

Terms of Reference

Evaluation of the ‘Using Motivational Interviewing and improved interpersonal communication between healthcare workers and caregivers to encourage timely completion of vaccinations in Romania.’”

Background

By protecting children against serious diseases, vaccines play a significant role in ending preventable child deaths. Vaccines now protect more children than ever before, but low immunization levels among poor and marginalized children compromise gains made in all other areas of maternal and child health.

In Romania, according to the National Institute for Public Health, the 2019 national coverage for measles containing vaccines is still below the WHO recommended threshold, the rate for the first dose is 90% and for the second dose is of 76%.

Since the beginning of the current measles outbreak in 2016, in Romania there have been registered 20,204 cases (as of 17 July 2020) and 64 deaths, of which the vast majority were unvaccinated children.

The low vaccination rates can be attributed to a broad range of factors: stockouts, lack of data on unvaccinated children, lack of information, migration of families with children.

The decision by caregivers to refuse or delay vaccinations for their children is one of the factors affecting the vaccination coverage. It is strongly connected to the availability of information about vaccination, its benefits and side effects and to the interaction between caregivers and health workers. A study conducted by WHO in Romania in 2017 shows that the health workers (especially family doctors) are perceived as the most reliable source of information regarding vaccination. Nonetheless, the data from the study reveals that:

- Almost one third (29%) of the caregivers did not agree with or did not respond to the statement that they know where to go for information about vaccination; and one fifth (20%) did not agree with or respond to the statement that they were satisfied with the information received from their family doctor.
- Less than half (46%) of respondents knew when it was time for their child’s next vaccination.
- Only 58% reported that they were informed by the health clinic about their child’s next vaccination.
- 21% of respondents did not respond or disagreed that their family doctor provided clear information about vaccination. 31% either did not respond or agree that their family doctor provided clear information about potential side effects.

Context

Motivational interviewing (MI) is an example of a brief behavioral counseling intervention that improves interpersonal communication (IPC) skills of health care workers (HCWs). IPC skills enable HCWs to engage with caregivers to encourage timely uptake of recommended vaccines, with the ultimate goal of changing knowledge, attitude, and practices of caregivers towards immunizations. MI and other IPC techniques have been used successfully to encourage uptake of a variety of health behaviors and improve interaction between HCWs and caregivers by encouraging active listening and provision of feedback to concerns expressed by caregivers.

UNICEF in Romania, in partnership with US Centers for Disease Control & Prevention, design, implement, and will evaluate a motivational interviewing-based (MI) intervention to increase timely immunization uptake among children in selected counties and localities in Romania. The intervention will teach hospital, primary and community-based health care workers how to initiate and maintain conversations with new mothers about vaccination and will teach community-based mobilizers how to approach caregivers who defaulted on childhood vaccination visits. The goal of these conversations will be to deliver information about vaccines, probe for vaccine hesitancy, address concerns, and establish a personal relationship with the caregiver. This will be achieved by the adaptation and implementation of the UNICEF Interpersonal Communication Training Package for Immunization as well as additional motivational interviewing techniques and tools.

The objectives of the improving IPC competencies of health workers and of motivational interviewing intervention are to:

1. Primary:
 - a. *Among children 6-15 months of age:*
 - i. Achieve an increase in coverage (estimated at 10-15%) of the third dose of Hexavalent vaccine (D-TT-aCP-IPV-Hib-HepB) and the first dose of measles-mumps-rubella (MMR) vaccine
2. Secondary:
 - a. *Among caregivers:*
 - i. Improve immunization-related knowledge, attitudes, and practices
 - ii. Assess quality and effectiveness of interpersonal communication with health worker
 - b. *Among HCWs:*
 - i. Improve interpersonal communication and counseling skills with caregivers

Evaluation Purpose and Scope

The evaluation will serve to assess if the assumptions underlying and objectives formulated for the implementation of Interpersonal Communication (IPC) and motivational interviewing (MI) with healthcare workers were validated and achieved as well as to ascertain whether they positively affect immunisation coverage in Romania.

This project will be implemented in Romania in collaboration with UNICEF and in-country partners. The governmental partner for this intervention will be the National Institute for Public Health (NIPH) and the implementing partner will be the Center for Health Policies and Services (CHPS). The evaluation will cover the period of approximately January 2021 – December 2022.

Evaluation Objectives and Methodology

Objectives

The evaluation will assess the impact of IPC and MI training has on:

- increasing uptake of immunization among children in the selected GP offices and
- quality and effectiveness of interpersonal communication of a cohort of HCWs and caregivers.

Methodology

The intervention and evaluation will be implemented in Brasov and Vrancea counties in Romania.

