Improving Immunization through Increased Community Ownership:

My Village, My Home

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Genesis: India

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FIELD ACTION REPORT

Engaging Communities With a Simple Tool to Help Increase Immunization Coverage

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Use of a simple, publicly placed tool that monitors vaccination coverage in a community has potential to broaden program coverage by keeping both the community and the health system informed about every infant's vaccination status.

CONCLUSION

"My Village Is My Home" is a promising tool that can strengthen community participation in immunization. It has the potential to increase demand for immunization within health services and among the public, increase identification of young children requiring immunization, improve timeliness of vaccination, and boost coverage. Further trials and evaluation of its ability to improve vaccination coverage as well as community participation are merited.

https://www.ghspjournal.org/content/3/1/117

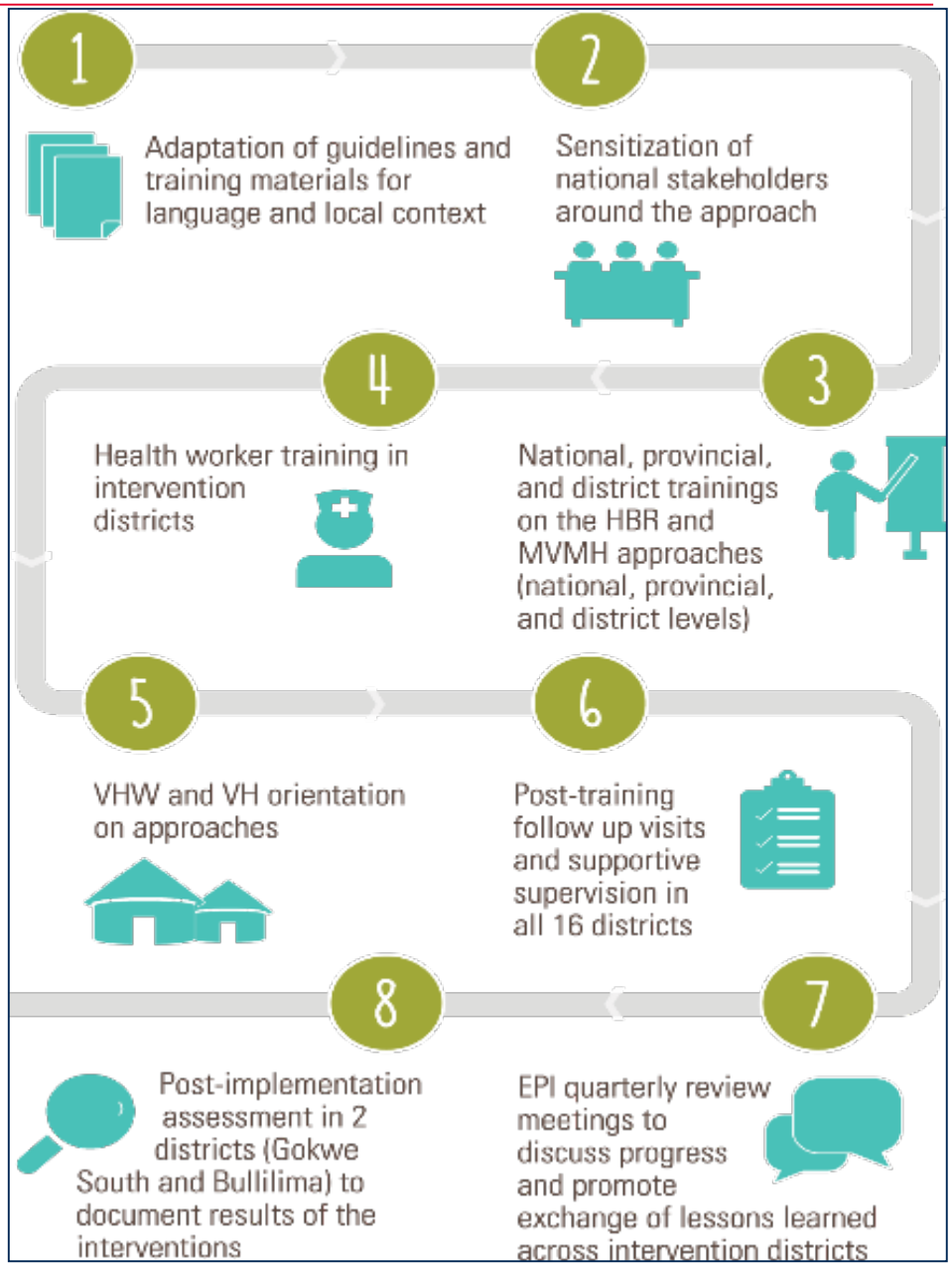
My Village My Home Tool and Home-Based Records

How does it work?

RI improvement: MVMH Approach

Note: In ***every*** country, MVMH has been part of several linked tools and approaches for:

- Newborn vaccination,
- CHW and community engagement,
- Addressing under-vaccinated/drop-outs
- Use of HBRs/cards and registers
- Process monitoring
- Service delivery and RED/REC quality improvement and equity



Zimbabwe example

- In 2017, JSI supported two districts in Manicaland province—Makoni and Chipinge—for MVMH and HBR interventions (with Village Heads and VHWs)
- In 2018, JSI supported rollout of MVMH and HBR strategies to 16 districts with low Penta3 <80% vaccination coverage (proxy indicator).

