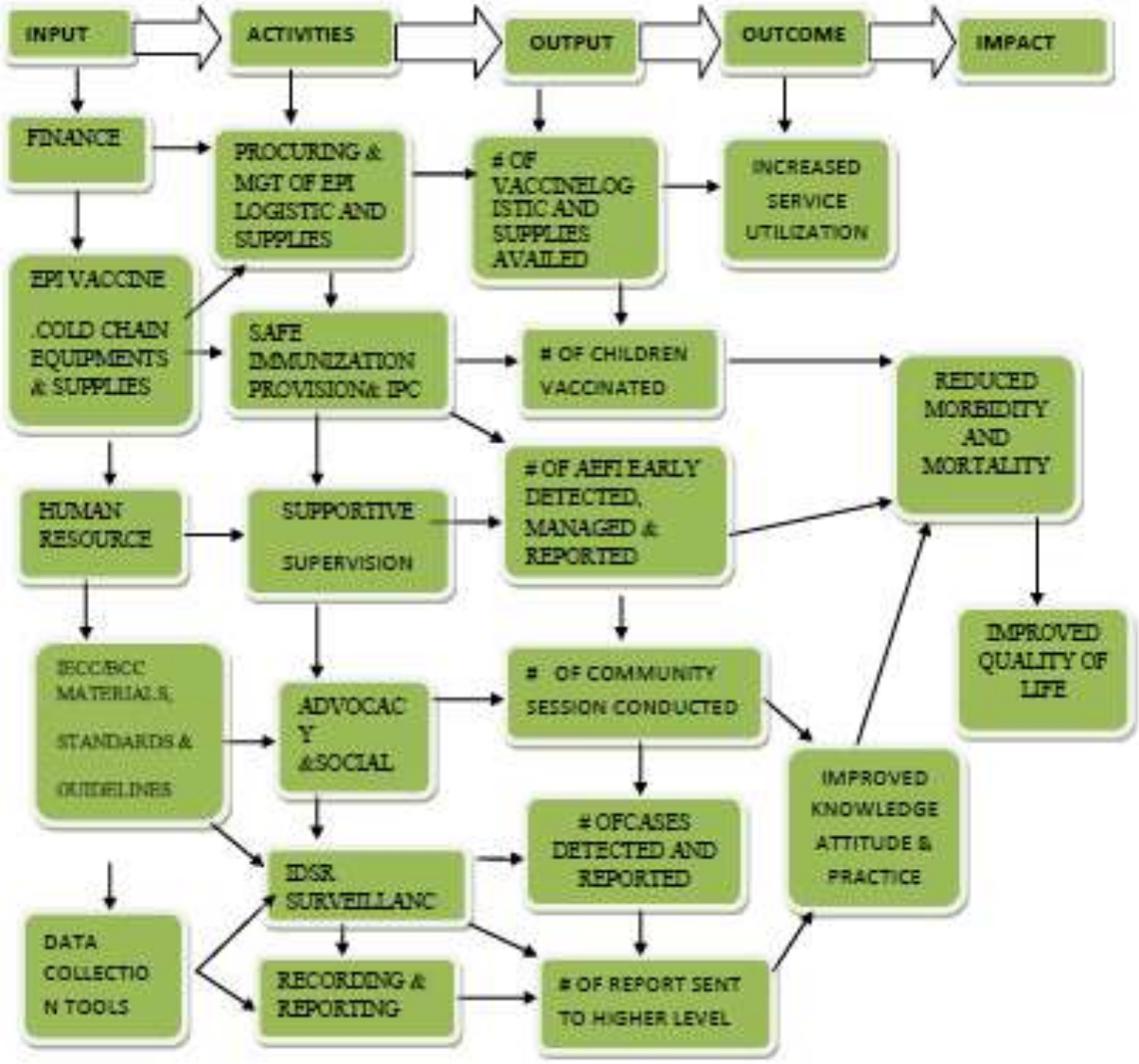
1.2.4 Programme logic model

Logical model- is a visual and systematic way to present the relationship between the intervention and effects, this include needed resources to make the program operational, planned activities, and changes or effects that the program intends to achieve. Therefore, elements for logic models are resources, activities, out puts and short and long term out comes. Frequently presented with a flow of schedules, a map or table, which explains the sequence of steps to reach the program effect

Figure 1.1: EPI LOGICAL MODEL

PROBLEM STATEMENT Low immunization coverage remains a problem in some of the District Unguja and Pemba Island. The routine data shows a decline in coverage from 92% 2011 to 86% in 2012

GOAL : To contribute the reduction of morbidity and mortality for children under five years due to vaccine preventable diseases


INPUT
ACTIVITIES
OUTPUT
OUTCOME
IMPACT
FINANCE
PROCURING & MGT OF EPI LOGISTIC AND SUPPLIES
OF VACCINELOGISTIC AND SUPPLIES AVAILED
INCREASED SERVICE UTILIZATION
EPI VACCINE
.COLD CHAIN EQUIPMENTS & SUPPLIES
SAFE IMMUNIZATION PROVISION& IPC
OF CHILDREN VACCINATED
REDUCED MORBIDITY AND MORTALITY
HUMAN RESOURCE
SUPPORTIVE SUPERVISION
OF AEFI EARLY DETECTED, MANAGED & REPORTED
IMPROVED QUALITY OF LIFE
IEC/BCC MATERIALS, STANDARDS & GUIDELINES
ADVOCACY &SOCIAL
OF COMMUNITY SESSION CONDUCTED
IMPROVED KNOWLEDGE ATTITUDE & PRACTICE
OFCASES DETECTED AND REPORTED
IDSR SURVEILLANC
DATA COLLECTION TOOLS
RECORDING & REPORTING
OF REPORT SENT TO HIGHER LEVEL

1.2.5 Stakeholder analysis

A stakeholder is someone that is involved in your project or has a vested interest in its success or failure. EPI program had different stakeholders which who have different roles and interests on the program. The following key stakeholders were identified basing on their roles to the program. The roles of each stakeholder in the program and in the evaluation are explained below.

Table 1.2: Stakeholders and their roles

S/N	Stakeholder	Roles
1	**Health workers**	These are health professionals who are working in the health facilities in the study area and are involved in vaccination, community mobilization, supervision and management of cold chains of the program. They are very important for program performance and effect
2	**Communities**	These are the direct beneficiaries of the program services because the program objective is achieved through their participation.
3	**District health Management Team:**	These are stakeholders who are monitoring and supervising the program implementation very closely and give important support to vaccination staffs.
4	**Zonal Health Management Team**	These are involved in supervision and monitoring of EPI services.
5	**Medical Teaching Institution**:	public and private organization working in support the EPI program in capacity building and provision of services
6	**Ministry Of Health**	organizer and facilitator of all EPI activities
7	**World Health Organization**	Partner involved in EPI program logistic, technical and financial support
8	**UNICEF**	Partner involved in EPI program logistic, technical and financial support
9	**GAVI**	International organization working with EPI especially in logistic support
10	**Central Medical Store**	Supplier store, procure and distribution of EPI supplies
11	**ZHMIS**	Data entry, analysis and reporting
12	**Mnazi Mmoja Referal HospitaL**	provide service provider, data collector
13	**PHCU, PHCC & District Hospital**	Service providers, data collection & social mobilization
14	**Private Hospitals& Faith Based Hospital**	Service providers, data collection & social mobilization

Stakeholder analysis see stakeholder analysis matrix (Appendices 1)

1.3 Statement of the problem

Low immunization coverage remains a problem in some of the districts in both Unguja and Pemba Islands (Table 1.1). Routine data show a decline in the coverage from 92% in 2011 to 86% in 2012 with North "A" Unguja leading by 78%, followed by Micheweni (63%) and Mkoani (60%), and finally Pemba having the least overall performance of **61.5%**.

Reaching unreached children remains one of the major immunization challenges in many developing countries. It is with this realisation that Reach Every District (RED) approach was implemented in 2002. This approach was initiated by World Health Organization (WHO) and its partners with the aim of improving stagnating immunization coverage and effectiveness in Africa.

Reaching Every District (RED) Approach was introduced in Zanzibar in 2009 with the aim of increasing immunization coverage in every district (Unguja and Pemba) so that all eligible children are reached. The implementation of the RED Approach is indispensable in accomplishing Millennium Development Goals (MDGs) and the Global Immunization Vision and Strategy (GIVS). The RED Approach proposes **5** operational components that include effective planning and management of resources, reaching all target population, supportive supervision, monitoring for action, and linking services with community. The RED approach also encourages countries to use coverage to make analysis of the distribution of un-immunized children and thereby prioritizes districts with poor access and utilisation of immunization services.

Reaching all target population is one of the five essential components of the WHO/RED Strategy, and an operational approach to attain 90% DTP3 coverage at national level and at least 80% DPT3 coverage at the level of District.

Reaching all target populations: reach out to previously under-served, un-reached comm unities in giving support and access to services.

Different approaches to reaching target population enhance delivery of the services to a large proportion of the population that is Outreach (fixed site or mobile), Mass campaign and Village Health Day and Nutrition,

Lack of qualified staff to reaching all the target population and to execute immunization activities in marginalized areas is an ongoing challenge. A study conducted in Anambra State, Nigeria (2011) on analysis of policy development and implementation of the Reaching Every Ward Strategy explored the shortage of qualified staff at the health facility level that directly impinge on implementation of the strategy

Health worker, from Orumba South of Nigeria explained,

"We don't have enough health workers to carry out the outreach services, and when we do, we have to close the health centre. Even when we have staff, they are mainly untrained or auxiliary workers. We are only two trained health workers. This is a rural area and the nurses especially don't like to work here".... (Uzochukwu et al 2011)

1.4 Evaluation questions

1. Does the outreach service contribute to increasing immunization coverage?
2. What are the mechanisms used in the implementation of outreach services?
3. Are there adequate resources availed during the outreach session?
4. What challenges hinder performance of the outreach services?

1.5 Objectives

1.5.1 General Objective

To determine the contribution of outreach services on immunization coverage to reach 90% National target.

1.5.2 Specific objectives

1. To determine the proportion of immunization coverage due to an outreach services?
2. To assess the implementation of an outreach services?
3. To assess the availability of resources during outreach session?
4. To describe challenges that hinders performance of an outreach services?

1.6 Significance of the evaluation

Monitoring and evaluation are important components of a program that should be done at a regular basis in order to determine the program implementation level and its achievements. Therefore the rationale or the need for the evaluation of the reaching the target population through an outreach immunization services are of the following reasons, firstly there is no any evaluation study done so far which describe the implementation of an outreach immunization services, secondly integrated outreach services of EPI program should be frequently assessed to ensure quality services, thirdly to assist the program stake holders to know their program implementation level by providing important information for decision making which improve the services, and lastly the findings obtained will help the program to take the corrective measures for improving immunization coverage so as to reach the targeted population.