Intervention design

Healthcare workers will be recruited to participate in 2-day training that will cover introduction to motivational interviewing (MI), how to identify and communicate with mothers and address their concerns, fears, misconceptions, and how to identify and address vaccine hesitancy. HCWs will be trained to deliver the IPC and MI approaches they learn to all their patients.

Selection of HCWs for MI training

The training will be advertised to the target populations of HCWs (doctors/neonatologists in maternity wards, GPs, GP nurses, community nurses, and health mediators). All HCWs in the target population will receive an invitation to express interest in participating in the training using an online “pre-registration”, which will collect data on key demographic variables such as position title (e.g. GP, nurse, etc.), age, and clinic location.

All HCWs in the target population interested in participating in the training will be eligible to register to participate in the training, irrespective of completion of the pre-registration. HCWs will be enrolled in the training until all available training spots are filled. Approximately 20 HCWs will be enrolled in each training, and trainings will be completed over a 4-month period.

The length of the training delivery period and the number of participants per training is the desired one. The actual data will be determined by the COVID-19 safety recommendations in place in April - August 2021.

Recruitment of HCWs for Evaluation

The evaluation partner will recruit a sample of 200 HCWs who express interest in and register to participate in the training (hereafter referred to as “treatment HCWs”). Treatment HCWs will be recruited in stages: 1 week prior to each training the implementing partner will provide the evaluation partner with a list of HCWs registered for the training from which they can recruit. The list will include the contact information of all HCWs, and the evaluation partner will contact each individual HCW until the target sample size in each county is reached.

In addition, the evaluation partner will recruit a sample of 200 HCWs that expressed interest in participating in the training in pre-registration but did not or could not register in the training (hereafter referred to as “control HCWs”). Control HCWs will be recruited at one time point after the completion

of all trainings. The evaluation partner will use data collected in pre-registration to identify control HCWs that are matched to treatment HCWs with respect to position title, age, and clinic location for the evaluation.

If the number of HCWs who express interest in the training is not sufficient to ensure recruitment of 200 treatment and 200 control HCWs, the evaluation partner will in consultation with UNICEF and CDC amend the recruitment strategies and sampling frame as needed to ensure equal recruitment of treatment and control HCWs.

Recruitment of Caregivers for Evaluation

The evaluation partner will recruit a sample of 200 caregivers with children aged 0-4 months of age who are receiving care from treatment GPs (hereafter referred to as “treatment caregivers”) and 200 caregivers of children aged 0-4 months of age who are receiving care from control GPs (hereafter referred to as “control GPs”). Caregivers will be recruited from a subset of treatment/control GPs and will be clustered by GP (e.g. 20 caregivers per GP).

Treatment GPs that are registered for the training but have not yet participated and control GPs will be asked to introduce the study using a script on the phone or in-person to the caregivers of their patients aged 0-4 months of age and ask if they are willing to have their contact information shared with the evaluation partner. Treatment GPs and control GPs will be asked to recruit all caregivers with a last name starting with a randomly selected letter of the alphabet, which will be assigned by the evaluation partner each day. The evaluation partner will contact each caregiver until the target sample size in each county is reached.

Data Collection: Quantitative

1. Registry Data

- a. To evaluate the primary impact of MI on vaccination coverage, vaccination registry data of all patients aged 6-15 months receiving care from treatment and control GPs will be abstracted prior to receipt of the intervention in the treatment group (hereafter referred to as “baseline”). Vaccination coverage will be aggregated by each individual treatment/control GP and will be abstracted for all antigens.
- b. Following baseline, vaccination data will be abstracted on a monthly basis for independent cross-sectional samples of all patients aged 6-15 months receiving care from treatment and control GPs.
- c. Monthly abstraction of vaccination data will continue until **15 months post-intervention**. Data at 15 months post-intervention will provide an estimate of post-intervention vaccination coverage. Pre- and post-intervention vaccination coverage for all vaccines offered in the first year of life will be compared to assess differences over time.
- d. In Romania BCG and pediatric hepatitis B is offered at birth in maternity; hexavalent vaccine is offered at 2 months, 4 months and 11 months and MMR is offered at 12 months and 5 years. Because of the outbreak of measles another first vaccination for measles is offered at 9 months.

2. Cohort Knowledge, Attitudes, and Practices (KAP)

To evaluate the secondary goals of the intervention, we will collect KAP data from treatment/control HCWs and treatment/control caregivers at two time points.

i. Caregivers:

KAP data will be collected from the same cohort of treatment/control caregivers at baseline and 12 months post-intervention. Baseline KAP assessments for treatment caregivers will take place in stages immediately after each training for HCWs is completed. Baseline KAP assessments for control caregivers will take place at one time-point after all trainings have been completed.