Position	# 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
Total trained in the two approaches	**4,933**

Evaluation Methodology

Questionnaire	Who was interviewed	Number of interviewees
Caregiver Exit Interview questionnaire	Caregivers who had visited the health facility	45
Health Worker Interview	Nurse found on duty at health facility	10
Village health worker Interview	Village health worker who was oriented on MVMH HBR	17
Village Head Interview	Village Head who was oriented on MVMH HBR	18
EPI Manager In-depth interview	National EPI Manager	1
Provincial Nursing Officer In-depth interview	Provincial Nursing Officers from Mat South and Midlands	2
District Nursing Officer In-depth interview	District Nursing Officers from Bulilima and Gokwe South	2
Total Number of people Interviewed	95	

- **Location:** Matabeleland South and Midlands provinces in 2 randomly selected districts: Bulilima and Gokwe South
- **Timeline:**

  4-10 November 2019
- **Approach:**
  - 10 randomly selected rural health centres (5 per district)
  - Exit interviews with caregivers
  - In-depth interviews conducted with staff from the selected facilities, VHWs, and VHs
  - Evaluators examined completeness and use of the VHW register

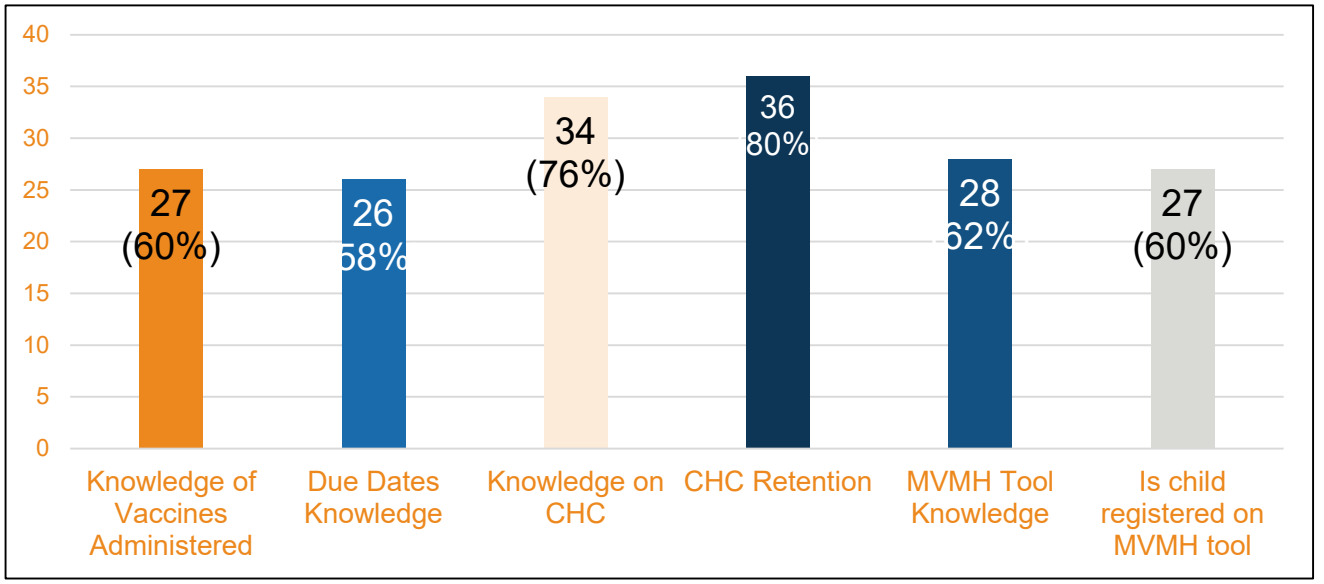
Summary of Findings

The village health worker with the ZEPI register and Village Head with MVMH tool

Caregiver Knowledge : CHC Importance, Vaccines and Due Dates

(n=45)

Improved understanding of card, but more HW communication needed on due dates and vaccines received

