BID INITIATIVE

Better data. Better decisions. Better health.

BID INITIATIVE BRIEFS: RECOMMENDATIONS AND LESSONS LEARNED

Rollout strategy

The BID Initiative is grounded in the belief that better data, plus better decisions will lead to better health outcomes. It was designed in partnership with countries to enhance immunization and overall health service delivery by improving data collection, quality, and use. The BID Initiative takes a holistic approach to address immunization data challenges and strengthen evidenced-based decisions through a package of interventions including people, products, policies, and practices. These briefs summarize the approaches and interventions that the BID Initiative rolled out and shares recommendations and lessons learned for others interested in improving immunization data quality and use.

BACKGROUND

The BID Initiative's rollout strategy addresses aspects of implementation with products, practices, and people as it brings interventions to districts and facilities. The goal of the rollout strategy is to build the awareness, access to information, motivation and empowerment to act, and skills needed to improve data quality and use across the health system.

The initial rollout strategy for the data quality and use interventions was developed in September 2014. It focused on conducting five "touches" (or visits) to every facility offering immunizations in the targeted region/ province to provide on-the-job training to health workers. One or two BID staff members conducted each visit, which featured specific activities designed to strengthen the data use culture and provide continuity with other touches to ensure smooth implementation of the full

package of interventions.

Since completion of the initial rollout design in 2014, both Tanzania and Zambia have learned many lessons that have led to the evolution of the strategy for both countries.

WHO CONDUCTS THE ROLLOUT

Tanzania, which began implementation of data use and data quality interventions first, learned that to strengthen intervention sustainability and accelerate rollout, ownership would need to come from the district. Although the Community Health Management Teams (CHMTs) originally provided ongoing technical support to health facilities, because of time demands and various areas of technical focus, the CHMTs shifted to a supervisory role. In the new strategy, individuals working for a particular

PATH

Data Use Mentors

Knowledge and skills needed by Data Use Mentors included knowledge of the health system, experience using data for decision-making, and basic computer skills. Their responsibilities included:

1. Training and mentoring health care workers on data quality and use interventions.
2. Offering ongoing technical support to users in facilities.
3. Providing technical inputs and support on data use to the CHMT during supportive supervision.
4. Offering ongoing mentorship to health care workers on data use.

district (local government staff) were identified by the district authority and received comprehensive training to enable them to lead the rollout of interventions to health workers. These individuals became known as District Immunization Mentors and later as Data Use Mentors. This shift improved the rollout by allowing more facilities to receive the interventions in a shorter time and to receive more timely and ongoing support. Consequently, the adoption of the interventions became smoother and more sustainable.

Based on the success of this rollout strategy in Tanzania, Zambia adjusted its strategy to cover three phases and transitioned the touches over time from BID staff to district staff. BID staff conducted the first touch. For the second touch, BID staff led a two-day lecture-style training of trainers with district staff so they could become experts and owners of the interventions. Within two days after this training, district staff, with support from BID, led a lecture-style training for health workers in their district on how to use the electronic immunization registry (EIR) for data entry and data use. The remaining two touches were then led and owned by the district for reinforcement and ongoing support in building a culture of data use.

TIMING OF THE TOUCHES

The timing of touches was orchestrated to give nurses enough time to adopt and practice using the new tools as well as have enough data to begin monthly supportive supervision with the district. Initially, the time between touches was determined based on whether facilities provided a high or low volume of immunizations. The timing was adjusted as we learned more about the back entry of data into the EIR (how much data was needed, what the data source would be, and who would do that back entry), and with the shift to more district-led rollout strategies. The time between Touch 2 and Touch
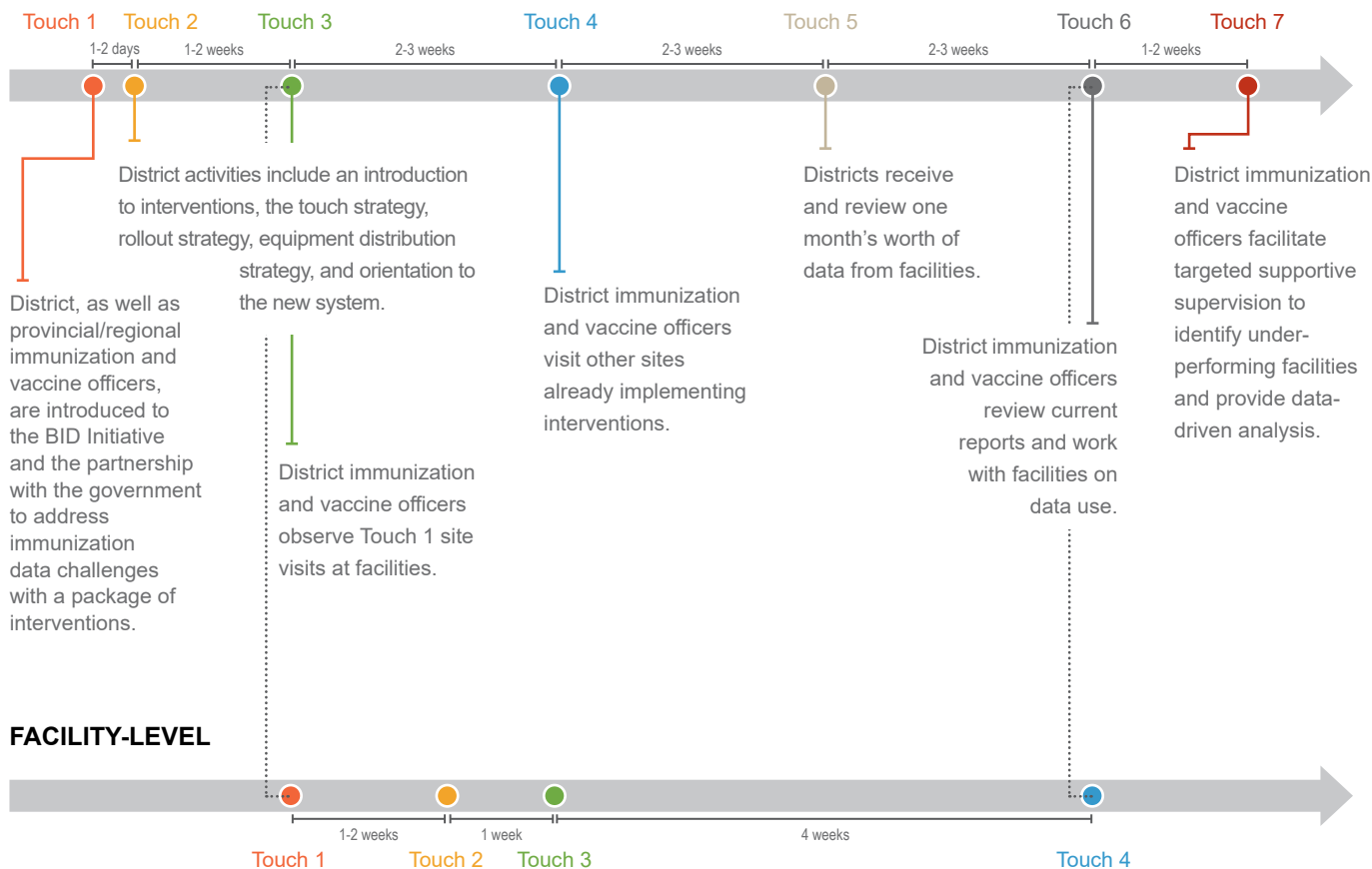
High-volume facilities see more than 50 children each month. Low-volume facilities see 49 or fewer children each month.