CHAPTER TWO

LITERATURE REVIEW

Access to health care refers to the ability of a person to receive health care services, which is a function available and ability to pay for those services **(**McGraw, 2002**)** Utilization of healthcare services for the most vulnerable and underprivileged populations have been recommended by the World Health Organization as a basic primary healthcare concept.

Access to immunization outreach posts and sites is often held back by the topographic characteristics and geographical location to hard to reach areas. It has been suggested that healthcare should be universally accessible without barriers based on affordability, physical accessibility, or acceptability of services. However, even within the developed world, this goal is difficult to achieve, and there are no internationally recognized standards on how to define and measure "equitable access" big disparities exist between the poor and the better off, rural and urban (Brigit *et al*., 2007)

Re establishing of outreach services is an operational approach to reaching the target population aiming to extend the services or to reach the un reach population, Reaching all target population is a service delivery strategy for giving support and access to services to under-served, or un-reached communities.Outreach, Mass campaign and Village Health and Nutrition Day involves delivering immunizations to a large number of people at one or more locations in a short interval of time. All the times reaching >50% of the target population. . The number of outreach sessions has been increased following implementation of RED approach per district; MOHSW (1999) Quality assurance training guidelines for Health workers, defined Outreach services are those activities of a health facility extended to service area or to inaccessible communities to provide service or care of chronically ill patient.

Fixed site refers to services offered at a health facility and or mobile are those that require a trip of more than one day and mobile teams to execute outreach activities,

Therefore, An outreach sessions offer an opportunities to provide women, children, and their families with other vital interventions, such as vitamin A supplementation, de worming tablets, and insecticide-treated nets (ITNs) **WHO/RED** fact sheet (2002)

Mass Immunization Campaign According to MOHSW Zanzibar (2012) EPI Comprehensive Multi Year Plan 2010-2015, Mass immunization campaign involves delivering immunizations to a large number of people at one or more locations in a short interval of time. Also this is an opportunity for community outreach and education about local diseases and the vaccinations used to prevent them.

For instance, Measles mass campaign is a second strategy for measles control and also an opportunity to reach those children who were not reached during the routine immunization services. Study conducted in Zanzibar from 1999 to 2008, showed an increased in immunization coverage, in the first two years (1999-2000), of immunization campaign targeting children under five years in Zanzibar.

While in 2001 and 2002, the campaigns were for children from 9 month to 15 years of age, in 2005 the measles campaign covered children age 9 months to 5yrs.

The coverage increased from 67% in 1999 to 92% in 2002 and decreased by 84% in 2005. The most recent measles SIA (supplementary immunization Activity) in 2008 vitamin A and Mabendazole targeted the under 10years achieved 86% nationally

Child Health Days which became routine in many African countries, have achieved high coverage and have reduced inequalities in accessing basic health services. Child Health Day is conducted twice a year. The strategy led by UNICEF, is to promote routine immunization. The concept of Nutrition Health Day emerged from attempts to increase coverage of basic health and nutrition services in rural areas which are not served by health facilities. It combine the principles of fixed day, fixed-site provision of outreach services such as immunization, antenatal care, food supplements distribution, health and nutrition education with the principles of convergence of services and community participation and monitoring. Preliminary analysis (undated) done in Ethiopia, Uganda and the United Republic of Tanzania shows that child health days have helped to deliver

multiple interventions effectively (including immunization). It has been utilized to improve routine immunization coverage, and to reduce operational costs per child reached. In contrast to other health programmes, successful implementation of immunization programmes in most of African countries it has resulted in high rates of vaccination coverage , reduce missed opportunities and drop-out, increase coverage in poorer performing regions and districts, and promote integrated health services

WHO and partners has marked the last week of April each year as World Immunization Week, aiming at raising the public awareness of how immunization saves lives, encouraging people everywhere to vaccinate themselves and their children against vaccine preventable diseases. Through Vaccination week more than 200 million children and adults worldwide have been reached especially in difficult-to-reach populations, isolated communities and towns with low immunization coverage. In 2013, under the global slogan "Protect your world – get vaccinated", more than 180 countries, territories and areas marked the week with activities including vaccination campaigns, training workshops, round-table discussions and public information campaigns.

Planning and management of resources entails the process of using organization's resources in the most efficient way in terms of man power, goods, equipment and financial. Effective planning depends on proper management of available health resources.Shortage of trained staffs in some areas, insufficient funds, inadequate equipments and supplies, and stock out of vaccines is an ongoing challenge to implement RED Approach to All AFRO countries. By using this plan it has been possible to identify the quantity of the manpower, equipment and material required.

In-depth Evaluation of the Reaching Every District Approach in the African region (2007) Report founded that the program encourage districts to incorporate **RED** activities in their District Comprehensive Health Plans. Most of the Districts and Health facilities plan how to reach the underserved communities. Also maps for catchment

area were obtained in almost of the health facilities did not locate population, and un-reached communities.

Supportive supervision Marquez and Kean (2002) define supportive supervision as a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources , promoting high standards, teamwork, and better two-way communication. The facilitative supervision approach emphasizes mentoring, provision of constructive feedback, joint problem solving, and two-way communication between supervisors and supervisee.

Irregular supportive supervision from national, zonal and to the district level reduces provider's performance on delivering health services. National EPI program supervises districts on quarterly basis while districts supervise health facilities monthly. Some supervisors reported conducting <50% of planned visits due to lack of resources such as staff, transportation and fuel.

In-depth Evaluation of the Reaching Every District Approach in the African region (2007) Report found that in both Kenya and Ethiopia there is no on job training during supervisory visits. Moreover, Services should be evaluated regularly for quality from the client's perspectives. Providers need to be able to create a supportive environment in which clients are sufficiently informed, confident, and encouraged to voice their opinions (Brown et al,. 1986).

Monitoring for action: promoting the use of data for action through utilization of data at all levels (national, zone, districts and facility level).Data quality has improved across the countries; the study was done on Improving quality and use of data through data-use workshops in Zanzibar, United Republic of Tanzania (2012) this was done in quarterly basis where by every district assessed their routine data, critique and share lesson learned. And on the other hand In DRC (Democratic Republic of Congo), the immunization coverage data were analyzed monthly and shared the results with division

directors and the technical subcommittee of the inter-agency coordinating committee, whereby corrective measures were proposed for low-performing areas.

Linking services with communities “Plus” integrating or "linking" vaccination service with other health services and interventions or refers to a set of essential maternal and child health interventions that include vitamin A supplementation, birth registration,

Growth monitoring, distribution of ITNs, immunization, curative care etc. - aiming at to improving and sustaining immunisation coverage by involving the community in all a spects of immunisation services (planning, implementation, monitoring and evaluation)
Integration of immunization with other interventions has grouped as:

- Integrated service delivery example: immunization plus vitamin A for older infants and postpartum women during immunization contacts
- Immunization plus messages about another service example: messages on birth spacing; nutritional counseling
- Immunization plus access to commodities example: vouchers for insecticide-treated nets (ITNs)
- Integrated tools for managing services examples: integrated child health card, integrated supervision checklist

The Earth Institute Columbia University, Columbia Global Centre and South Asia (2013) reported that Village Health and Nutrition Days (VHNDs) were conducted in Medak district by Increasing vaccination coverage and bringing services closer to communities.

Factors for unreached target population

Client -Provider interaction (Zahr, et al 1996) reported that poor women without formal education are more likely to be poorly treated by health professionals. A variety of studies have found that health workers often treat women in a sensitive manner, pay inadequate attention to their concerns and treat them rudely, particularly when they come late for treatment or do not comply with medical advice Nevertheless, positive interactions between women and health care providers can chip in to client confidence and compliance. Staff attitude toward patient factors like lack of motivation, poor working condition, poor remuneration and low social economic status are responsible for the poor staff attitude toward patient. Byamugisha et al.(2010) reported that harsh, critical language directed at Ugandan women from skilled health professionals was a barrier to male participation Harsh treatment of men by health providers discouraged them from returning or participating in PMTCT activities . Furthermore, some providers did not allow men access to ANC settings A study conducted in Kenya by Reece M, Hollub A, Nangami M & Lane K (2010) showed that certain male clients trust traditional healers neither hospitals nor attend ANC clinics.

Distance (Barton and Baganda 1990) found that quality of services were significant barrier to health service utilization, some women may prefer to travel to a far distant facility if they feel that it provides better services, including a range of care options, effective counseling, and convenient hours. In Nigeria, 40 percent of women interviewed at 141 service delivery sites did not attend the clinic nearest their homes. Of those using more remote clinics, 90 percent said that they did so to get better service (Mensch et al. 1994). A study found in Tanzania "Distance might not matter as long as one knows the advantages associated with such a long walk" (Makundi 2001: 20).In turn , a study found in Kenya by Ndiritu et al 2006 on immunization coverage declined with increasing distance from vaccination clinics in Kilifi district.

Supply shortages and infrastructure problem (Leslie J and Gupta, G.R 1998) found that many facilities lack basic supplies and equipment can cause frustration among health workers affecting their interaction with patients seeking care (WHO, Geneva (1995) reported that qualified staffs are working with adequate resources, they are able to manage health problems more effectively, reducing fatalities when services are appreciated and valued by community members

Costs including fees for transportation, services, and supplies, can be another barrier to care. In the 2000 Cambodia Demographic and Health Survey (DHS), women said that lack of money was the main hindrance to obtaining health care (National Institute of Statistics and ORC Macro 2000).

In a study in China, one woman explained,

> *"Of course [when you are sick] you should seek a doctor. But if you have no money, how can you talk about going to see a doctor? Money is the important thing. If you have money, you will go to see the doctor, even if there is no way to go but to walk"* (Wong et al.1996: 1152).

Even free or low-cost reproductive and other health care involves costs, including the opportunity cost of time away from income generating activities (Zahr 1996).

Affordable Services (Ndhlovu 1995) A study in Kenya found that low costs and proximity of services were the two most important factors that attracted them to services).

A study in Bangladesh indicated that families spent money on health care only in a crisis situation. Clients may be willing to accept higher costs if they believe that services are of high quality. In Indonesia, a nongovernmental organization found that clients were willing to pay reasonable fees for quality services on a assortment of women's health needs, including pre- and post-natal care, immunization, nutritional monitoring, and education and birthing facilities (Sadasivam 1995).

Convenient Schedules and Waiting Times Long waiting times and inconvenient clinic hours can prevent clients from obtaining the services they need. A study in Kenya found

that although clinics were officially open from 8 a.m. to 5 p.m., providers discouraged clients from coming in the afternoons and often did not provide services to women who were only able to attend in the afternoon (Population Council 1995).