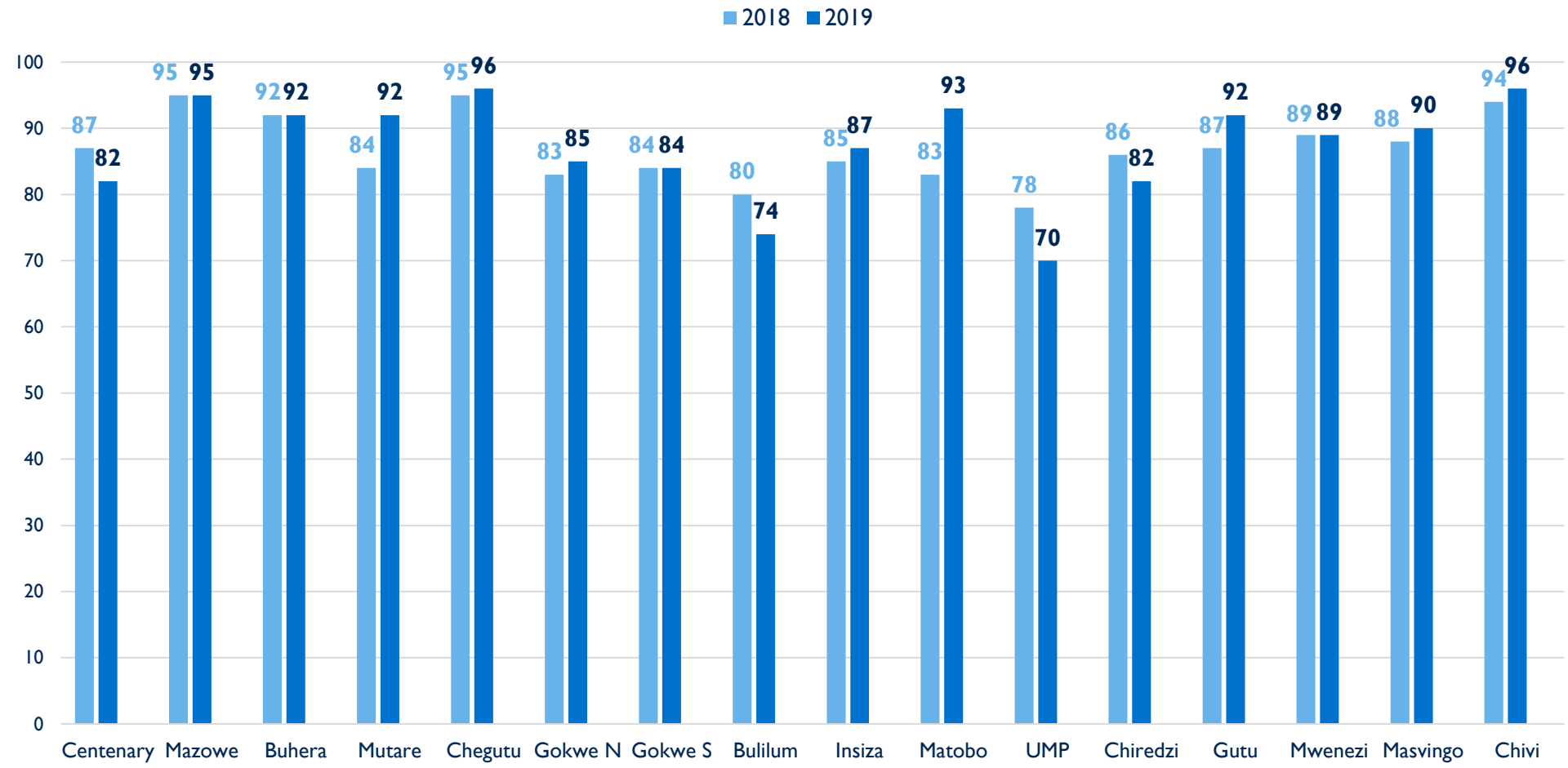


VHW responsibilities

- 14/17 (82%) of VHWs interviewed reported that they are now able to reach more children through use of the MVMH tool
- 17/17 (100%) of VHWs **are conducting defaulter tracking, updating VHW ZEPI register, and have knowledge of CH card**
- 5/17 (29%) VHWs reported missing bricks on the MVMH tool since implementation started -

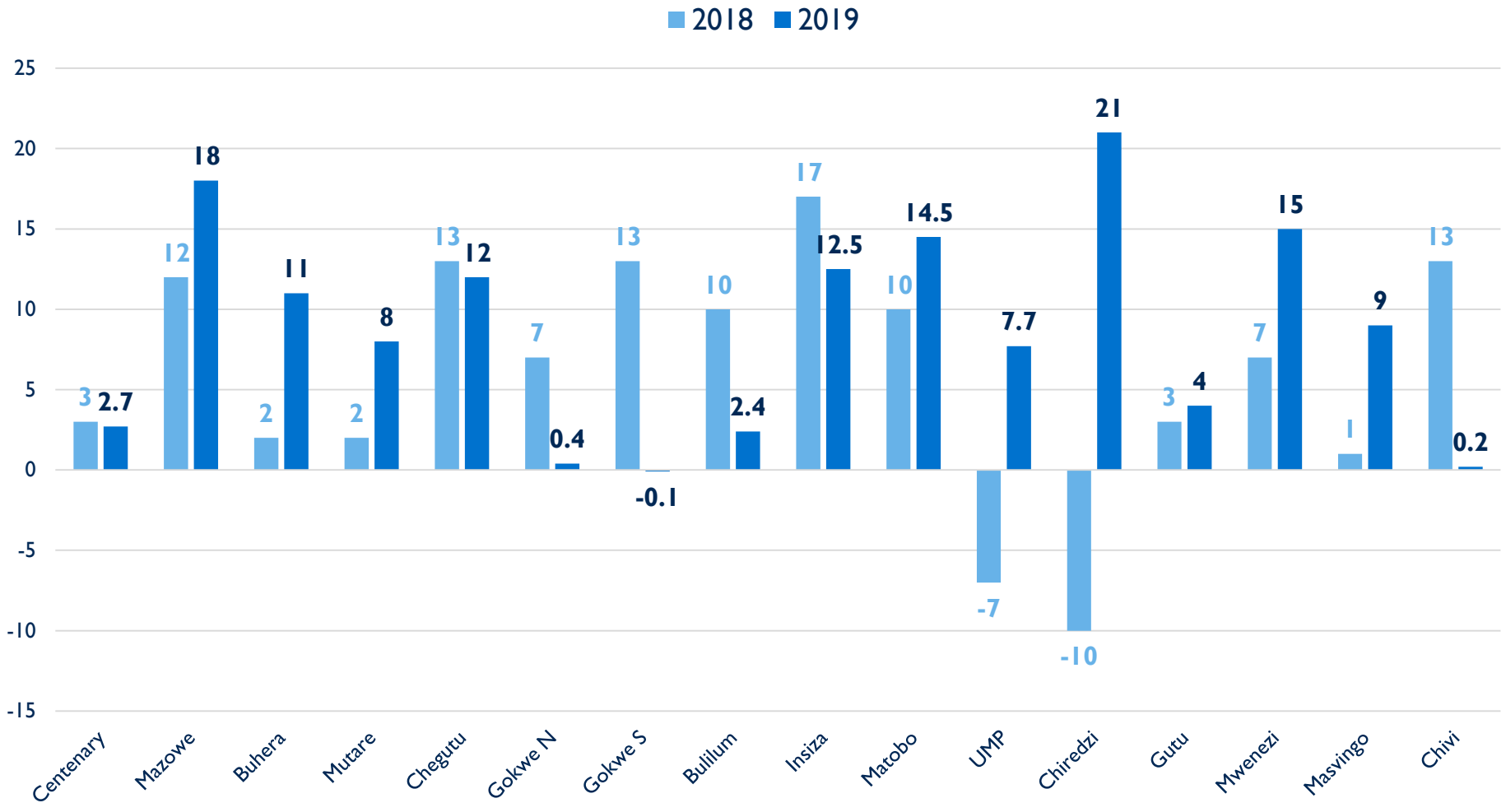
  verification with Village Heads noted caregivers by name, with defaulter reasons as: caregiver travel, lack of knowledge, religious beliefs

DTP 1 Coverage Jan - Sep 2018 & 2019 in Project Districts



Note: As these are percentages, it is useful to **compare with trends in #s vaccinated over a 3-4 year period**, particularly where there are known denominator issues

