Health FacilityReadiness for MR2 Roll-out

- Most health facilities (HF) had updated child health cards and a good defaulter tracking system in place. A few had updated registers and tally sheets
  59% HF were completely prepared for MR2 roll-out, 38% partially prepared, and 2% did not know
- Overall health system support needed for MR2 roll-out: HCW Training, Communication materials, support supervision for HCW, financial support and vaccination supplies and sundries used during immunization

Community readiness for MR2

- Willing to embrace MR2 because they know its value of protection against measles. Community leaders reported routine vaccination is highly accepted and sensitization will improve acceptability of MR2

Health care worker-caregiver interaction

- HCW perspective: 77% of HCW found it very (56%) or somewhat easy (21%) to communicate with caregivers
- Community perspective: Caregivers experienced unpleasant interactions, sometimes harsh treatment:
  - » HCW blamed caregivers for carrying children in dirty linen
  - » HCW spoke to mothers harshly when they missed appointments or brought children late for vaccination or treatment
  - » Bypassed mothers and their babies in queues without greeting; mothers described them as not caring

RECOMMENDATIONS

Suggested strategies to improve MR2 roll-out

- Effective communication strategies and materials for caregivers such as:
  - » Messengers: VHTs, HCW, health educators, community and religious leaders
  - » Mode: Large-scale campaigns, churches, schools, pictorial short messages on posters and billboards
  - » Content: Benefits of MR2, information on AEFIs and how to manage them, dispel any myths and rumors.
- Continuous sensitization of caregivers by HCW on vaccines
- Peer-to-peer approaches: to share their positive experiences and success stories about measles and promote MR2
- Using family-based approaches to involve fathers and other influential family members to support the mother and child(ren) for vaccination
- School-based approaches to involve teachers to talk about MR2
- Vaccine mandates, where appropriate
- Improving access to vaccines, especially in hard-to-reach areas
- Improve human resources for health services
- Improve coordination within existing health systems and community structures for improving vaccine supply, logistics, and delivery
- Capacity building of health care workers for vaccine delivery and communication
- Improving use of information, communication, education (IEC) materials to reach wider community beyond only mothers

THE REPUBLIC OF UGANDA MINISTRY OF HEALTH

CDC Centers for Disease Control and Prevention

AFENET African Field Epidemiology Network

UNIPH Uganda National Institute of Public Health

Makerere University

IDI Infectious Diseases Institute

THE REPUBLIC OF UGANDA MINISTRY OF HEALTH

Rapid Community Assessment (RCA) to Understand Knowledge, Attitudes, and Perceptions of Measles-Rubella Second Dose (MR2) Introduction

Project Collaborators:
UNEPI, CDC Global Immunization Division, CDC Uganda, AFENET, IDI and NIPH

BACKGROUND

Project objectives:

1. Explore community knowledge, perception, and potential facilitators and barriers of MR2 uptake in Uganda
2. Understand health care worker knowledge, training, skills, and capacity building on the introduction of MR2
3. Identify strategies from a community and HCW perspective that can support the introduction of MR2 in Uganda

METHODS

RCA conducted in: 18 districts (8 lowest, 8 highest MCV1 coverage and 2 recent measles outbreak districts) in September 2022

Key Outputs of MR2 Roll-out RCA Project

- Rapid survey with HCW completed in 71 facilities among HCW (4 in each district)
- Qualitative interviews completed (18 FGDs with caregivers, KII with 17 Health managers and 18 key community representatives)
- Data analysis, synthesis, and triangulation conducted. Related findings were shared with UNEPI and other stakeholders

RESULTS

Barriers – knowledge and perceptions of MR2

Among caregivers

- Most noted concerns about adverse events following immunization (AEFIs)
- Need a better understanding of the purpose MR2
- Fear of receiving multiple vaccines at once

Barriers – household and community

- Household barriers: lack of support from husbands for vaccination due to low knowledge and awareness, poverty, domestic violence, and alcohol abuse
- Community barriers: Some religious sects are against vaccination (e.g. triple 6 cult, Bisaka) which may cause caregivers to hide their children from vaccination. Others like Rwakisaka don't allow any activity on worship days ; political affiliations and mistrust of vaccines (e.g., negative talk about vaccination side effects, like barrenness), poor communication channels may affect effective communication
- Limited time and workload during harvest season prevents female caregivers from taking their children for vaccination

Among ADHO

- Barriers – infrastructure: Poor transport means to reach facility, long distance, poor terrain and weather
- Barriers – health system: Vaccine stock-outs, cold chain issues, vaccine wastage, and inadequate funds to support vaccination, capacity to manage AEFI, community receptivity of multiple vaccines being introduced so closely (e.g., COVID-19, polio)

Readiness for MR2 Roll-out

Health care worker readiness for MR2 introduction

- 4% of HCWs were aware of upcoming training on MR2, 49% were not aware, and 47% did not know (this was prior to the roll-out of cascade trainings and may have changed)
- Only 7% of HCW had received training on MR2
- 72% of HCW were ready and confident in implementing MR2 rollout
- Training & Mentorship: HCW need training on immunization practices, including the administration of MR2 and related communication to recipients; need continuous mentorships (lower level HCW)