Some clinics do not post their hours of service, or do not serve clients during certain hours when they are supposed to be open. (Family Planning Service Expansion and Technical Support/John Snow, Inc. 2000: 38. Moreover (Zahr, Vlassof, and Kumar, 1996). Found that, Poor quality can also result from lack of respect for users' needs, inconvenient operating hours, service organized around fixed or rigid time tables, and regulations on who can accompany a woman to a health facility.

Byamugisha et al (2010) Almost women often have to wait for a long time before receiving ANC services because of burdensome administrative procedures which result in poor patient/client through-put in health facilities in turn Men, who frequently are in the paid workforce, are often not in a position to spend nearly the entire day participating in ANC services

Health Belief Model (HBM)

The HBM was developed in 1950's by Rosenstook and Barker to explain why people did not use health services eg use of immunization services, HBM) is an example of the application of value expectancy theory to health education, the model help people to believe that they are susceptible to diseases and feel that it was serious and it would be prevented. It provides checklist for points of emphasis in communicating health messages to public on the other hand it does not consider social pressures and enabling factors existing in communities eg to go to vaccination session.

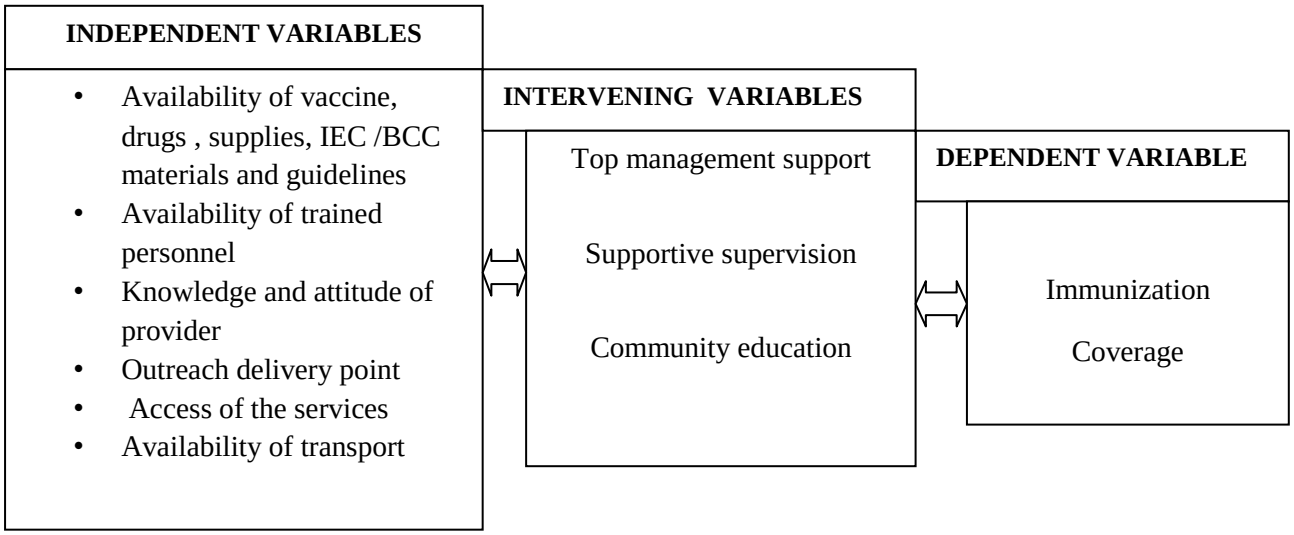
The HBM assumes that behavior change occurs with the existence of three ideas at the same time (Evan Burke 2013)

- ✓ An individual recognizes that there is enough reason to make a health concern relevant (perceived susceptibility and severity)
- ✓ That person understands he or she may be vulnerable to a disease or negative health outcome. (perceived threat)

- ✓ Lastly the individual must realize that behavior change can be beneficial and the benefits of that change will outweigh any costs of doing so. (perceived benefits and barriers)

Thus a person may believe one of the factors above may not perform the action because he did not believe the others. The theory implies that knowledge toward illness, benefit to health care services both preventive and curative and absence of socio cultural disparities are the driving forces for individual and society to utilize health services

Figure 2.1: Conceptual Framework



Source; Researcher's Construct (2014)

The conceptual framework model for this study shows the contribution of an outreach immunization services to reached the all target population that increases immunization coverage (as a dependent) is determined by independent variables; availability of vaccines ,drugs supplies, IEC/BCC materials and guidelines, availability of trained personnel, knowledge and attitude of provider, status of outreach delivery points, access of the services and availability of transport and intervening factors are top management support, supportive supervision and community education to reached the un reach population or un-reached communities.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Evaluation Approach

Formative evaluation is a rigorous assessment process designed to identify potential and actual influences on the progress and effectiveness of implementation efforts (Stetler et al, 2006). This evaluation seeks to strengthen or improve a program or intervention of an outreach immunization services. Therefore the evaluation approach applied for the assessment of an outreach immunization services as a strategy to reaching the target population on increasing immunization coverage.

3.2 Evaluation Design

Case study design was done to assess the contribution of an outreach immunization services to reaching the target population in 5 selected Shehia North "A" District of Unguja namely Bandamaji, Kinyasini, Kandwi, Fukuchani and Kigongoni. The researcher adopted case study design because of its flexibility, less expensive and less time consuming compared to other study designs.

3.3 Evaluation Period

The field work started on 1st February 2015, and was concluded by the submission of final report to relevant authority on 30thJune 2015.

3.4 Study area

North "A" District has been selected to be a site of the study area rather than other districts because of low immunization performance (below 80%) to all antigens for 3 consecutive years (Source: Adopted from Zanzibar Annual Health Information Bulletin (2012)

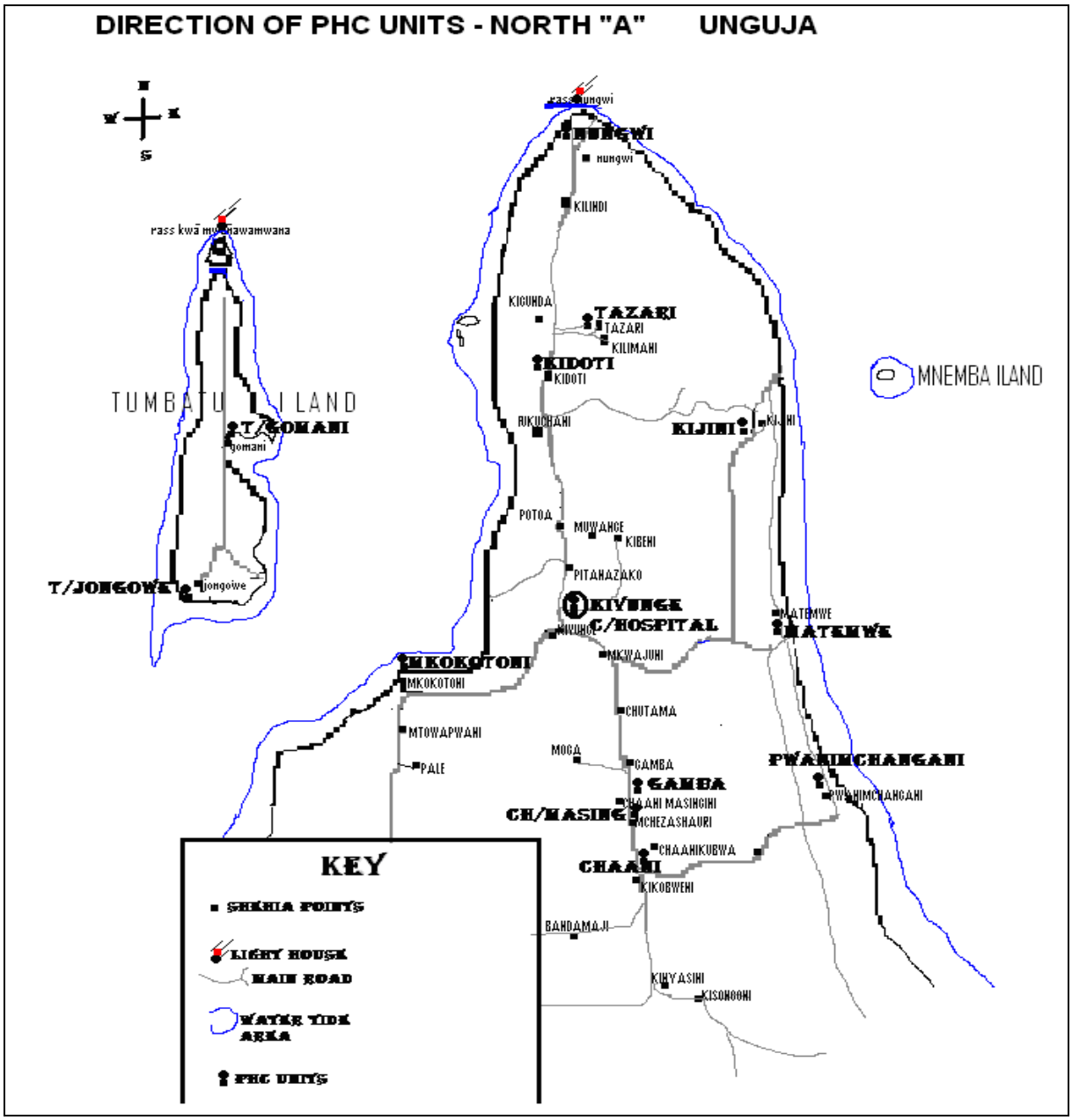
The North ‘A” District is one among two districts of Unguja North region, it is bounded by North “B” District and occupies the area of about 211 sqkm, It has a population of about 112,658 whereby 4,732 are under one age, Under five are 18,025, Women at Reproductive Age are 31,391, surviving infants 4,490, and under 15yrs 47,429 (NBS 2013).

Administratively, North ‘A’ District is headed by the district commissioner (DC) who represent the Central Government while district council is another administrative organ, which represent local Government. North ‘A’ district is divided into 38 Shehias, and (5) constituents.

There are 8 nursery schools, 27 primary schools and 14 Secondary schools that provide formal basic education. There is only one vocational training centre in the district. Also education is acquired through adult education classes which are scattered all over the Shehias and villages.

The District has 12 Primary Health Care Units (PHCUs), one Primary Health Care Centre as a public health services, one maternity wing and three private dispensaries. These health facilities provide both preventive and curative services, which include reproductive and child health services

Figure 3.1: Map of North "A" District of Unguja



Source: North 'A' District profile; CDHP Report of 2014-2015

3.5 Study population and units of analysis

The study population comprised of mothers/caretakers coming to the outreach setting with under 5 years children during data collection period as well as health personnel who provide health services.