DTP1 to MRI drop out rate 2018 & 2019 in project districts



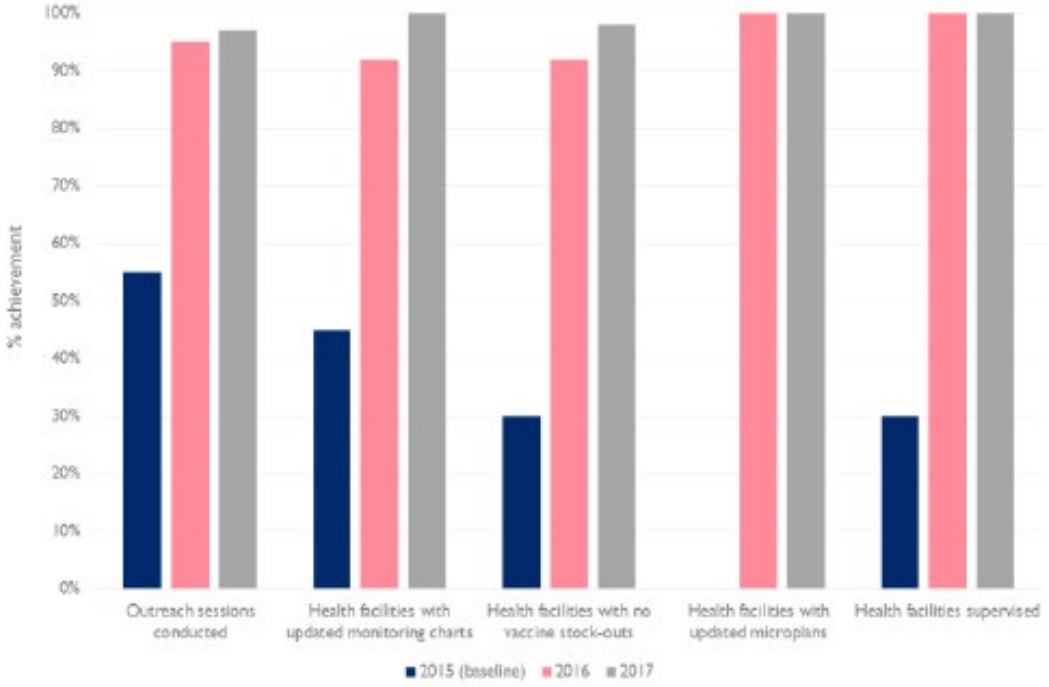
Issues: Uncertain denominator, Measles vaccination after 11 months and/or infants being turned away if insufficient # to open vials?; Specific issues with birth recording and infants reached in first months of life – e.g. UMP, Chiredzi?

Malawi

From 2015 to 2017, immunization process indicators in the two districts improved in several areas as the chart below displays.

For further information, contact Asnakew Tsega (asnakew_tsega@jsi.com).

MCSP supported the Ministry of Health to significantly improve process indicators since 2015



Community members use My Village My Home
[Source: Asnakew Tsega/MCSP]

[My Village My Home: Strengthening Routine Immunization in Malawi - YouTube]

Currently: 3 districts implementing;
expanding to 10 districts with HSS and PEF funding

Lessons Learned

- Implementation needed on a larger scale to fully measure impact and ensure sustainability
  - part of microplanning and resourced community initiatives long-term
- Multi-faceted approach that includes other monitoring tools (registers, HBRs), process monitoring, and supervision
- MVMH empowers community leaders and facilitates sense of shared responsibility and collective accountability
- Continuous follow-up needed with the village heads to sustain motivation to improve demand for immunization services
- Involvement of other ministries adds value and ownership to register newborns, address 'denominator issues,' and reduce vaccine preventable diseases

Zimbabwe learning: Challenges

- Timeframe of the project implementation period was short which made assessing full impact on the immunization program difficult
- Due to funding limitations, implementation was in a very small geographic area
- Data quality presented an issue where data on the T5 summary sheets don't match the HMIS data for the same health facility

Improvement in Defaulter Tracking:
Village Heads and Caregivers

"I don't want my village to be destroyed by a cyclone of preventable diseases. I will make sure all bricks for each child are in place."

- 67% of VHs reported that one of their roles is keeping the MVMH tool up to date with no missing bricks
- 94% of VHs understand that their role is to work in collaboration with the VHW to follow-up with immunization defaulters
- 96% of the caregivers who knew about the tool had their child registered on it

Reflections

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

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

-Village Head

Using the MVMH tool I am now able to assess vaccination status of children in my village at a glance. The Village Head is very keen to make sure children in his community are vaccinated so that the tool has no holes at all.

-Village health worker

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Maternal and Child Survival Program

Community Monitoring of Individual Children's Vaccinations:
SIX COUNTRY EXPERIENCES