FIGURE 1: The following figure depicts the duration between each touch at a district and facility level. This timeline reflects Tanzania's and Zambia's consolidated strategies, but based on lessons learned, each country has adapted the timeline to their specific needs.

DISTRICT-LEVEL

Touch 1 — 1-2 days — Touch 2 — 1-2 weeks — Touch 3 — 2-3 weeks — Touch 4 — 2-3 weeks — Touch 5 — 2-3 weeks — Touch 6 — 1-2 weeks — Touch 7

District, as well as provincial/regional immunization and vaccine officers, are introduced to the BID Initiative and the partnership with the government to address immunization data challenges with a package of interventions.

District activities include an introduction to interventions, the touch strategy, rollout strategy, equipment distribution strategy, and orientation to the new system.

District immunization and vaccine officers observe Touch 1 site visits at facilities.

District immunization and vaccine officers visit other sites already implementing interventions.

Districts receive and review one month's worth of data from facilities.

District immunization and vaccine officers review current reports and work with facilities on data use.

District immunization and vaccine officers facilitate targeted supportive supervision to identify under-performing facilities and provide data-driven analysis.

FACILITY-LEVEL

Touch 1 — 1-2 weeks — Touch 2 — 1 week — Touch 3 — 4 weeks — Touch 4

---

3 was shortened to one week in both countries as we learned that nurses needed to be followed up with after receiving the new data entry tools (e.g., tablets or revised paper forms) to support their use of the tools. The time between Touch 3 and Touch 4 in both countries was set at one month, which allowed facilities time to enter one month's worth of data, produce reports, and then receive supportive supervision from their district on the use of the data in their daily work.

RECOMMENDATIONS BASED ON LESSONS LEARNED

Several key recommendations have emerged based on lessons learned from the BID Initiative's partnerships with the governments of Tanzania and Zambia to roll out various data use interventions:

1. **Engage the community.** It's important to engage mothers so they understand the changes they see at the facility and what those changes mean for the health services they receive. In Tanzania, we learned that the barcodes used for the unique identification of children caused alarm in the community when the stickers were placed on the child health cards. Some people worried that the stickers may be used

to locate and kidnap children. Nurses subsequently received talking points to explain what the barcodes meant and how the data were used. Posters were also developed and hung in the facilities to explain the purpose of the barcodes.

2. **Pause before scaling up interventions.** When Tanzania deployed the first EIR, we scaled quickly through the district, providing tablets to the facilities. However, we found that there were back-end issues with the EIR and had to recall the tablets. This experience modified our testing plans in both countries. Subsequently, the test facilities used the production version of the EIR for a longer period to find and fix critical issues and bugs. Both countries tested the EIR for three to four weeks before deploying it further to the district and then across the region/province.

3. **Introduce tools with all facility staff.** To address issues with staff turnover, it's important to have nurses who work in care services outside of immunization available to see their colleagues use the data collection tools. Leadership should also be exposed to tools so they can reinforce and encourage adoption. This creates a feeling of facility ownership rather than ownership only by those working with the Expanded Program on Immunization.

4. **Document different iterations of interventions.** The design of data quality and use interventions will go through several changes during the testing and implementation phases based on user feedback and rollout experiences. It is important to document user feedback for each version of the intervention design to understand why the changes were made as well as the decisions and context that led to those changes.

5. **Use rollout tools for planning.** Many lessons will be learned during rollout, and it's important for the team to adjust its plans based on these experiences, while keeping an eye on the milestones. To assist with planning, a rollout projections tool was used to capture high-level milestones so the team knew when touches would start and finish in each district and each facility. A complementary planning board was designed to use for day-to-day logistics, indicating which team members would conduct which touch on a specific day and at a specific facility. These tools are now used by each district with support from BID staff.