The units of analysis comprises health service providers; supervisors; individuals, children; pregnant mothers; lactating mothers; caretakers; geographical units (Shehia, health facility, outreach setting and district); archival records; books and reports

Variables

Dependent variables

- Immunization coverage

Independent variables

- Availability of financial resources, vaccine, drugs, equipments, supplies, IEC/BCC materials and guidelines to implement outreach immunization services.
- Availability of transport including vehicle, fuel to reach the unreached population so as to track and follow up the outreach services.
- Availability of personnel particularly trained personnel to execute outreach immunization services.
- Knowledge and attitude including acquired skills and positive client interaction on providing the services.
- Outreach delivery point including status of the outreach delivery point to carryout outreach services
- Access of the services including acceptability of the outreach services and uses.

3.6 Sample size and sampling techniques

3.6.1 Sample size

The study had a total number of 100respondents as sample size. This included eighty (80) community members from 5 selected Shehia in North "A "District of Unguja (Bandamaji, Kinyasini, Kandwi, Fukuchani and Kigongoni); 13 service providers from Chaani Kubwa, Kidoti and Pwani Mchangani health facilities and; 7 supervisors from the District Health Management Teams (North "A") who were selected purposively

3.6.2 Sampling techniques

The researcher used both probability and non probability sampling technique to carry out this study. Non probability sampling techniques was used purposively to obtain supervisors from North "A "District of Unguja (DHMTs) as well as health facilities. The Probability sampling was also applied in obtaining service providers and community representative who participated in the study.

3.7 Types and sources of data

The study involved two types of data, primary and secondary data. Primary data were collected through interviews using structured questionnaires and observation while secondary data were obtained from various documentary sources including published and unpublished records and reports.

3.8 Data collection methods

Quantitative and qualitative data collection methods were used. Data collected using questionnaires, in-depth interviews for administrator, documentary review and observation

3.8.1 Interview

A researcher was opt self-administered questionnaire where by some questionnaires were filled by Service providers. Also a researcher used the questionnaire to interview community representatives and supervisors.

3.8.2 Documentary Review

The researcher used documentary review method in the study. By reviewing the different published and unpublished documents. The reason was to identify various available information from various documents related to the study. Various sources explored by the researcher including Comprehensive District Health Plan Report 2014-2015, Zanzibar Annual Health Information Bulletin2011, EPI Comprehensive Multiyear Plan 2010-2015, Zanzibar HIS strategic Plan 2012 -2020, information from past researchers on topic related research reports, journals on WHO/RED strategy reports, internet searching and other related documents.

3.8.3 Observation

The observation method was also used by the researcher to collect data without asking the respondents. Through this method the researcher used two types of observation namely participant's observation and non participant's observation. Both methods were used to identify gaps that influence to reach the unreached target population.

Table 3.1: Variables and their measurements

Variables	**Measurements**.
Availability of vaccine, drugs, equipment, Supplies ,IEC/BCC and guidelines	Ordinal measurement
Availability of trained personnel	Nominal measurement
Knowledge and attitude of health care workers	Ordinal measurement
Outreach delivery point	Nominal measurement
Availability of transport	Nominal measurement
Access of the service	Nominal measurement

3.9 Validity issues

The data collection tools were provided with numbers instead of respondents' name, each filled data set was handed over to the supervisor. Data was stored, arranged in sequences and was checked if there were complete and accurate filled and keep them in the safe place.

3.10 Data management and analysis

3.10.1 Data management

Data were manually processed followed with data analysis. The data were checked for its completeness, consistence, outlier, missing, and errors before coding and then entered in the computer for analysis.

3.10.2 Data analysis

For quantitative data

Data-entry was done using Excel software where by data file was exported to SPSS software version 16 for analysis. Results were presented using tables, graphs for clear interpretation.

For qualitative data

Field notes were taken during qualitative data collection by principal evaluator and data collectors. Field notes were transcribed, typed in Ms Word and then summarized into key thematic areas for manual analysis. This intended to get additional information to supplement quantitative data on the research questions, objectives and the findings will be compared and displayed using tables and graphs for clear understanding.

3.11 Ethical issues

Ethical clearance was obtained from Mzumbe University and permission was also obtained from Zanzibar Medical Research Board and North ”A” District commission office/ DHMTs North ’A” District of Unguja and Informed written consent were obtained from the respondents prior administering tools to them (questionnaire and interview guide) The confidentiality maintained throughout of the study.

CHAPTER FOUR

PRESENTATION, ANALYSIS, AND DISCUSSIONOF FINDINGS

4.1 Introduction

This chapter presents the research findings from the study which aimed at exploring the contribution of outreach immunization services as a strategy to reaching the target population that would contribute to increased immunization coverage. The findings were analyzed in response to research objectives and research questions. The objectives of this study were to answer 4 questions: (i) Does outreach services contribute to increasing immunization coverage? (ii) What are the mechanisms used in the implementation of outreach services? (iii) Are there adequate resources availed during the outreach session? And (iv) What challenges hinder performance of the outreach services? The findings have been presented in tabulation and chart for clear interpretation.

4.2 Presentation and Analysis of Findings

4.2.1 Socio-demographic Characteristics

Table 4.1: Distribution of respondents

Respondents	**Frequency**	**Percentage**
Community member	80	80
Service provider	13	13
Supervisor	7	7
Total	**100**	**100**

Source: Field Data (2015)

Table 4.1 shows the number of respondents who were participated in the interviews whereby 80(80%) were community members, 13(13%) were service providers and 7 (7%) were supervisors.

Table 4.2: Distribution of interviewed respondents by sex

Sex	Frequency	Percentage
Female	90	90
Male	10	10
Total	**100**	**100**

Source: Field Data (2015)

Table 4.2 shows that the number of respondents interviewed were 90(90%) female and 10 (10%) were male. This implies that the different respondents participated in the study. There were more females than males because females were using the service more than male and also female personnel were allocated more than male in providing reproductive and child health services.

Table 4.3: Distribution by level of education

Category	Community		Service provider	
Level of education	Frequency	Percentage	Frequency	Percentage
Not attended	28	35.00	0	0
Primary education	13	16.25	1	7.69
Secondary education	39	48.75	5	38.46
College level	0	0	7	53.85
University	0	0	0	0
Total	**80**	**100.00**	**13**	**100.00**

Source: Field Data (2015)

Table 4.3 shows the distribution of the community members interviewed, with their level of education; 28 (35%) did not attend to school, 13 (16.25%) completed primary education, and 39 (48.75) completed secondary education while service providers interviewed shows that 1 (7.69%) finished primary education, 5 (38.46%) completed secondary education and 7(53.85%) had completed college education.

The data shows that majority of respondents have acquired the formal education and know the important of using outreach services.

Table 4.4: Distribution by cadres

Category cadres	**Service provider**		**Category cadres**	**Supervisor**	
	Frequency	**Percentage**		**Frequency**	**Percentage**
Nursing professional	2	15.38	Medical Officer	1	14.28
Public health nurse	5	38.46	Environmental Officer	3	42.87
Maternal and child Aid	**0**	0	Nursing Officer	1	**14.28**
Health Orderly	6	46.15	Pharmaceutical technician	1	14.28
Others	0	0	Administrative Officer	1	14.28
Total	**13**	**100**	**Total**	**7**	**100**

Source: Field Data (2015)

Table 4.4 shows the distribution by cadres whereby 6(46.15%) of service providers interviewed were auxiliary workers, 5(38.46%) were Public health nurse and 2(15.38%) were Nursing professional. This implies that the majority of the service providers interviewed were unskilled personnel who were executing outreach immunization services. The number of supervisor interviewed were 7 (100%); in which 3 (42.87%) were Environmental officers and 1 (14.28%) were Medical Officer, Nursing officer, Pharmaceutical technician, and Administrative Officer respectively. The data shows that the supervisors had mixed background to facilitate supervision.

Table 4.5: Distribution by marital status

Category Marital status	Frequency	Percentage
Single	3	3.75
Married	74	92.50
Divorced	2	2.50
Widow	1	1.25
Others	0	0
Total	**80**	**100.00**

Source: Field Data (2015)

Table 4.5 shows the distribution of the respondents interviewed by marital status were asked to mention their marital status. Service providers and supervisors did not answer this question. 74 (92.50%) of the respondents were married while 3 (3.75%) single, 2(2.50%) divorced and 1(1.25%) percent were widow.

Table 4.6: Type of services offered during outreach

Type of services	frequency	percentage
Immunization only	0	0
Growth child monitoring	0	0
Integrated reproductive and child health	5	38.46
Vitamin supplementation and Mebendazole	0	0
Others	8	61,54
Total	**13**	**100.00**

Source: Field Data (2015)

Table 4.6 shows type of services offered during outreach program. The majority 8 (61.54%) of the respondents mentioned other type of services (including variety of services) and 5(38.46%) revealed integrated reproductive and child health services This implies that during community outreach session there are different type of services provided including vitamin A supplementation, and mebendazole, immunization, Growth child monitoring, health education and bed nets treated with insecticide.

Table 4.7: Distribution of information in relation to return visit

Response	Information		Response	Return visit	
	Frequency	**Percentage**		**Frequency**	**Percentage**
Yes	72	90	Yes	80	100
No	8	10	No	0	0
Total	**80**	**100**	**Total**	**80**	**100**

Source: Field Data (2015)

Table 4.7 shows that 72(90%) of the respondents had received information and 8(10%) received little information. This could be interpreted that the majority of the respondents understood information given by the service provider on the day of outreach immunization services, while 80(100%) of the respondents said that they receive information on their return visit. It means that the majority of the respondents interviewed understood the date for the next outreach services visit.

Table 4.8: Distribution of respondent by waiting time

Category	Frequency	Percentage
Less than 15 min	0	0
30-45min	4	5.00
More than 1 hrs	76	95.00
Others	0	0
Total	**80**	**100.00**

Source: Field Data (2015)

Table 4.8 shows distribution of respondent by waiting time, 76 (95%) spent more than 1 hours and 4(5%) took 30 – 45minutes to wait for the services. This implies that the majority of the respondents spent more time waiting to receive the outreach services; and this is due to the providers that they have to do thoroughly examination with accurate and proper management.

Table 4.9: Distribution of respondent by distance

Category	Frequency	Percentage
Less than 5 km	80	100
5 – 10 km	0	0
10 – 15 km	0	0
15 -20 km	0	0
More than 20 km	0	0
Total	**80**	**100**

Source: Field Data (2015)

Table 4.9 shows the distribution of respondent by distance. 80(100%) of the community members are within 5 km of reach. it implies that the majority of respondents live nearby delivery points and took few hours to reach them..

Table 4.10: Distribution of categories on quality responses

CATEGORY	COMMUNITY		PROVIDER	
	Frequency	Percentage	Frequency	Percentage
Satisfactory	3	3.75	4	30.77
Bad	1	1.25	0	0
Good	76	95.00	9	69.23
Total	**80**	**100.00**	**13**	**100.00**

Source: Field Data (2015)

Table 4.10 shows the distribution of categories on quality responses whereby 3 (3.75%) were satisfied with service providers interaction, 1 (1.25%) not satisfied and 76(95%) thought that the interaction with the providers were good. On the other hand the service providers interviewed out of 13, 4(30.77%) were satisfied with the client interaction and 9 (69.23%) felt good with client interaction. This implies that the clients and service providers had good interaction and relationship during outreach services.

