

# Improving Immunization in Zimbabwe through Increased Community Ownership:

## Expanding Use of the My Village My Home Tool and Home-Based Records

Community engagement can easily be overlooked as a key factor in getting life-saving vaccines to all children—especially when so much effort is focused on monitoring and systems performance. With the implementation in Zimbabwe of the revised Reaching Every District/Reaching Every Child (RED/REC) guidelines, however, community engagement will be recognized and expanded as one of the five strategies for increasing immunization coverage. And, with fuller community engagement, comes the sort of community empowerment that can help make full immunization not just a goal but an achievement.

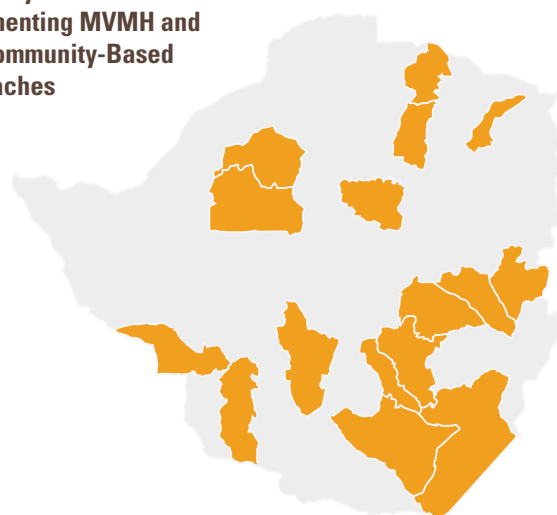
Although there has been commitment in this regard, a situational analysis conducted in Manicaland in 2017 through the United States Agency for International Development (USAID)-funded Maternal and Child Health Integrated Program (MCHIP) with technical support by JSI Research and Training Institute (JSI) found that improvements were needed with: the documentation at the village level of community leader roles in monitoring immunization activities; updating of village health worker (VHW) registers; increasing understanding of the value of the home-based record (HBR) as a reference for a child's health history; infrequent recording of return dates on the HBR; and immunization issues not routinely discussed during community meetings. Furthermore, maintenance and utilization of community level data need to be enhanced to enable name-based tracking of children who have not completed vaccination.

In 2017, to increase community ownership for immunization, JSI supported the Zimbabwe Expanded Programme on Immunization (ZEPI) in piloting two community-based approaches—the My Village My Home (MVMH) immunization tracking tool and strengthening of HBR (known locally as the Child Health Card [CHC])—in two priority districts in Manicaland Province. These low-cost approaches engage known cadres—village health workers (VHWs) and traditional Village Heads—in increasing community involvement to ensure full immunization. The pilot showed promising improvements in immunization uptake and reinforced the links between the communities and facilities in rural areas. Subsequently, with financial support from Gavi, the Vaccine Alliance, JSI and ZEPI expanded implementation in 2018 to 16 priority districts in Zimbabwe. This brief describes the adaptation and expansion of these two community-based approaches; summarizes the findings; and offers lessons learned to support further rolling out the strategy.

**“We are now fishing out those who refuse to have their children vaccinated through using the chart (MVMH tool).”**

**- Village Head**

### 16 Priority Districts in Zimbabwe Implementing MVMH and CHC Community-Based Approaches



### COMMUNITY EMPOWERMENT AND DATA-LED APPROACHES

Two client-focused tools are empowering communities to monitor immunization achievements with easy-to-use data at their fingertips. The MVMH tool visualizes the immunization status of each eligible child in a given village. The tool, developed by JSI under the USAID BASICS project and first used in [India](#), is a monitoring chart for all village children under age two years. “Owned” by the village head, but available for all residents to check, the MVMH tool depicts a house made of “bricks” that represent each vaccine dose needed for full immunization of each child in the village. These bricks are filled in by the VHW as each dose is delivered, starting with the oldest children, so that the “wall” of the house grows as new children are born and receive each vaccination.

VHWs play a critical role in ensuring—and recording—the immunization status of their village's children. Data are triangulated by VHWs across facility and community/client tools, including the VHW health register, the CHC with parents, the health facility-based ZEPI register, and the MVMH tool with communities. During trainings on the MVMH approach, JSI emphasized reinvigoration of the VHW health register to track the immunization status of the children in the community and the review of CHCs to verify and update the VHW health register. VHWs review CHCs—the health record kept by parents in their homes to document vaccinations and other health services received—during home visits with caregivers and transfer this information into both the VHW health register and MVMH tool. During monthly meetings at the



local health facility, the VHW works with the rural health center nurse to harmonize her VHW register with the facility-based ZEPI register (which is not brought to outreach sessions)—thus ensuring accurate, matching data for the CHC, the VHW register, the MVMH tool, and the ZEPI register.

