

**EVALUATION OF THE REPORTED MIGRANT VACCINATION PRACTICES WITHIN THE LINE OF
THE SEVEN MAIN ASPECTS OF THE EVALUATION TOOL
(Horizontal evaluation)**

As a first step we have evaluated the programs **generally**, on the basis of the mathematically weighted ranking list, and the programs have received an **overall index**. However, we think it would provide additional information if we will analyze the programs according to the main items of the evaluation tool horizontally.

For the general evaluation the order of and the allocated scores to these 7 main evaluating aspects were the followings (See the mathematical model!):

1. Timing

We allocated 7 scores to those programs, which considered **Timing** as an important aspect of their practice.

2. Mobilization/ way of motivation

We allocated 6 scores to those programs, which considered **Mobilization/ way of motivation** as an important aspect of their practice.

3. Financial coverage

We allocated 5 scores to those programs, which considered **Financial coverage** as an important aspect of their practice.

4. Training for the care givers

We allocated also 5 scores to those programs, which considered **Training for the care givers** as an important aspect of their practice.

5. Immunization Profile

We allocated 3 scores to those programs, which considered **Immunization Profile** as an important aspect of their practice.

6. Program Evaluation and Research

We allocated 2 scores to those programs, which considered **Program Evaluation and Research** as an important aspect of their practice.

7. Use of Immunization Information system. Record keeping

We allocated 1 scores to those programs, which considered **Use of Immunization Information system. Record keeping** as an important aspect of their practice.

Secondly, we evaluated the programs **horizontally**, in details, by aspects. We do make efforts to find those elements of each of the programs which could be considered as the best practices regarding the certain project. As a whole, finally, we may find the unmitigated best program, which may be the best regarding each of its elements.

1. Timing

Of the evaluated 33 vaccination-programs 30 were continuous and 27 also sustainable. Among them, 16 programs took into account also the time availability of the target group (i.e. clinic working hours, these are the followings: Nr.1, 5-10, 13-14, 16-18, 21-22, 25, 31. Among these 16 programs one (Nr. 10) could be characterized as periodically, seasonably organized practice, while the other 15 programs are not typically periodic. The duration of these interventions has lasted for more than 12 months.

Of these 16 selected practices 7 were awarded previously with the TOTAL SCORE 29 (which means, that these programs were also generally considered as the 'best' programs, as they considered each of the 7 main evaluating aspects (A-G).

From this point of view these 7 programs could be adjudged as the 'best' practices regarding **Timing**. These programs are the followings: Nr. 1, 5-10.

2. Mobilization/ way of motivation

Great majority of the delivered programs (32/33) adressed cultural diversity barrier. Half of them (17/33) reported that the program provided training for the care givers in order to improve cultural competencies (Nr. 1-3, 5-14, 16-18, 20), and the same programs also addressed the language barriers.

In 14 cases (Nr. 2-3, 5, 7-10, 11-14, 16-18) different forms of health education materials (leaflets, posters, promotional activities) were also available for the migrants.

Also in 14 cases (Nr. 2-3, 5-9, 11-12, 14, 16-18, 20) special migrant tailored on site health programs were available.

In 7 cases (Nr. 1-3, 5, 9, 14, 20) interpreters were available during the doctor-patient encounter.

In 6 cases (1, 5, 7-9, 18) the leaders in the migrant community used in order to reach migrants.

Eleven programs (1, 6-10, 13-14, 16-18) assessed the needs of the target migrant group or, at least conducted a needs assessment.

We could find only one program (Nr. 9) regarding **Mobilization/ way of motivation** in which each of the eight (above mentioned) measures were taken into account coincidentally, in this meaning this could be considered as the 'best' program.

On the other hand, if we do not consider the necessity of the use of an interpreter (e.g. there is no language barrier during the doctor-patient encounter) we may consider 4 programs as 'almost the best' practices (Nr. 6, 7, 8, 18), among which 3 were also scored with the generally available TOTAL 29 SCORES (Nr. 7, 8, 9).

3. Financial coverage

Immunizations were provided for free for the migrants in 28 cases among 33 programs, but this regards to compulsory vaccines. (For example, by program Nr. 21, it was noted, that some minimal co-payment is also required from the migrants: *'...by law the compulsory immunizations are provided free of charge by the State. These include mumps, measles, rubella, tetanus, diphtheria, pertussis, hepatitis B, poliomyelitis, Haemophilus influenzae. Other vaccines can required minimal co-payment.'*

The core budget of the immunizational program was 'State health insurance system' in 23 cases (Nr. 1-5, 10-15, 20-22, 24-30, 31, 33). In two cases (Nr. 2, 19) 'Special governmental fund for migrants' health care' sources were involved, but program Nr. 2. could be also considered as 'EU/ WHO co-funded project' as well. Programs Nr. 5 and 19 were 'NGO action financed by government', while Programs Nr. 3, 4, 6, 8, 19 and 25 were also 'NGO action financed but from other resources'.