Table 4.11: Availability of vaccines, drugs and supplies

Response Vaccines, drugs and supplies	Frequency	Percentage
Yes	20	100
No	0	0
Total	**20**	**100.00**

Source: Field Data (2015)

Table 4.11 shows the availability of vaccines, drugs and supplies , all respondents acknowledged the availability of vaccines, drugs and medical supplies, this implies that there was no vaccine stock out during outreach services.

"All 7 supervisors from DHMTs North"A" District of Unguja stated,

"We thank God for these three months in the past the stock out existed for some vaccines(such as penta and polio) and now we don't have shortage of vaccine in the health centers, district and at national level".....(Supervisor1,2,3,4,5,6 &7)"

Table 4.12: Outreach setting in relation to in conducive setting

Response Outreach setting	**Frequency**	**Percentage**	**Response In conducive setting**	**Frequency**	**Percentage**
Satisfactory	53	66.25	Open space	5	26.32
Fair	8	10.00	No benches	5	26.32
Un satisfactory	19	23.75	Dirty place	4	21.05
Total	**80**	**100.00**	Poor infrastructure	2	10.53
			Shortage of staff	3	15.78
			Total	19	100.00

Source: Field Data (2015)

Table 4.12 shows that 19 out of 80 (23.75%) of respondents agreed that outreach setting were not conducive to perform outreach services, this implies that majority of the respondents mentioned open space 5(26.32%) percent, no benches 5(26.32%) percent, dirty places 4 (21.05%) percent, poor infrastructure 2(10.55%), shortage of staff 3(15.78%) this should be the reason for the need of in conducive outreach setting.

Table 4.13: Cost of services in relation to service satisfaction

Response Cost of service	**Frequency**	**Percentage**	**Response Service satisfaction**	**Frequency**	**Percentage**
Yes	0	0	Yes	67	83.75
No	80	100.00	No	13	16.25
Total	**80**	**100.00**	**Total**	**80**	**100.00**

Source: Field Data (2015)

Table 4.13 shows that 80(100%) of the respondents did not incurred financial costs for the services, while 67(83.75%) of the respondents had satisfied with the services they received and 13(16.25%) did not. It is not that few respondents were not satisfied with services provided at the outreach setting, though services were user friendly.

Acceptability of outreach services

The researcher asked the providers if the outreach services increase immunization coverage. All 7 supervisors (100%) agreed that acceptability of the services and utilization increased time to time. Interpretation of this is that outreach immunization services make changes on service utilization, and differences were noted before and after outreach immunization services,

> One supervisor from DHMTs North "A" District of Unguja stated,
>
> *Yes," in general, outreach immunization services have contributed to raising the level of coverage, at past, people did not go to the health centre for various reasons such as distance, poor roads, shortage of medicines and staff but now the level is increasing and service is acceptable to follow customers where they are"..... (Supervisor 1)*
>
> And other supervisor added *"some children would have missed, for those who cannot reach the health centre but now are receiving immunization services through outreach delivery points"..... (*Supervisors 3&7**)**

The researcher also asked the supervisors if outreach services, activities are included in district comprehensive health plans. The respondents agreed to this that is why an increase of budget allocation for outreach activities.

> All 7 supervisors from DHMTs North"A" District of Unguja stated, "Every *year we set aside district funds outreach services in the comprehensive district health plan. 2012/13* ***Budget*** *3,200,000/=, 2013/14* ***Budge****t 3,810,000/= 2014/15* ***Budge****t 5,685,000/=* (Supervisor1,2, 3,4,5,6 &7)

Furthermore, researcher asked the mechanism used to mobilize community for outreach services. The respondents mentioned that different mechanisms were used to mobilize community to utilize outreach services.

Supervisors stated**,**

> ***"****We use Shehas (village leaders)to motivate people as well as in quarterly meeting we do request providers to educate the public about the outreach immunization services " (Supervisors1&7)*
> *And "we use in the village health day to educate the public about the use of outreach immunization service".....* (Supervisors 4 & 2**)**
> **"***We encourage them to use Shehas (village leader) midwives and health committees"..... **(****Supervisors5&6)*

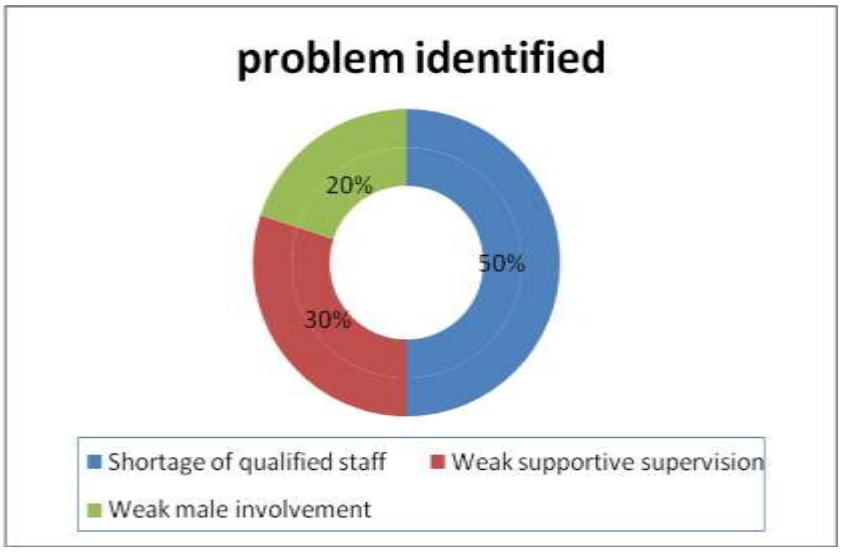
Supportive supervision for improvement of outreach services

Marquez and Kean (2002) define supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources , promoting high standards, teamwork, and better two-way communication…..,The goal of supportive supervision is to improve the quality of workers' performance as it deals with and solves the existing gaps, On the other hand , Services should be evaluated regularly for quality from the client's perspectives. Providers need to be able to create a supportive environment in which clients are sufficiently informed, confident, and encouraged to voice their opinions (Brown et al,. 1986) In-depth Evaluation of the Reaching Every District Approach in the African region(2007) Report found that in both Kenya and Ethiopia there is no on job training during supervisory visits the same the study finding revealed that there is no supportive supervision during outreach services,

Supervisors from DHMTs North "A" District of Unguja said that,

> *"They did irregular supportive supervision*"**....** **(**Supervisors1, 4&5) and others stated, "*there is no reliable transport and delay to release the fund for fuel, this makes difficult to track and follow up the outreach services*"....(Supervisors 6,7,2&3).

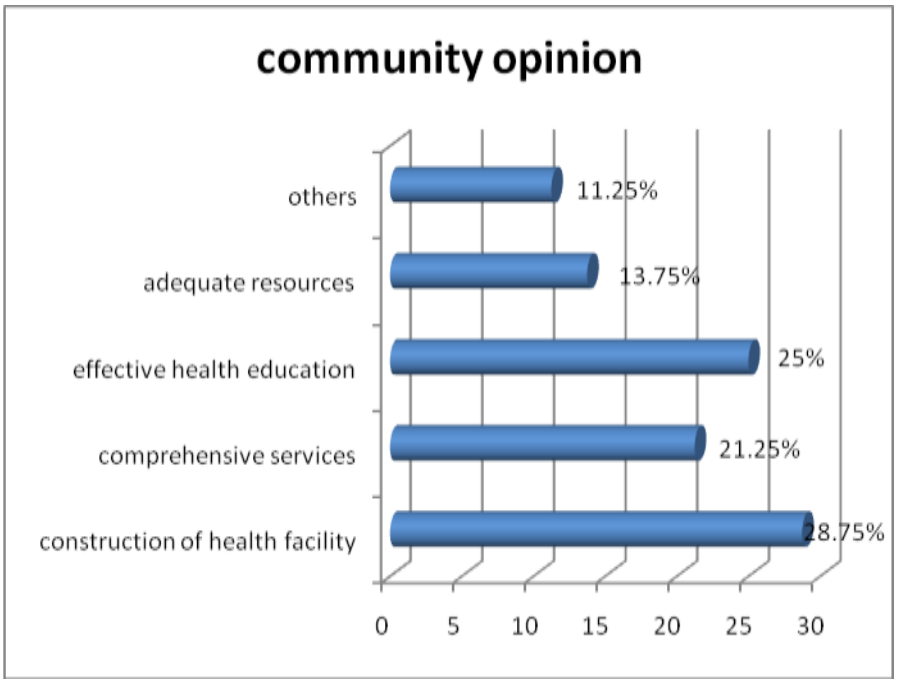
Figure 4.1: Problem that hinder performance of outreach services



Source: Field data 2015

Figure 4.1 shows problems that hinder performance of outreach services. These were identified by the providers and supervisors in delivering outreach services includes shortage of qualified staffs 10 (50%), weak supportive supervision 6 (30%) and weak male involvement 4 (20%). shortage of qualified staff is the most challenging problem followed by weak supportive supervision and weak male involvement.

Figure 4.2: Community opinion(s) for improvement of outreach services



Source: Field data 2015

Figure 4.2 shows that the community opinions for improvement of outreach services include increased number of resources, effective health education, provide comprehensive services, and construction of health facility and others. This study revealed that (28.79%) mentioned that construction of health facilities could improve outreach services. This is followed by effective health education (25%),adequate resources (13.75%) and lastly others (11.25%).

4.3 Discussion of Findings

4.3.1 Proportion of immunization coverage

Regarding to the research objective, it was noted that an outreach services could increase immunization coverage. The increase in immunization coverage was attributed by an increase in the number of outreach delivery points which are easily accessible. This encourages mothers/caretakers to take their children for outreach immunization services. The study noted that,

"Many *children we would have missed, immunization services since they were not able to reach the health centres but now are coming to outreach delivery points".....* **(**Supervisor 3&7)

and this result was supported by the *Zanzibar EPI*-cMYP(comprehensive multiyear plan) **(**2010-2015)report of mass immunization campaign delivered to a number of people at one or more locations in a short interval of time and also an opportunity to reach those children who were not reached in routine immunization services. Study conducted in Zanzibar from 1999 to 2008, showed an increased coverage from 67% in 1999 to 92% in 2002 and 84% in 2005 and in 2006 (86.7%)respectively.