- The assessment will primarily be a quantitative survey administered to caregivers face to face. These surveys will assess: (1) Knowledge, attitudes, and practices related to vaccination; (2) Barriers and challenges getting their children vaccinated; (3) Quality and effectiveness of interpersonal communication with health workers.
- Using appropriate analytic software, the evaluation partner will conduct preliminary data analysis in collaboration with other study partners, to determine change in indicators over time.

ii. HCW:

- KAP data will be collected from the same cohort of treatment/control HCWs at baseline and 12 months post-intervention. Baseline for treatment HCWs will occur in stages prior to each training. Baseline for control HCWs will occur at one time-point after all trainings have been completed.
- The assessment will primarily be a quantitative survey administered to HCW at the facilities where they work. These surveys will assess: (1) knowledge, attitudes and practices related to vaccination (2) barriers and challenges providing vaccination services; and (3) quality and effectiveness of interpersonal communication with caregivers
- Using appropriate analytic software, the evaluation partner will conduct preliminary data analysis in collaboration with other study partners, to determine change in indicators over time.

Data Collection: Qualitative

1. Focus Group Discussions (FGDs)

b. To evaluate the secondary goals of IPC and MI, in-depth interviews (IDIs) and focus group discussion (FGD) data will be collected from HCWs and caregivers.

i. Caregivers: A small number of treatment/control caregivers will be asked to participate in in-depth interviews (12-16 IDIs per county of intervention) to

better understand their knowledge, attitudes, and practices towards vaccination as well as their interactions with HCWs.

- ii. GPs: A small number of GPs will be asked to participate in focus group discussions (6-8 focus group discussions per county of intervention) to better understand their knowledge, attitudes, and practices towards vaccination as well as their interactions with caregivers
- iii. FGD data will be collected at the same time with the endline KAP surveys.

Compensation

Caregivers will receive non-financial compensation equivalent to \$10 USD for time spent upon completion of each KAP survey or FGD. GPs will not receive compensation for completion of KAP surveys or FGDs. If participation rate among control GPs is not sufficient to ensure adequate recruitment and retention of control GPs, the evaluation partner will in consultation with UNICEF and CDC amend the compensation strategies for control GPs.

Tasks and deliverables

Under the guidance of UNICEF and CDC, the implementing partner will perform the following tasks:

Evaluation Component	Tasks & Deliverables
General	<ul style="list-style-type: none"> • Obtain Institutional Review Board (IRB) and/or other relevant government or health body approvals required to conduct evaluation, including defining informed consent process for all enrolled caregivers and HCWs and others who participate in evaluation; • Undertake recruitment of data collectors and supervisors for quantitative and qualitative evaluation activities; • Organize training for all survey data collectors and supervisors, including on aspects related to ethics, GDPR and infection prevention and control; specifically arranging a training venue, procurement of materials, duplication of formats and payment to participants. Facilitate and coordinate logistics and supervisors in pre-agreed quantity with a budget breakdown; • Monitor and supervise field activities of data collectors; ensure that field operators are equipped (with masks and disinfectants) and knowledgeable about the prevention of the infection with SARS-COV 2. • Organize payments to data collectors and supervisors for all survey activities in the field as per the pre-agreed cost breakdown and mode of payment by assigned responsible person. Manage payments and keep receipts and supporting documents (including copy of ID cards for any payments made to individuals) for future verification; • Organize compensation of study participants for all data collection activities in the field as per the pre-agreed incentive breakdown and mode of payment;

	<ul style="list-style-type: none"> • Prepare and submit any agreed upon financial and technical reports for funds disbursed, to UNICEF Romania country office in a timely manner and in accordance with the signed agreements; • Participate in monthly calls with UNICEF, CDC and the implementation partner for the duration of the project period and 1-2 additional calls per month as needed; • Prepare revisions of all evaluation deliverables if standards of quality are not met.
Quantitative	<ul style="list-style-type: none"> • Develop, in consultation with UNICEF and CDC informed consent tools and SOPs; • Program data collection tools; • Develop and program an online “pre-registration” data collection form; • Develop sampling frames for HCWs and caregivers using data collected from pre-registration; • Develop a script to be used by treatment/control GPs to recruit eligible caregivers; • Conduct recruitment of treatment/control HCWs and treatment/control caregivers for participation in KAP surveys; • Conduct data collection activities for all aspects of the evaluation: KAP surveys and vaccine registry data abstraction; • Support data cleaning and basic descriptive/preliminary analysis of KAP survey and vaccine registry data under CDC and UNICEF guidance; • Databases of cleaned KAP survey data submitted to UNICEF in English and Romanian within two weeks of completion of the KAP surveys at baseline and 12 months post-intervention; • A database of vaccine registry data from all treatment/control GPs submitted to UNICEF in English and Romanian every six months; • A basic descriptive report of baseline KAP data within 4 weeks of completion of all baseline KAP surveys; • An intermediary report of all (baseline and 12 months post-intervention) KAP data within 4 weeks of completion of all KAP data collection activities; • Final assessment report within 2 weeks of receiving feedback on the intermediary report; • A PowerPoint presentation summarizing the key findings of the final assessment report.
Qualitative	<ul style="list-style-type: none"> • Develop, in consultation with UNICEF and CDC informed consent tools and SOPs; • Develop, in consultation with UNICEF and CDC a sampling frame for HCWs and caregivers • Develop, in consultation with UNICEF and CDC tools for conducting the FGs and IDIs; • Conduct recruitment for a subset of treatment/control HCWs and treatment/control caregivers for participation in FGDs; • A sample of transcribed data and recordings from a subset of FGDs during the first week of qualitative data collection submitted to UNICEF in Romanian to verify data quality; • A database of transcribed data from all FGDs submitted to UNICEF in English and Romanian within 2 weeks of completing qualitative data collection.