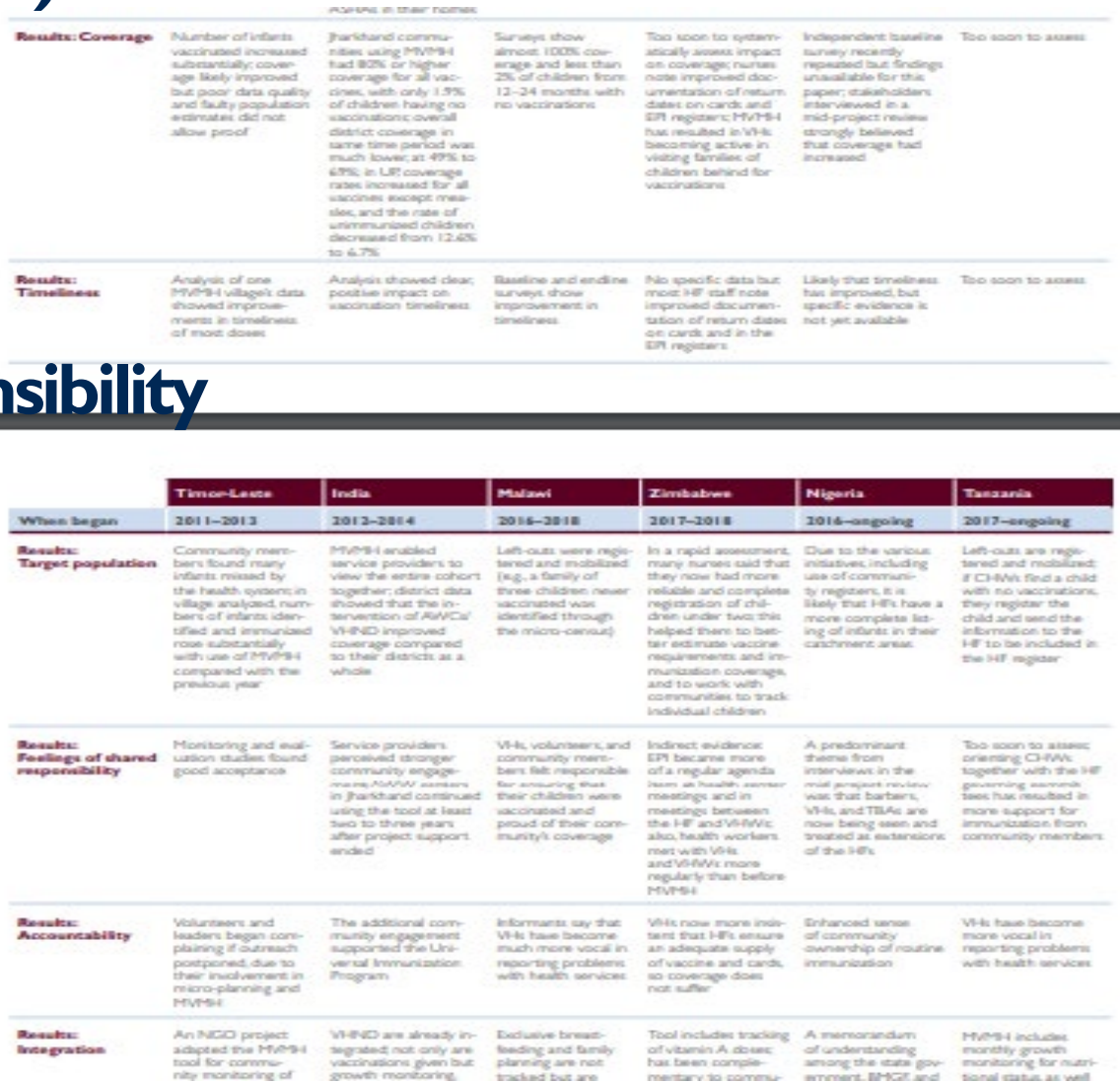
December 2018

www.mcsprogram.org

	Timor-Leste	India	Malawi	Zimbabwe	Nigeria	Tanzania
When began	**2011–2013**	**2012–2014**	**2016–2018**	**2017–2018**	**2016–ongoing**	**2017–ongoing**
How updated	From home-based records and recall during home visits and monthly village health days; hamlet MVMH tools were compared with the EPI register during monthly meetings at the village council office	ANMs and AWWs updated the MVMH tool at the end of each VHND	VHs and volunteers updated MVMH tools during home visits and outreach sessions	VHWs first updated their registers (for all children under two) by comparing them with the HF registers; then they checked child health cards and updated the tool monthly	Traditional leaders update the name-based records in house-to-house visits, and meet with the local HF monthly to reconcile the community and HF registers; volunteers update MVMH weekly	CHWs enroll newborns and also visit HFs to compare the MVMH tool with facility register and identify defaulters (no census)

Results (as of Dec 2018) summarized by:

- coverage
- timeliness
- target population
- feeling shared responsibility
- accountability
- integration



	Timor-Leste	India	Malawi	Zimbabwe	Nigeria	Tanzania
When began	2011–2013	2012–2014	2016–2018	2017–2018	2016–ongoing	2017–ongoing
Results: Coverage	Number of infants vaccinated increased substantially; coverage likely improved but poor data quality and faulty population estimates did not allow proof	Jharkhand communities using MVMH had 80% or higher coverage for all vaccines, with only 1.9% of children having no vaccinations; overall district coverage in same time period was much lower, at 49% to 69%; in UP, coverage rates increased for all vaccines except measles, and the rate of unimmunized children decreased from 12.6% to 4.7%	Surveys show almost 100% coverage and less than 2% of children from 12–24 months with no vaccinations	Too soon to systematically assess impact on coverage; nurses note improved documentation of return dates on cards and EPI registers; MVMH has resulted in VHWs becoming active in visiting families of children behind for vaccinations	Independent baseline survey recently repeated but findings unavailable for this paper; stakeholders interviewed in a mid-project review strongly believed that coverage had increased	Too soon to assess
Results: Timeliness	Analysis of one MVMH village's data showed improvements in timeliness of most doses	Analysis showed clear, positive impact on vaccination timeliness	Baseline and endline surveys show improvement in timeliness	No specific data but most HF staff note improved documentation of return dates on cards and in the EPI registers	Likely that timeliness has improved, but specific evidence is not yet available	Too soon to assess
Results: Target population	Community members found many infants missed by the health system; in village analyzed, numbers of infants identified and immunized rose substantially with use of MVMH compared with the previous year	MVMH enabled service providers to view the entire cohort together; district data showed that the intervention of AWCs' VHND improved coverage compared to their districts as a whole	Left-outs were registered and mobilized (e.g., a family of three children never vaccinated was identified through the micro-census)	In a rapid assessment, many nurses said that they now had more reliable and complete registration of children under two; this helped them to better estimate vaccine requirements and immunization coverage, and to work with communities to track individual children	Due to the various initiatives, including use of community registers, it is likely that HFs have a more complete listing of infants in their catchment areas	Left-outs are registered and mobilized; if CHWs find a child with no vaccinations, they register the child and send the information to the HF to be included in the HF register
Results: Feelings of shared responsibility	Monitoring and evaluation studies found good acceptance	Service providers perceived stronger community engagement/AWW centers in Jharkhand continued using the tool at least two to three years after project support ended	VHs, volunteers, and community members felt responsible for ensuring that their children were vaccinated and proud of their community's coverage	Indirect evidence: EPI became more of a regular agenda item at health center meetings and in meetings between the HF and VHWs; also, health workers met with VHs and VHWs more regularly than before MVMH	A predominant theme from interviews in the mid-project review was that barbers, VHs, and TBAs are now being seen and treated as extensions of the HFs	Too soon to assess; orienting CHWs together with the HF governing committees has resulted in more support for immunization from community members
Results: Accountability	Volunteers and leaders began complaining if outreach postponed, due to their involvement in micro-planning and MVMH	The additional community engagement supported the Universal Immunization Program	Informants say that VHs have become much more vocal in reporting problems with health services	VHs now more insistent that HFs ensure an adequate supply of vaccine and cards, so coverage does not suffer	Enhanced sense of community ownership of routine immunization	VHs have become more vocal in reporting problems with health services
Results: Integration	An NGO project adapted the MVMH tool for community monitoring of	VHND are already integrated; not only are vaccinations given but growth monitoring,	Exclusive breastfeeding and family planning are not tracked but are	Tool includes tracking of vitamin A doses; has been complementary to commu-	A memorandum of understanding among the state government, BMGF and	MVMH includes monthly growth monitoring for nutritional status as well

References

Field action report (journal articles):

Engaging Communities With a Simple Tool to Help Increase Immunization Coverage

Community Monitoring of Individual Children's Vaccinations: Six Country Experiences

My Village My Home: A Tool to Optimize Immunization Coverage (India)

MVMH video (India)

My Village My Home: A Tool That Helps Communities Track Vaccinations of Individual Infants (Malawi)

My Village My Home: Strengthening Routine Immunization in Malawi - YouTube

Improving Immunization in Zimbabwe Through Increased Community Ownership

MVMH Zimbabwe video

Thank you!