For their immunization action 4 programs used two different financial sources at the same time (Nr. 3-5, 25), while 3 different financial sources covered the program in the case of practices Nr. 2, 19.

Of these programs, that used more than one source for financing, programs Nr. 2, 3, 4, 5 were generally awarded with TOTAL SCORE 29, so, they may be considered as 'best practices' also regarding the **Financial coverage** aspect.

(Program Nr. 7 reported, that the immunization was free for the migrants, but not reported the coverage of the budget.)

4. Training for the care givers

Of the 33 programs in the case of 18 programs some preparatory training were also a consistent part of the practice (Nr. 1-3, 5-18, 20). Among these 18 programs the content of the training was approaching communication in multicultural, multi-religious environment in 14 cases (Nr. 1-3, 5-10, 12-13, 16-18). In great majority of them (12/14) (Nr. 1-3, 5-10, 12, 16-17) professional providers, who work in health care (e.g. doctor or nurse) were primarily addressed by the training. Five programs (Nr. 1, 9, 13, 16, 18) primarily addressed by the training those people, who are already in the migrant community and by training they could learn how to handle the 'hard to reach population'. Two programs (Nr. 9, 18) addressed the leaders in the migrant community how to assist for the care givers.

There were 3 programs which addressed two groups of care givers coincidentally (Nr. 1, 16, 18), among those program Nr. 1 was previously awarded with 29 TOTAL SCOREs, the other two programs with 25 TOTAL SCOREs. Only one practice (Nr. 9) targeted at the same time each of the three groups of the above mentioned groups of care givers, so regarding the aspect of **Training for the care givers** this could be considered as the 'best' practice.

5. Immunization Profile

Of the 33 practices in the case of 20 programs the immunizations provided was based on the age of the migrants (Nr. 1-9, 11, 19, 21-28, 30). In the case of 12 programs (Nr. 2, 6-10, 12, 19, 22-23, 28-29) the immunization provided was based on migrant's occupational risks, and

by 11 programs (Nr. 1-2, 6-10, 19, 22, 23, 28) the immunization profile of the country of origin was taken into account.

There were 9 practices which considered each of these aspects at the same time, they were the followings: Nr. 2, 6-9, 19, 22-23, 28.

Among these 9 immunization practices 7 involved individual vaccines (Nr. 2, 6-7, 19, 22-23, 28). Five programs were outreach initiatives (Nr. 2, 9, 19, 22-23) while 2 of them took place at the workspace (Nr. 9 and 22).

There was only one single practice (Nr. 22) in which all of the conditions of the **Immunization Profile** were reported to be realized, in this meaning it may be considered as the 'best' practice.

6. Program Evaluation and Research

Of the 33 practices there were 15 (Nr. 1-2, 4, 6-10, 16-19, 22-23, 31) which were evaluated for its effectiveness (e.g. reaching to target population, increasing awareness, promoting access to health care and immunizations etc). Among these 15 programs only in 2 cases (Nr.9 and 18) get the target population (migrants) the opportunity to evaluate the program (totally or partly), on the other hand in 11 cases (Nr. 1, 6-10, 16-18, 22, 31) the target populations comments and suggestions were also used in order to improve the immunization program. In 3 cases (Nr. 9, 10 and 18) programs' outputs evaluated (i.e. educational material produced during the project) while 11 practices collected data on migrants; e.g. health status and socio-demographic status. Results of 6 programs (Nr. 2, 4, 9-10, 18, 22) disseminated (published, presented in scientific conferences etc.)

There were only 2 programs (Nr. 9 and 18) which concerned **Program Evaluation and Research** in totality, with this end in view, these could be evaluated as the 'best' practices regarding this aspect of evaluation.

7. Use of Immunization Information system. Record keeping

Majority of the evaluated programs reported (28/33) that their activities performed and immunizations provided recorded. Most of them also used immunization cards (25/28). Besides the immunization cards in 23 cases registry was also used (Nr. 1-7, 9-15, 19-20, 26-30, 31, 33).

Of these 23 practices 9 were previously awarded with TOTAL SCORES 29 (Nr. 1-7, 9-10). In this meaning these programs concern as well with all the other aspects of evaluation and also the aspect of **Use of Immunization Information system. Record keeping**, thereby they could be assessed as the 'best' practices regarding this issue.