Desired Background and Experience Required:

Competencies required from the members of the evaluation team are a combination of a number of years of experience in the subject area and of evaluation methods as per below:

- Advanced university degree in social sciences and health;
- Familiarity with rights-based approaches;
- Good knowledge and expertise in designing and conducting studies, evaluations, knowledge management and research (two samples needed);
- Proven experience in conducting data collection for various research, qualitative and quantitative data collection, including participatory approaches and methods; proven ability to conduct interviews, focus group discussions and writing reports for publication; proven experience in conducting desk reviews and field visits; everything above related to evaluation process experience;
- Strong analytical and conceptual thinking;
- Excellent oral and written English language skills, demonstrable with samples of publications (evaluation reports, relevant research, etc.); ability to synthesize complex information into key messages;
- Familiarity with the work of the United Nations an asset;
- Ability to communicate with and expertise in cooperation with different stakeholders, professionals, communities, families and children.

Successful applicants will provide samples of evaluations conducted; those should include, but not be limited to programme evaluations.

Roles and responsibilities of stakeholders in the evaluation process

External stakeholders

- At local level: caregiver vaccination data aggregated by GP will be abstracted from registries and caregivers and general practitioners will participate in the surveys
- At county and national level: professionals from the Public Health Directorates, health workers associations and organizations, representatives of the National Institute for Public Health, Ministry of Health and other bodies will participate in the evaluation through discussions, and consultations.

UNICEF

The UNICEF focal point for the Evaluation are the Programme Specialist for Health and the Communication for Social Change Officer, who will ensure that the evaluation process is carried out as per UNICEF policies and provide technical support throughout the process.

- The Programme Specialist for Health is the manager for the evaluation on behalf of the office. The Communication for Social Change Officer is a key informant throughout the evaluation process. They will: liaise with evaluation team and provide initial briefing to the selected team on the framework and expectations of the evaluation; provide feedback on evaluation design and research tools and all reports and deliverables; facilitate contact with county and local stakeholders included in the evaluation exercise; facilitate access to complementary

background documents to be included in the desk review and to all necessary documents throughout the evaluation process. The UNICEF Europe and Central Asia Regional Advisor and Specialist for Communication for Social Change will be part of the team providing the initial briefing to the selected team and provide feedback on deliverables.

US Centers for Disease Control & Prevention

- Will provide initial briefing to the selected team on the framework and expectations of the evaluation
- Collaborate and provide technical assistance on evaluation design and research implementation
- Support data analysis and drafting of all reports and presentations

Evaluation team

- Has the overall responsibility for successful completion of all phases of the evaluation including inception, data collection and reporting;
- Manages and carries out all consultations, meetings, focus groups and interviews with key informants, including logistics related to travel, financial and other arrangements that are related to the implementation of the evaluation;
- Submits deliverables and invoices in a timely manner.

General conditions

Reporting. The evaluation contractors will report to the UNICEF Health Specialist and will work closely with the UNICEF Communication for Social Change Officer.

Payment calendar. Considering the tasks and timeframe mentioned above, fees will be paid in three instalments after submission of deliverables and upon approval by UNICEF Specialist for Partnerships and Horizontal Cooperation, as follows:

- 20% upon signature of contract
- 30% after the baseline data collection (upon delivery of baseline data base)
- 30% after the endline data collection and qualitative data collection (upon delivery of endline data base and FG and IDI transcripts) ;
- 30% after submission and approval by UNICEF of final report and all requested deliverables.

Ownership. Romania MOH, National Institute of Public Health, UNICEF, and CDC will have sole ownership of all final deliverables; no parts of the methodology will be reproduced without the permission of these entities.

Evaluation budget and source of funding

A detailed and transparent budget for the evaluation will be part of the financial proposal from the evaluation teams when they express their interest for conducting the evaluation. The estimated budget does not include organization of consultative meetings with stakeholders and launch of the report, which will be covered by UNICEF separately.