As the MVMH tool is updated, the Village Head and the community can track the status of their growing “house”: whether the walls are solid (with immunizations received) or showing holes (where incomplete immunization could result in an unprotected village). Village Heads can easily identify children who have missed vaccinations by looking for holes in the house and work with the VHW to track these children and ensure that they complete their vaccinations.

## SCALING UP COMMUNITY IMMUNIZATION IN PRIORITY REGIONS

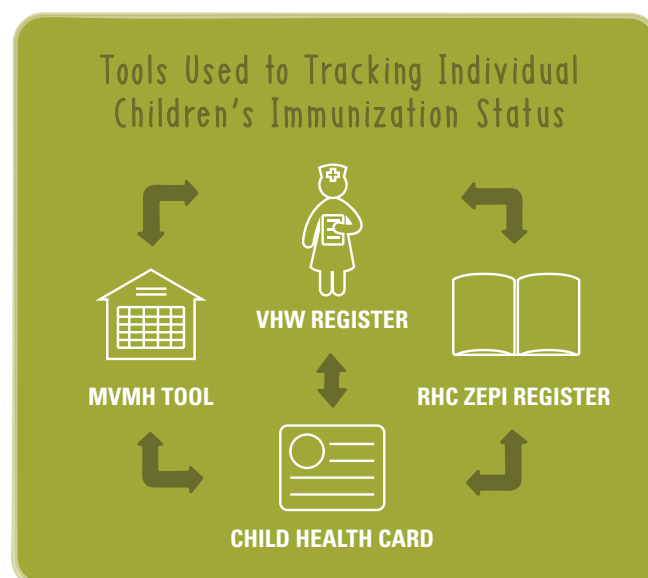
Findings from the 10 facilities where the approaches were piloted ([along with findings from MVMH interventions](#) in other countries) demonstrated that this two-part strategy led to increased compliance with vaccination schedules and reduced dropouts, and increased local engagement in immunization services.

Beginning in 2018, JSI provided Gavi-supported technical assistance to help the Ministry of Health and Child Care (MOHCC) to expand implementation of these two approaches to 16 high-priority districts. Based on findings from the pilot intervention, JSI collaborated with the MOHCC to adapt and tailor existing guidance and training materials to the intervention areas. This adaptation was followed by cascade-style training, starting with a core team of national trainers, and resulting in 4,933 people trained (Table 1).

Following the training, and throughout the intervention, MOHCC and JSI conducted visits for post-training follow-up and supportive supervision to reinforce the key components of these approaches. In addition, progress and early findings from the scale-up were shared at each quarterly review meetings, particularly within the context of the nationwide rollout of the RED/REC approach. This emphasized the importance of community engagement approaches to achieving improved coverage and equity.

**Table 1. Number of people trained, by level, in the two approaches across 16 districts.**

POSITION	NUMBER OF PEOPLE TRAINED
EPI MANAGER	1
SENIOR NATIONAL OFFICER	4
PROVINCIAL NURSING OFFICER	8
EPI OFFICER	8
DISTRICT NURSING OFFICER	16
COMMUNITY HEALTH NURSE	16
RURAL HEALTH CENTRE NURSE	510
VILLAGE HEALTH WORKER	2,185
VILLAGE HEAD	2,185
<b>TOTAL TRAINED IN THE TWO APPROACHES</b>	<b>4,933</b>



## ASSESSMENT

In November 2019, JSI supported the MOHCC to assess the scale-up and equity improvements from these approaches in two randomly selected districts (Bulilima in Matabeleland South Province and Gokwe in Midlands Province). Trained evaluators collected data in five health facilities in each district (for a total of 10 facilities). The assessment included interviewing district- and province-level nursing officers and EPI managers, administering questionnaires and interviews to one EPI nurse, two VHWs, and two village heads in each facility; and conducting exit interviews with four or more mothers per facility. Evaluators also examined the completeness and use of the VHW register.

## FINDINGS

Introducing the MVMH vaccination tracking tool and linking it with the monitoring tools kept by the health facility (ZEPI register), VHWs (VHW register), and parents (CHCs) led to a range of improvements: increasing community awareness of the need for immunization to protect village children; engaging non-health stakeholders; and improving follow-up of defaulters. Specific major accomplishments include:

- **Development of realistic target populations for immunization and accurate, up-to-date records of immunization in rural villages by facility-based workers, with the help of Village Heads and VHWs.** Maintaining community-based immunization registers was not previously a regular practice for VHWs. However, all 17 VHWs interviewed said that they now keep and update their own registers. The availability of an updated VHW register, which is shared with the health facility and cross-checked with the ZEPI register, ensures that the health worker is aware of and up to date on the children living in the village, their vaccination status, and whether or not follow-up is required.
- **Tracking of defaulters improved.** There is no standard MOHCC tool or procedure for tracking defaulters. However, all 17 VHWs interviewed reported that they tracked families whose children had missed a needed vaccination. This helps to fill a gap in the health care system by supporting the RED/REC goal, and—since the Village Head, a well-respected community leader, knows who is defaulting and can follow up directly—emphasizes that families have a responsibility to immunize. Further, the links with facilities clarify the role of the VHWs and the Village Heads in the larger EPI system to reach national targets.