4.3.2 Implementation of outreach services

Regarding to the research objective, it was noted that outreach immunization services were coordinated and supported by district, and Health facilities were implemented accordingly. The study found that in Zanzibar, every district allocate money in each year to implement outreach immunization services,

All 7 supervisors from DHMTs North "A" District of Unguja stated that,

> "Every *year we set aside district funds outreach services in the comprehensive district health plan. 2012/13 Budget **3,200,000**/ =, 2013 /14 Budget **3,810,000**/= 2014/15 Budget **5,685,000**/=* (Supervisor 1, 2, 3,4,5,6 &7)

And this result support the study conducted in Anambra state Nigeria, one immunization officer, from Ekwusigo ward explained,

> *"Every month UNICEF release money to us for collection and distribution of vaccines as well as for outreach. We have motorcycles. They also sponsor our monthly health workers' meetings and are planning to conduct training for outreach services for our health workers,....(Uzochukwu et al 2011)*

4.3.3 Availability of resources

Regarding to the research objective, of availability of resources, it was noted that availability of resources is a key factor in delivering health care services. The study found that there were no vaccines stock out.(Table 4.11) WHO/Geneva (1995) reported that if qualified staffs are working with adequate resources, they are able to manage health problems more effectively, reducing fatalities when services are appreciated and valued by community members. In turn the study by (Leslie J and Gupta, G.R 1998) found that many facilities lack basic supplies and equipment can cause frustration among health workers affecting their interaction with patients seeking care

4.3.4 Challenges that hinder performance of outreach services

Regarding to the research objective, of challenges that hinders performance of an outreach services, it was noted that factors and challenges are inter twin that banned the implementation of outreach services and provider's performance. The study found some obstacles which delayed reaching the intended goals such as shortage of qualified staffs (50%), weak supportive supervision (30%) and weak male involvement. (20%). These result are supported by the study conducted in Anambra State, Nigeria (2011) on analysis of policy development and implementation of the Reaching Every Ward Strategy explored the shortage of qualified staff at the health facility level that directly impinge the implementation of the strategy to reach the un reach population. (Uzochukwu et al 2011) and then pointed frequent and prolonged vaccine stock-outs, shortfall of resources and transportation for covering hard-to-reach population and this

contributed to failure in adhering to set service schedules, postponement or cancellation of outreach activities, inability to provide services when mothers came to the centre,

Table 4.14: Evaluation Dissemination Plan

The dissemination of the evaluation report will be done immediately after my supervisor approval. The report will be disseminated as follows

- Conduct a one day meeting with key stakeholders including Ministry of Health Zanzibar
- Submit the final report to Mzumbe University
- Share findings report with communities

The dissemination schedule is indicated below

SN	Stakeholder	Information needs	Dissemination format	Means of communication
1.	Mzumbe University	Dissertation report of the evaluation findings	Written report and oral presentation	Conference Meeting / workshop
2.	Donors	Evaluation report findings	Written report	Email
3.	MOH	Evaluation report findings	Oral presentation	Briefing meeting
4.	EPI Program officers	Evaluation report findings	Written report	Briefing meeting
5.	Zonal /District health management Teams (supervisors)	Evaluation report findings	Written report	Briefing meeting
6.	ZHMIS unit	Evaluation report findings	Written report	Sharing evaluation meeting
7.	Service provider	Evaluation report findings	Written report	Data use workshop
8.	Public and private health institutions	Summary of the report Findings	Written report	workshop
9.	Community	Summary of the report findings	Fact sheet Display IEC materials	Social mobilization evaluation meeting

Source: Researcher's construct (2015)

CHAPTER FIVE

SUMMARY, CONCLUSION, AND POLICY IMPLICATIONS

5.1 Summary

In this chapter, the researcher provide the summary, conclusion of finding and policy implication, the main objective of this study was to determine the contribution of outreach services on immunization coverage to reach 90% National target ,examine if outreach service met its goal for reaching the target population but specifically was to determine the proportion of immunization coverage due to an outreach services, to assess the implementation of an outreach services, to assess the availability of resources during outreach session and lastly to describe challenges that hinders performance as well implementation of an outreach services.

5.2 Conclusion

In light of the above findings, the researcher therefore concludes that there was some factors that hinder the contribution of outreach services to un reached target population in Zanzibar (North 'A' District of Unguja):

- Shortage of qualified staffs
- Weak supportive supervision and
- Weak male involvement

5.3 Policy Implications

5.3.1 Areas for Further Action

Based on the result found from the study and conclusions given, there was various area identified where by action should be taken:

(a) Shortage of human resource for health

This is a worldwide problem and is a critical factor for health service delivery.

For the aim of providing quality of outreach services and to ensure community satisfaction the problem of qualified staff are existing, so there is a need for Ministry of health (MoH) and District health management team (DHMTs) to priorities employment and fairly distribution of qualified staff to district especially those difficult to reach area in order to meet minimum staff requirements as to execute outreach immunization services as a strategy to reaching all the target population. This is also in consistency with (Uzochukwu et al 2011) explored the shortage of qualified staff at the health facility level that directly impinge on implementation of the Reaching Every District (RED) strategy.

(b) Weak male involvement

Involving men in reproductive health is crucial to the achievement of 4^{th} and 5^{th} Millennium development goals within and beyond the health sector. In most families the men are empowered financially and are the main decision-makers in all issues including reproductive health. Similarly a study conducted by the United Nations Population Fund (UNFPA) in Kenya found that husbands greatly influence women's decisions to use reproductive health services such as family planning (UNFPA 2009).

More education is required to impart the men with knowledge on the importance of their involvement and uses for better reproductive health services. A study conducted in Kenya by Reece M, Hollub A, Nangami M & Lane K (2010) showed that certain male clients trust traditional healers neither hospitals nor attend ANC clinics and some providers did not allow men access to ANC settings and discouraged them from returning or participating in PMTCT activities Furthermore, the policy need to mainstream male involvement in reproductive health , and intensified community education through mass media such as radios, news papers, TV, leaflets and posters, community theatre groups can be used to ensure the message reaches to the all community.

(c) Weak supportive supervision

Regular supportive supervision is vital that provides critical support and guidance for the delivery of health services and managing human resources for health care .By doing so, Supervisors play a critical role in achieving high quality service provision. But there is no reliable transport and delay to release the fund for fuel, this makes difficult to track and follow up the outreach services. Therefore, Ministry of health (MOH) can ensure that adequate funds are timely available as well as to encourage district health management teams (DHMTs) to adhere to integrated supportive supervision guideline so as to conduct standard integrated supportive supervision to improve provider performance and make changes to improve services at a health facility. As well as a supportive and conducive working environment is a key success factor for any organization, this is because results are achieved to service providers performance .And also Ministry of health (MoH) can consider the impact of employees' needs, motives that drives increasing employees' commitment that will improve organization performance.

5.3.2 Programmatic implications and use of findings for strategic planning

Transport is necessary that facilitate supervision and outreach services to be done effectively, but unreliable transport and delay to release the fund for fuel cannot manage to implement the planned activities. It is crucial for the program to set into consideration not only vaccines but also availability of all necessary resources. MOH can foster the employment of professional staff so as to achieve a goal, towards the reduction of under five and maternal morbidity and mortality through disease control initiatives.

Moreover , In order to make the programs to perform more successful, Training Plan should be put in place for all health workers (proficiency in-service training, proficiency specialty training) so as to up-to-date their knowledge, attitude and skills in delivering health services for betterment of the provider - client's needs and satisfaction.

5.3.3 Limitations

This evaluation study have some limitation like other studies, the study conducted in North ”A” District, particularly in a selected facility due to financial constraint it does not give the whole picture of outreach immunization services of the program in the region

5.3.4 Areas for further research/evaluation

Further studies specifically focused to service provider on cold chain management will be useful for monitoring and evaluation of vaccine management in North A district, Zanzibar.

REFERENCES

Benjamin, Onwughalu, Erick, Blas, Obinna, Onwujekwe, Daniel Umeh, Uche Ezeoke (2011)Immunization programme in Anambra State-Nigeria, *Analysis of policy implementation of Reaching Every Ward Strategy.*

Brown, L, D.et el. (un dated) *Quality Assurance of Health Care in Developing Countries* 'The Quality Assurance Project, Centre for Human Services.

Brugha RF, Kevany JP: Maximizing immunization coverage through home visits: a controlled trial in an urban area of Ghana. *Bulletin of the World Health Organization* 1996, 74(5)**:**517-524.

Byamugisha R, Tumwine JK, Semiyaga N, Tylleskär T. *Determinants of male involvement in the prevention of mother-to-child transmission of HIV programme in Eastern Uganda*: a cross-sectional survey. Reprod Health. 2010;7:12. doi: 10.1186/1742-4755-7-12.

Coninx R, Dupuy C, Hermann C, Ribeiro GC, Margot M, Lucic K: Vaccination of the civilian population in a country at war: it can be done; it can also be evaluated**.** *The ICRC experience in Mozambique. Journal of Tropical Pediatrics* 1998, 44(3)**:**186-188.

Cutts FT, Kortbeek S, Malalane R, Penicele P, Gingell K: Developing appropriate strategies for EPI: A case study from Mozambique. *Health Policy & Planning* 1988, 3(4)**:**291-30

Children's Vaccine Program, Path (December 2003) Guidelines for Implementing Supportive Supervision*: A step-by-step guide with tools to support immunization*

EPI(2012) Annual IRCH/EPI Review meeting report.

Gorgens,M,Kusek,J,Z (2009) Making Monitoring and Evaluation System Work

Global Immunization Vision and Strategy 2006-2015 Geneva: WHO and UNICEF; 2005.

Global Polio Eradication Initiative. *2005 annual report* Geneva: WHO, Rotary International, CDC, UNICEF; 2006 (WHO/Polio/06.02)

Graham. And Murray, S. (1997) *A Question of Survival?* Review of Safe motherhood", Ministry of health Kenya.

http:/safe motherhood fact sheet: improve the quality of maternal health care.org

http://www.nhchc.org/wp-content/uploads/2012/02/Outreach_OrganizingHealth

Journal of Public Health 2009, **32**(1)**:**18-25.

Jørn B,a Arthur H & Sundeep S.(2011) *Improving quality and use of data through data-use workshops,* Zanzibar, United Republic of Tanzania

Partapuri, T, Steinglass,R and Sequeira,J (2012**)** Integrated Delivery of Health Services During Outreach Visits: *A Literature Review of Program Experience Through a Routine Immunization Lens*

Penchansky R, Thomas JW. The concept of access: *definition and relationship to consumer satisfaction.* Med Care 1981; 19(2):127–140.

Reece M, Hollub A, Nangami M, Lane K. Assessing male spousal engagement with prevention of mother-to-child transmission (PMTCT) programs in western Kenya. AIDS Care. 2010;22(6):743–750. doi: 10.1080/09540120903431330

Liz C. Creel, Justine V. Sass, and Nancy V. Yinger (july 2002)sclient-centered quality: clients' perspectives and barriers to receiving care, population Council and Population Reference Bureau

Mangeni, J N, Mwangi, A , Mbugua S and Mukthar V, (February 2013): Male Involvement in Maternal Health Care as a Determinant of Utilization of Skilled Birth Attendants in Kenya, A Review by the United States Agency for International Development.