Name of Child
BCG
DPT1
DPT2
DPT3
MV1
1. Tapiwa Moyo
2. Mary Miti
3. Peter Choto
4. Rudo Sambo
5. James Pasi
6. Rose Tshuma
7. Joan Siziba
8. Sipho Nkala
9. Soneni Zenda
10. Sakile Mathe

Additional slides:

- **BRICKS** (structure for blended learning)
- Zimbabwe **MVMH learning**
- Malawi **MVMH learning**

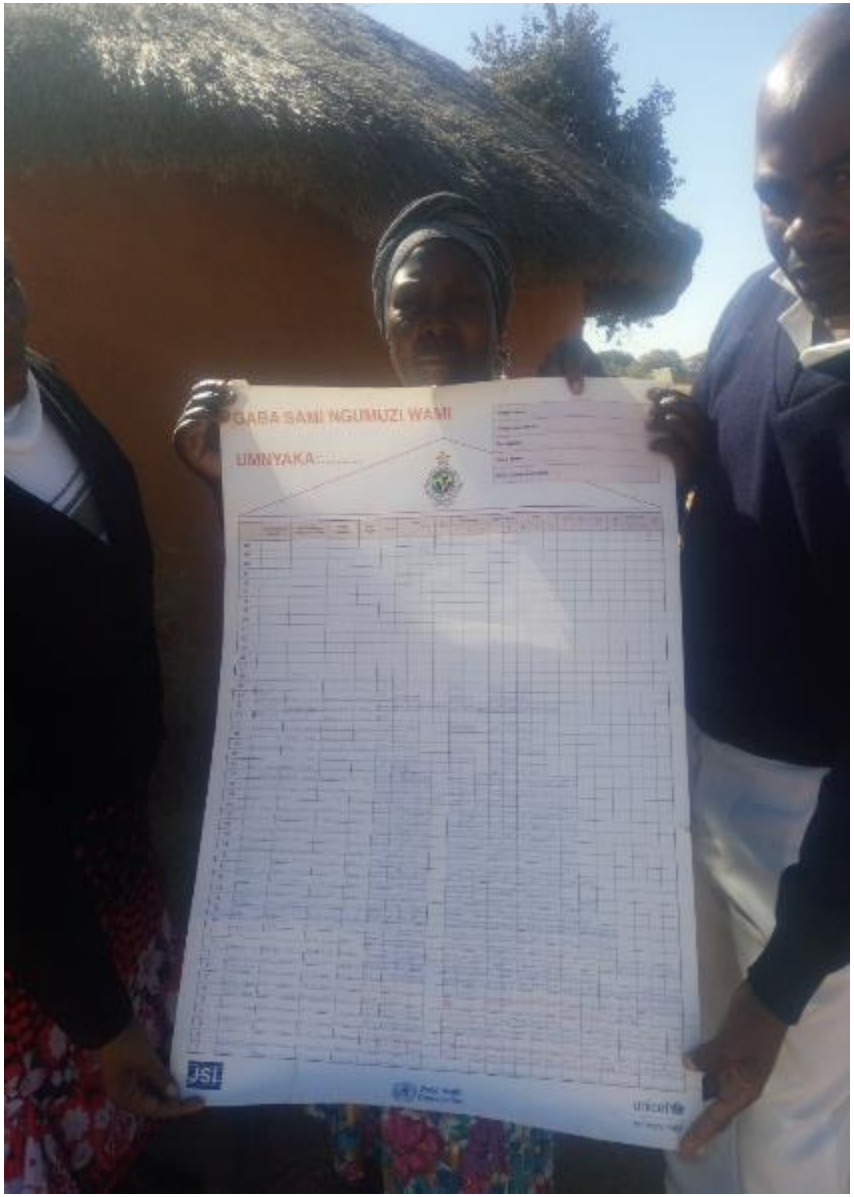
Recommendations

[Building Routine Immunization Capacity, Knowledge and Skills (BRICKS) - JSI]