## USING LOCAL TOOLS TO IMPROVE EQUITY

“In the area where we did the training, there were some kids not being reached before, but they are now doing follow-up and tracking them to make sure the village head’s house is strong because all the bricks represent a vaccine for a child. Each child vaccination represents a brick and the village head is taking it up and making sure all the children in their village are vaccinated to prevent disease outbreak. It will be a milestone if we try to decentralize and involve other villages. Even the coverage in some of the health facilities we support, improved after the intervention of MVMH.”

- Provincial EPI Officer

- **Reduction in dropouts.** Only five VHWs reported missing bricks on their village’s MVMH tool over the past nine months; and all 17 (100%) of VHWs reported that they are conducting defaulter tracking. In addition, 17/18 Village Heads understand that their role is to follow-up with immunization defaulters in their village. These actions contributed to a reduced DPT1-Measles 1 dropout rate in the assessment areas, from 4.8% to 2.4% in Bulilima and 13.3% to 0.4% in Gokwe between 2018 and 2019. This underscores that the VHWs understand how to use the data available in the MVMH tool to reach the children who miss vaccinations.

- **Increasing acceptance for vaccination.** Where bricks were missing in the MVMH tool, VHWs cited such reasons as families leaving the village, religious objections, and caregiver ignorance. In the latter case, the support of the Village Head enabled them to persuade reluctant families to vaccinate; and the Village Heads in some cases, have imposed a fine, such as a chicken, on families whose children are missing vaccinations. This in effect engaged the Village Heads and VHWs stakeholders in the greater goal of ensuring that immunization services reach as many children as possible.
- **Community members empowered to take more control of their community well-being through use of the MVMH/CHC approach.** Prior to the implementation of the combined MVMH/CHC interventions, Village Heads were not engaged with the EPI. Their use of the MVMH tool enables them to visually track the immunization status of the village children, engage with families around the importance of vaccination and the vaccination schedule, and connect them with the VHW and the health system. VHWs are using the MVMH during community meetings to visually show the community’s vaccination status, discuss immunization with community members and inform them of the ‘strength’ of the village, and ultimately empower them to take responsibility for the village children’s health.

“I do not want my village to be destroyed by a cyclone of diseases. I will make sure all bricks are in place.”

- Village Head



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“The link between the health facility, the VHW and Village Head is clearly demonstrated when using the MVMH tool and results in collective accountability for ensuring children are protected from vaccine preventable diseases.”

- District Nursing Officer

- **The MVMH/CHC approach facilitates a sense of shared responsibility and accountability between communities and health facilities.** Since it is used by health care workers, VHWs, and caregivers, the CHC fosters mutual responsibility to ensure each child's complete vaccination. Furthermore, Village Heads are now more insistent that health facilities ensure an adequate supply of vaccine and CHCs, so coverage does not suffer.

## LESSONS LEARNED

This dual approach has shown impact through increased engagement of Village Heads and expanded awareness of and commitment to immunization by non-health stakeholders. VHWs have also improved their practices with record keeping, and are following up with those who have not completed their vaccinations, while sharing accountability with the Village Heads. Similarly, the visual depiction of the im-

munization status of each child in the village has helped build shared ownership and responsibility for immunization among the community.

The short timeframe for the project made it difficult to assess the full potential of combining the MVMH and CHC approaches on immunization coverage. However, the outcomes suggest strong potential that should be examined further via broader implementation with ZEPI. A next step is that the MVMH/CHC approaches have been integrated into the revised RED/REC Zimbabwe guidance document and tools, which will roll out nationwide in 2020.

## CONCLUSIONS

Combining the MVMH and CHC approaches is a feasible, low-cost strategy to help advance the RED/REC strategy. By empowering community leaders, strengthening collective responsibility for immunization, and building VHWs' roles as community-facility liaisons, the MVMH/CHC strategy helps prevent child illness in participating villages. In addition, by instituting routine data checks via Village Heads and rural health center nurses, the strategy improves data quality at the lowest levels of the health care system. This intervention has engaged even remote communities to support reaching national immunization and health objectives. Wider implementation nationwide can provide greater understanding of the strategy's potential contribution to Zimbabwe's immunization goals.