MoH (2012)EPI Comprehensive Multi Year Plan 2010-2015.

MoH/ZHMIS (2011) Annual Health Bulletin

MoH/ZHMIS (2012) Annual Health Bulletin

MoH/HMIS (2011) Zanzibar Health Information Bulletin

MoH/OCGS/RGO (2012 -2020) Zanzibar HIS Strategic Plan

Nath, B., Singh, V., Awasthi, S.,Bhushan, V., Kumar, V, & Singh, S.K.(2007) *Indian Journal Medicine*, 61(11)598-606.

Oruamabo RS, Okoji GO: Immunisation status of children in Port Harcourt before and after commencing the Expanded Programme on Immunisation. *Public Health* 1987, 101(6):447-452.

Rosslyn, VA (2007) More juice from the squeeze: linking immunization services with other health interventions. Snapshots Newsletter Issue 5.

Rosenstoch I. Historical origin of Health Belief model. Health Educ Monogr 2:334, 1974.

Ryman T, Macauley R, Nshimirimana D, Taylor P, Shimp L, Wilkins K: **2009** Reaching every district (RED) approach to strengthen routine immunization services: evaluation in the African region.

Tandon BN, Gandhi N, the Integrated Child Development Consultants: Immunization coverage in India for areas served by the Integrated Child-Development

Services programme. *Bulletin of the World Health Organization* 1992, **70**(4)**:**461-465.

The Earth Institute of Columbia University ,Columbia Global Centres & South Asia-Mumbai(2013) strengthening village health and nutrition days

Vandelaer J, Bilous J, Nshimirimana D: Reaching Every District (RED) approach: a way to improve immunization performance. *Bull World Health Organ* vol. 86(no. 3)

WHO (2013) Immunization Coverage Fact Sheet 378, Weekly Epidemiological Record 1, Nov2013 vol.88, 44/45(pp.477 -488).

WHO (Nov 2009) Immunization Vaccination Development, Reach Every District (RED) Approach

WHO: *Microplanning for immunization service delivery using the Reaching Every District Strategy.* (WHO/IVB/09.11) WHO Geneva;

WHO, Geneva,(march-june1995) *Quality of care :Doing Things the things the right way"* , Safe *motherhood Newsletter,No.17* WHO, UNICEF, CDC, USAID, Immunization Basics (2007) In – depth Evaluation of the Reaching Every District Approach in the African Region

APPENDICES

STAKEHOLDER ANALYSIS MATRIX

Appendix I

Stakeholder	Role in the program	Interest or perspective on evaluation	Role in the evaluation	Means of communication	Level of importance
Ministry Of Health (TWG)	Organizer, Set standards. Protocols and procedure Identify indicators for evaluation according to national priorities	-Adherence protocol, standards/procedures/progress of the planned activity.	Internal evaluator, Set indicators and targets according to strategy plan and essential health care package national and global priorities.	Meetings Sending written report	Medium
Zonal/ District Health Management Teams(Z/DHMTS)	Service supervisor at zonal and district level	Supportive supervision to district for the implementation of the EPI activities.	Partner in evaluation activities, provide human resources	Meeting &direct Conversation	High
Donors(WHO, GAVI,UNICEF)	Support financial and technical advisors	-Quality performance of the progress and outcome of planned and implemented interventions	-external evaluator -decision maker and Facilitation of evaluation activities including resource provision	Meeting. Report sharing	Low
ZHIMS	Data entry, analyses, reporting and storing	Provide quality data that can be used for decision making	Data entrant and data analyzer and reporter of all information.	Meeting and informing through formal conversation	Medium
EPI Technical working groups	Program implementer -facilitate/supervise Implementation of an activity.	-progress and performance of the evaluation activity.	-internal evaluator -advisor and support evaluation	-meeting /sharing evaluation report -reviews meeting report	Medium
PHCU,PHCC, District Hospital, Faith based and	Service provider data collector and social mobilization	Implement the planned intervention	Services of information	interview	High

private hospital					
Mnazi Mmoja Referral Hospital	Service providers, data collector.	See the outcome/ progress of the planned and implemented intervention.	Information providers (source of information)	Interview	High
Medical Training Institution	Service providers, data collection & social mobilization	ensure guidelines are reflected in their pre- and in – service training	Partner in evaluation activities	Information/ report sharing	Medium
Central Medical Store	Supplier store ,procure and distribution of EPI supplies	For clearing and storing of vaccines	Partner in evaluation activities	Report meeting	Medium
Community & Community Leaders	Beneficiary	Provide reliable information according to service received	Primary source of information	Interview/ small group discussion	High

Appendix 2

FOMU YA RIDHAA YA USHIRIKI KATIKA UTAFITI

MADA : TATHMINI YA HUDUMA YA MKOBA ZA CHANJO KAMA NI MKAKATI WA KUWAFIKIA WALENGWA KATIKA KUINUA KIWANGO CHA CHANJO KUFIKIA ASILIMIA 90 KITAIFA HAPA ZANZIBAR

Mimi, Mize Shah Abushir ni mwanafunzi wa shahada ya uzamili ya ufuatiliaji na tathmini huduma za afya (MSC in Health Monitoring and Evaluation) kutoka chuo kikuu Mzumbe – Morogoro Tanzania

Ili kukamilisha masomo yangu inanilazimu kufanya utafiti kuhusu tathmini ya huduma ya mkoba za chanjo kama ni mkakati wakuwafikia walengwa katika kuinua kiwango cha chanjo kufikia asilimia 90 kitaifa hapa Zanzibar, washiriki wake watakuwa ni wasimamizi wa huduma za Afya,wahudumu wa Afya na wananchi wanaopata huduma ya mkoba katika maeneo yao.

Napenda kuchukua fursa hii kukuomba ushiriki katika utafiti huu, uteuzi huu umekuja kwani wewe ni miongoni mwa watu muhimu katika kufanikisha lengo la utafiti huu.

HISTORIA

Utafiti na uteuzi huu unakusudia kueleza mchango wa huduma ya mkoba katika kuinua kiwango cha chanjo kama ni mkakati wakuwafikia walengwa, kwa kuangalia uwepo wa watoa huduma wenye taaluma, uwepo wa madawa na vifaa, utekelezaji wa miongozo ya kutolea huduma,kuanisha vikwazo na maoni ya kuboresha huduma ya chanjo za mkoba.Kukamilika kwa utafiti huu utasaidia katika kupanga na kuandaa mikakati ambayo itasaidia kuboresha huduma ya chanjo za mkoba na kuinua kiwango cha chanjo.

UTARATIBU

Ikiwa utakubali kushiriki katika utafiti huu, utatakiwa kujibu maswali ambayo yametayarishwa ili kugundua mambo yanayohusiana na huduma ya mkoba za chanjo.Usaili huu utachukuwa muda wa dakika 10 – 15 katika usaili huu hutapaswa kutaja jina lako na taarifa zote zitazotolewa zitatumika ili kufanikisha dhamira ya utafiti huu na si vyenginevyo.

FAIDA

Ushiriki wako utasaidia kuandaa mikakati ya kuboresha huduma ya mkoba za chanjo katika kuwafikia walengwa, hakutakuwa na faida nyengine yoyote utakayopewa kutokana na ushiriki wako katika utafiti huu.

USALAMA WA MSHIRIKI

Hakutakuwa na hatari au tishio la hatari litalotokana na ushiriki wako katika utafiti huu, taarifa zitakazopatikana zitakusanywa,zitafanyiwa uchambuzi na kutolewa tafsiri na mimi na baadae zitawasilishwa katika chuo kikuu Mzumbe, kazi hii hatopewa mtu mwengine au kuchapishwa kwenye mitandao bila ya kibali cha chuo, taarifa zote zitakuwa ni siri na zitatunzwa kwwa usalama katika idara ya utafiti ya chuo kikuu Mzumbe.

HIARI

Ushiriki katika utafiti huu ni jaribio la hiyari, wakati zoezi likiwa linaendelea utakuwa huru kuuliza swali lolote, kuamua kuendelea au kujitoa katika utafiti bila ya adhabu au fidia yoyote, utakuwa na haki ya kukataa kujibu swali lolote wakati utafiti unaendelea.Kama kutakuwa na wasiwasi wowote ,utataka kuuliza swali au kutoa maoni baada ya usaili unaweza kuwasiliana nami kupitia simu ya mkononi nambari + 255777 767140 au barua pepe : mizebush@gmail.com

Mimi ……, nimefahamu maelezo , dhamira na utaratibu kuhusu utafiti huu, kwa hiyari yangu nimekubali kushiriki na nategemea matokeo mazuri kutokana na utafiti huu.

Sahihi / dole gumba la msailiwa …….. Tarehe ……..

Sahihi / dole gumba la msaili …….. Tarehe ……..

Appendix III

PROGRAM /SUPERVISOR QUESTIONNAIRE

Dear Sir / Madam,

My name is Mize Shah Abushir, a student pursuing Master in Health Monitoring &Evaluation in Mzumbe University .This study is part of requirements for the fulfilment of the award of Master in Health Monitoring & Evaluation. You are kindly requested to respond to this questionnaire. The required information will be treated confidentially and only for academic purpose and not otherwise. I thank you in advance for your good cooperation, assistance, time and effort spent to complete questionnaire.

1. Please answer all questions to the best of your knowledge. Your participation is entirely voluntary

2. Don't write your name. Indicate your response by ticking in appropriate box or filling in the blanks

Number of Respondent ☐

PART 1 Demographic Information

1). Sex/ Gender of Respondent

(1) Male (2) Female ☐

2). what is your current professional?

1). Medical Officer ☐

2) Environmental Officer

3). Nursing Officer

4) Pharmaceutical technician

5) Administrative Officer

6) Others (specify)……

PART 2 Services delivery

3).Does the outreach services contribute to increasing immunization coverage?

(1)Yes (2)No ☐

4) If, yes (specify)……

5) Who is involved in conducting outreach services?

1). Supervisor ☐

2) Service provider

3) Others (specify)……..

6) Do there any supportive supervision during outreach services?

(1) Yes (2)No ☐

7) If, no (state the reason)……

8) How many outreach services conducted per district?

Mention.....

9) Is there any difference in outreach immunization coverage before and after?

(1) Yes (2)No ☐

10) If yes, (explain)……

11) Are there adequate vaccines and supplies for the outreach session?

(1) Yes (2)No ☐

12) Does the district integrate an outreach services to the comprehensive district health plan?

1) Yes 2) No

13) If yes, specify how much money allocated to outreach services?

……

14) What is the mechanism used to mobilize community to outreach services?