Recommendations

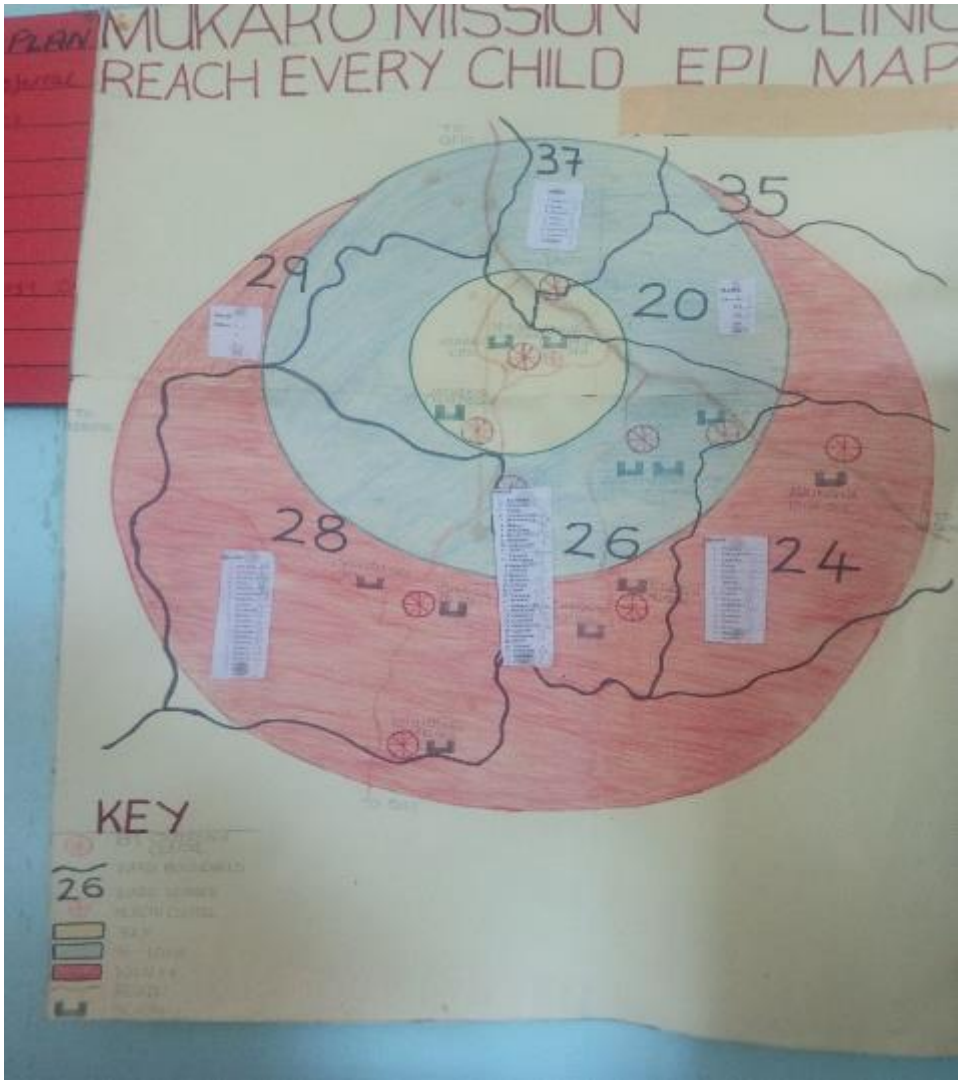
- Include follow-up on the MVMH/HBR implementation as an agenda item in supportive supervision visits, conducted by DNOs.
- National EPI program to provide defaulter tracking registers/standard tools for the health facility and village health workers.
- Link the MVMH/HBR approaches with other community-based efforts, like the community health dialogue between health workers and community members, to ensure sustainability.
- Engage the health promotion unit at all levels during planning and implementation as the MVMH/HBR interventions are demand related.
- Data triangulation to ensure data quality can be carried out during follow-up visits through comparison of the MVMH/HBR tools with the government data collection forms (i.e., T6 form, T5 consolidation form, and immunization monitoring graph).

Noted Improvements During Implementation



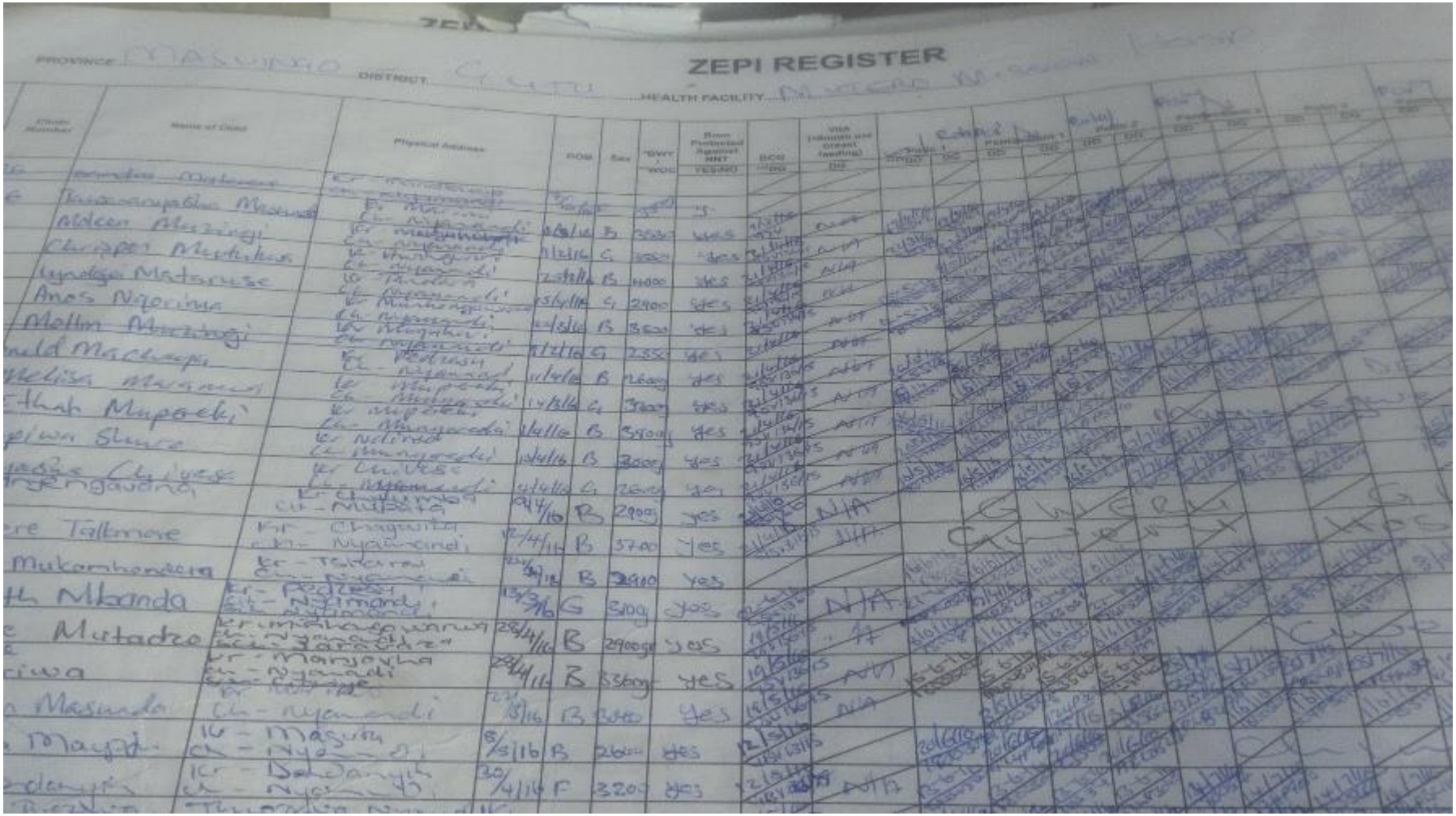
Knowing your hard to reach community

Well-drawn Reaching Every Child Map: Mukaro Mission Gutu District, Masvingo

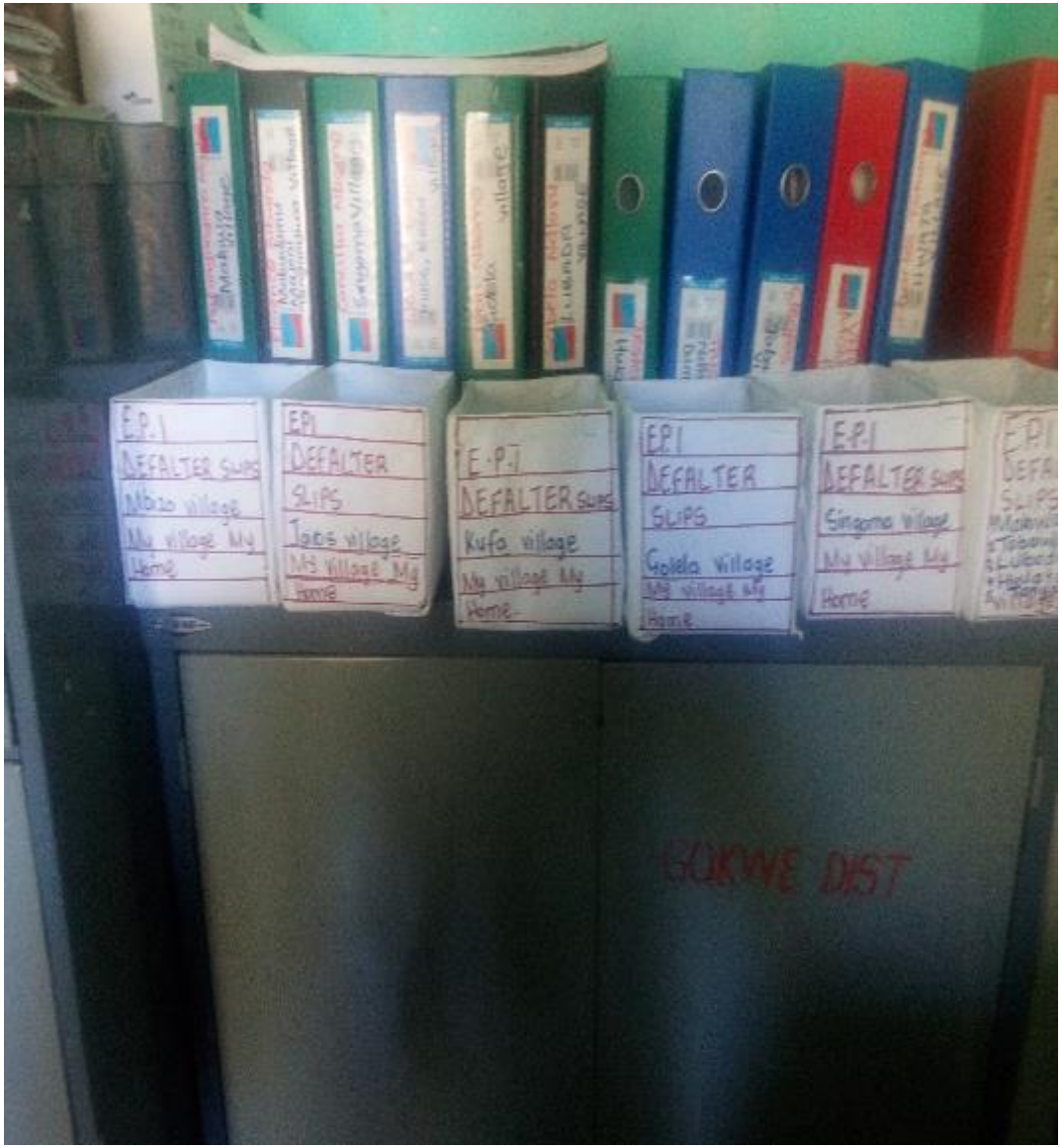


Well-documented RHC ZEPI register

Mutero Mission Hospital Gutu district



Defaulter tracking system: Nyaje Clinic, Gokwe South Midlands



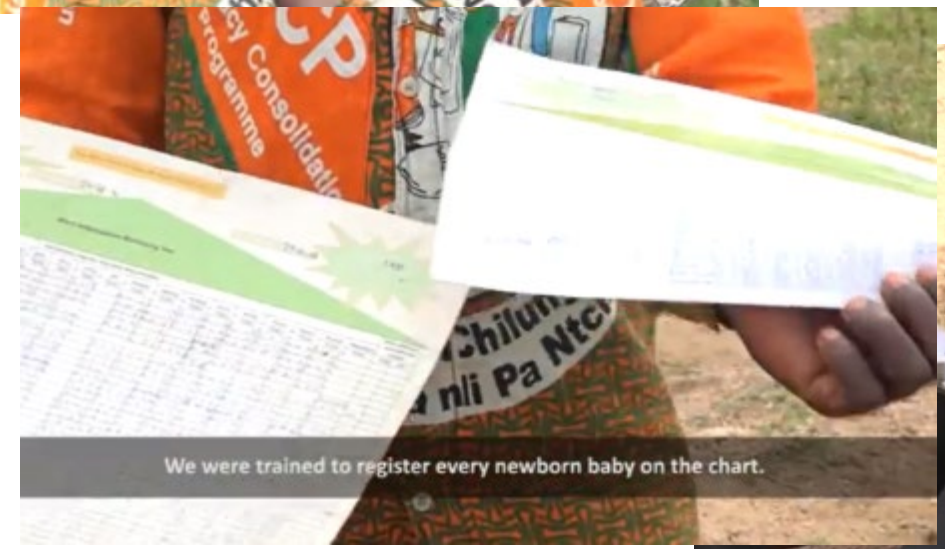
Testimonials from the Malawi MVMH video

Malawi local immunization officer

Resulting in training and engagement of:

Village Leader

Community volunteer



Caregiver and community volunteer

Health Center Administrator