……..

15) What are the challenges that hinder performance of an outreach services?

,…….

Thank you for your cooperation

Appendix IV

SERVICE PROVIDER- SELF ADMINISTERED QUESTIONNAIRE

Dear Sir / Madam,

My name is Mize Shah Abushir, a student pursuing Master in Health Monitoring &Evaluation in Mzumbe University .This study is part of requirements for the fulfilment of the award of Master in Health Monitoring & Evaluation. You are kindly requested to respond to this questionnaire. The required information will be treated confidentially and only for academic purpose and not otherwise. I thank you in advance for your good cooperation, assistance, time and effort spent to complete questionnaire. Please answer all questions to the best of your knowledge.

1. Your participation is entirely voluntary

2. Don't write your name. Indicate your response by ticking in appropriate box or filling in the blanks

Number of Respondent ☐

1). Sex/ Gender of Respondent

(1) Male (2) Female ☐

2) Age ☐

3) What is the level of education?

1) Not attended to school

2) Primary education ☐

3) Secondary education

4) College education

5) University

6) Others (specify)

4) What is your current professional?

1). Nursing professional

2) Public health nurse

3). Maternal and child Aid

4) Health Orderly

5) Others (specify)……

5) What type of services provided during outreach?

1) Immunization only

2) Growth child monitoring

3) Integrated reproductive and child health services

4) Vitamin A supplementation and Mebendazol

5) Others (specify).....

6) Are the outreach setting conducive to providing outreach services?

(1) Yes (2)No

7) If No, (state why)…….....

8) Are there adequate vaccines and supplies during the outreach session?

(1) Yes (2)No

9) if no ,where do you find the stock for outreach session?

.....

10) What are the client- provider interactions on providing outreach services?

1) Satisfactory

2) Bad

3) Good

11) What are the challenges that hinder performance of an outreach services?

……..

……

Thank you for your cooperation

Appendix V

CLIENT INTERVIEW QUESTIONNAIRE

Dear Sir / Madam,

My name is Mize Shah Abushir, a student pursuing Master of Science in Health Monitoring & Evaluation in Mzumbe University. This study is partial of requirements for the fulfilment of the award of Master of Science in Health Monitoring & Evaluation. You are kindly requested to respond to this questionnaire. The required information will be treated confidentially and only for academic purpose and not otherwise. I thank you in advance for your good cooperation, assistance, time and effort spent to complete this questionnaire.

Your participation is entirely voluntary

Number of Respondent ☐

1). Sex/ Gender of Respondent

(1) Male (2) Female ☐

2) Age ☐

3) Marital status

1) Single

2) Married ☐

3) Divorced

4) Widow

4) What is the level of education?

1) Not attended to school

2) Primary education

3) Secondary education

4) College education

5) University

6) Others (specify)

5) Did you get information on the day at outreach immunization services?

(1) Yes(2) No

6) Are the outreach setting comfortable for providing outreach services?

(1) Satisfactory (2) Fair 3) Unsatisfactory

7) If No,3 (state why)……

8) What is the estimated distance from your home to the outreach services?

1) Less than 5 Km

2) 5 – 10 Km

3) 10 – 15 Km

4) 15 – 20 Km

5) More than 20 Km

9) How long did you wait when you arrived at this facility up to when you got the services?

1) Less than 15 min

2)30 min

3) 30-45min

4) More than 1 hrs

5) Others (specify)……..

6) Are you satisfied with the services you received?

1). Yes2) No ☐

7) Did you incur any costs for the services you received?

1). Yes2) No ☐

8) What are the client- provider interactions on providing outreach services?

1) Satisfactory

2) Bad ☐

3) Good

9) Did the provider advised the client a return visit?

1). Yes2) No ☐

10) What are the community opinions for improvement of outreach services?

……

Thanks for your cooperation

Appendix VI

EPI CHECKLIST

Ministry of Health Zanzibar

Expanded Program me on Immunization (EPI)

Supervisory Checklist

Date of supervision ……..

Region …….. District …… Health Facility…… … Total population …… 0-11 months …… … Pregnant Women …….. WCBA…….

1. COLD CHAIN:

1.1 How many refrigerators and freezers are available? Fridges (….), Freezers (….)

Cold chain equipment specification and functioning

Make	Model	Source of Power	Balance of Gas/Kerosene	Temperature reading during visit

1.2 Is there non-functioning cold chain equipment? Yes ( ) No ( ). How many……

1.3 Is there a log sheet for each fridge/freezer? Yes( ) No. ( )

1.4 Review the temperature chart of the refrigerator(s)/freezer(s) at the district vaccine store or health facility for the last 3 months? Is it up to date? Yes ( ) No. ( ) Supervisor comment on temperature monitoring ……... ……

1.5 For H/facility: What is the average number of days does one full gas cylinder takes to run out of gas (…)

1.6 For electricity refrigerator, check if it has Voltage regulator/surge protector: Yes( ) No. ( )

1.7 Is the evaporator covered with thick frost? Yes ( ) No. ( )

1.8 Is door seal good (paper test)? Yes ( ) No. ( )

1.9 Is there a functional thermometer inside? Yes ( ) No. ( )

1.10 Check if temperature is recorded twice/daily? Yes ( ) No. ( )

1.11 Inspect the refrigerator and the vaccines and comment; (location, cleanliness, arrangement)……
……

1.12 Inspect the vaccines in the refrigerator, and look if there is frozen DPT-HB-Hib,rotavius, PCV or TT vaccines or freeze watch burst? (Do shake test)……..
……

1.13Any vaccines stock out (shortage) during or in the last 6 months? (Verify vaccine ledger) Yes ( ) No. ( )

1.14 Current Vaccine Stock:

Vaccine	No. of Vials (Physical count)	No. of Vials (Ledger readings)	Dose per vial	Stage of VVM	Date(s) of Expiry
BCG					
BCG diluents					
OPV					
OPV droppers					

Any comments……

……

1.16 Is there a separate store/shelter for storage of LP gas cylinders Yes ( ) No. ( )

1.17 Is there a Swahili user's manual for refrigerator? Yes ( ) No. ( )

2. RECORDING AND REPORTING:

2.1 Is a record kept for each child who attends the health facility Yes ( ) No. ( )

2.2 In the: Daily register Yes ( ) No. ( )

Permanent Register Yes ( ) No. ( )

2.3 Are there (a) specific immunization days Yes ( ) No. ( )

(b) specific centre hours Yes ( ) No. ( )

2.4 Is the annual target population for immunization estimated and recorded/displayed Yes ( ) No. ( )

2.5 Is the monthly target population to be immunized and those actually Immunized being monitored on a performance graph or chart? Yes ( ) No. ( )

2.6 Are there monthly reports from the health facility sent in within a period Of two weeks after the end of each month to the district/regional level

Yes ( ) No. ( )

3. FOLLOW-UP OF DEFAULTERS:

3.1 How many outreach/mobile sessions were done in the last 3 months …….

3.2 Do they have a clear plan for outreach/mobile service? ……..

Outreach services

Planned Outreach services	Conducted outreach services	%

3.3 Reasons for cancellation outreach services

……

3.4 Map of catchments and outreach/mobile area (micro plan)?

……

4. INJECTION SAFETY:

4.1 Did you have stock out of AD syringes or mixing syringes in the past 6 months?

(Verify with the ledger) Yes ( ) No. ( )

4.2 Which type?.....

After use, do personnel re-cap needles? Yes ( ) No. ( )

4.3 Which are the main reasons of recapping…….

4.4 Is a specific container used for discarded syringes and needles?Yes ( ) No. ( )

If so, which type? (e.g. safety box) …… (Inspect the container) …….

4.5 What happened to the content of the container with discarded syringes/needles?

i. Buried ( ) – Burned ( ) – Burned and buried ( ) – Incinerated ( )

ii. Discarded with health facility or hospital refuse ( )

iii. Discarded in public trash collection system ( )

iv. Other ……

v. Do you have incinerator Yes ( ) No. ( )

vi. If Yes, please mention type …….

vii. Year of construction……..

5. MULTI DOSE OPEN VIAL POLICY AND VVM:

5.1 Are there any open vials of BCG and Measles in the fridge?Yes ( ) No. ( )

5.2 Ask the health worker what is the open vial policy vials of DPT-HB-Hib/TT/OPV

……

5.3 Ask the health worker when an open vial of BCG / Measles should be discarded (Know) (Don't know)

5.4 Ask the health worker when does the VVM says do not use the vaccine (Know) (Don't know)

6. SUPERVISION:

6.1 Does DCCO/DRCHCO, RCCO/RCHCO, or national supervisor make regular supervisory visits? Yes ( ) No. ( )

SUPERVISION AND DISTRIBUTION CONDUCTED BY DCCO/DRCHCO/RCCO/RCHCO			
Date	Title	Purpose of Visit	Supervisors comment in Book 2

6.2 When was the last time the staff were invited for an EPI technical meeting at District or Regional level? ……

7. DISEASE SURVEILLANCE

7.1 Reported Measles Suspects

Age group	**No: of reported cases**	**No. Of Cases with Blood specimens**	**Vaccination status**	**Deaths**	**Positive Lab Results**
0 – 8 Months					
9 – 59 Months					
6 – 10 Years					
11 – 14 Years					
15 and Above					
Comments on the cause of outbreak					

7.2 **Reported AFP cases**

Number of cases	**Days of investigation after onset of paralysis**		**60 days follow up**	Remarks
	Within 14 days	**After 14 Days**		

7.3 **Reported suspected NNT cases**

Reported Neonatal deaths by community	**Facility neonatal deaths**	**Investigated**	**NNT**	**Remarks**

7.4 Reported AEFI ……Investigated ……

7.5 Does the health staff conducts community active search for Measles, NNT and AFP? Yes ( ) No ( )

7.6 If No, what are the main reasons……

8. COMMUNICATION AND SOCIAL MOBILISATION

8.1 Are there any immunization posters displayed in the health facility Yes ( ) No ( )

8.2 When was the last PHC meeting conducted? …… (Verify the meeting minutes)

8.3 Was there any community sensitization meeting/activity? Yes ( ) No ( )

8.4 Observe the first five clients if are given information on type of vaccine given, disease it prevent, possible side effects, number of doses needed for complete schedule and date for next dose Yes ( ) No ( )

9. REFERENCES IMMUNISATION MATERIALS AT HEALTH FACILITY

9.1 Is there a manual of Mwongozo wa mafunzo na utoaji chanjo, TanzaniaYes ( ) No ( )

9.2 Is there a manual of Jokofu Sharabu Litumialo Gesi Yes ( ) No ( )

9.3 Measles case based health facility manual Yes ( ) No ( )

9.4 Are there EPI standard case definition posters Yes ( ) No ( )

10. COMMENTS/VIEWS BY WHOM SUPERVISED

……

……