



MCSP/Kelsey Freeman

Documentation of REC in Malawi

Authors

Asnakew Tsega and Michael Favin

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The Maternal and Child Survival Program is a global USAID initiative to introduce and support high-impact health interventions in 25 priority countries with the ultimate goal of ending preventable child and maternal deaths within a generation. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP addresses these challenges through approaches that encompass household and community engagement, gender integration, and eHealth, among others.

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Acronyms

cMYP	comprehensive Multi-Year Plan
CSO	Civil Society Organization
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DQSA	Data Quality Self-Assessment
EPI	Expanded Program on Immunization
FP	Family Planning
HF	Health Facility
HSA	Health Surveillance Assistant
HW	Health Worker
IIP	Immunization in Practice
MCSP	Maternal and Child Survival Program
MLM	Mid-Level Managers (training modules)
MOH	Ministry of Health
MP	Microplan (microplanning)
MR	Measles-Rubella (vaccine)
MVMH	My Village My Home (tool)
REC	Reaching Every Child
SS	Supportive Supervision
USAID	United States Agency for International Development
VH	(Traditional) Village Head
WHO	World Health Organization

Introduction

In October 2016 the USAID global Maternal and Child Survival Program (MCSP) began its third year of activities in Malawi. Activities have included technical support for nutrition, breastfeeding, family planning (FP), and immunization. MCSP's immunization work focuses on collaboration with the Ministry of Health/Expanded Program on Immunization (MOH/EPI) and partners at the national level; and provision of intensive support for implementing the Reaching Every Child (REC) approach in two low-coverage districts, which were selected from among seven districts in Malawi with Penta 3 coverage under 80%. REC aims to fully immunize every infant with all vaccines in the national immunization schedule.

Since October 2015 MCSP has supported implementation of all five REC components—(1) planning and management of resources; (2) reaching target population; (3) monitoring and use of data for action; (4) linking services with communities; 5) supportive supervision—in Ntchisi and Dowa districts. About 90% of villages in these districts, under the leadership of local Village Heads (VH) and volunteers, actively track the immunization status of infants using the My Village My Home (MVMH) tool introduced by MCSP in January 2016. In 2016, the quality of immunization services improved: the proportion of health facilities (HFs) with no stock-outs of vaccines increased from 31% to 80%; the proportion of HFs using monitoring charts increased from 46% to 85%. All (100%) HFs in the districts now monitor refrigerator temperatures twice daily, compared to 75% at baseline.

MCSP Immunization Support Overview

National-level Support

- Mid-Level Managers (MLM) training, involving all 28 districts
- National-level review meetings
- Supportive supervision (SS) by Technical Working Group (TWG) members
- Measles Second Dose introduction, switch from tOPV to bOPV
- National Effective Vaccine Management Assessment with MOH/EPI participation
- National EPI long-term and annual plans drafting assistance
- Prototype immunization curriculum revision, printing and distribution
- Revision and dissemination of immunization monitoring tools
- Integration of immunization data into DHIS2 Information System

REC Implementation in Two Districts

- REC HF and district microplanning (MP)
- Monthly supportive supervision by District Health Management Teams (DHMTs)
- Quarterly review meetings at district level
- Infant tracking / monitoring by VHs and volunteers using My Village My Home (MVMH) tool
- DHMT mentoring, via MCSP district officers

Capacity Building of Health Workers and Managers

- Immunization in Practice (IIP) training
- RAPID supportive supervision skills training
- Data Quality Self-Assessment (DQSA) training
- cStock (for vaccine supply monitoring and ordering) training

Family Planning (FP) and Immunization Integration Activities

The Review Exercise

After implementing REC and infant tracking and monitoring for over one year in focus districts, MCSP decided to conduct an internal review and documentation of the results. The broad objective of the review, developed in consultation with the national MOH/EPI team and USAID/Malawi, was to identify strengths, weakness, and lessons in order to strengthen immunization REC approaches and implementation in the country.

Specific objectives included:

- Document MCSP immunization assistance at national, district, and local levels
- Collect feedback from stakeholders
- Summarize data relevant to MCSP support
- Propose changes in strategy and activities for discussion with key partners

The methodology was primarily qualitative, and included semi-structured interviews with stakeholders ranging from national officials to community members. Interviews were conducted with the following:

- National EPI manager
- Key national partner staff
- MCSP national and district staff
- District Health Management Teams (DHMTs) and facility in-charges in Dowa and Ntchisi
- Senior Health Surveillance Assistants (HSAs) (polyvalent health workers who administer most vaccinations in Malawi)
- HSAs from five HFs (to represent high, average, and low coverage) in Dowa and three HFs in Ntchisi
- Traditional VHs and volunteers
- Mothers from communities representing eight HF catchment areas

Question guides were prepared for each respondent type, covering: immunization planning and management; reaching the target population; collection and use of data; community engagement; supportive supervision; and immunization/FP integration. The questions aimed to solicit facts, opinions, and suggestions.

Two headquarters-based MCSP Senior Technical Officers, one from the Malawi team and the other not, interviewed respondents over six days with assistance from MCSP Malawi and MOH/EPI staff. Research was supplemented by analysis of immunization and family planning performance data from MCSP, DHMTs, and a sample of MVMH tools. Data sources included: MCSP's program monitoring plan indicators; supportive supervision data; analysis of immunization coverage data from the community tracking tool (MVMH) from the communities visited and data from mini-surveys conducted by DHMT with support from MCSP; and available sources such as the 2015 Demographic and Health Survey (DHS) for Malawi.



Mothers' group interviews (MCSP)

While the interviewers faced challenges, they feel confident in the general findings. Although they intended to visit randomly selected communities, HF's usually selected conveniently located places. Nearly all HF's (and facility-based providers) were occupied by their work, so the review team had to adjust its schedule often by visiting communities first, and giving providers time to attend to their work. Interviewers needed to interpret when respondents were being frank or praising MCSP to please the interviewers. Near the end of documentation, the team debriefed USAID and presented findings at an Immunization Technical Working Group meeting chaired by the EPI Manager with the MOH and partners. MCSP/Malawi staff agreed to present and discuss findings with the two DHMTs.

General Findings

- District respondents universally appreciated MCSP support, and felt it made their immunization program stronger.
- The infant tracking initiative and quarterly review meetings were considered the most useful among many valuable interventions.
- The immunization program and health system as a whole depend on HSAs. Some are fully competent, while others require more skills and/or motivation.
- MCSP is considered a good and flexible national partner.



Interviews with HSAs and supervisors (MCSP/Mike Favin)

A number of process indicators show that MCSP support has greatly strengthened the competence and ability of the two district's health services, both to deliver vaccination services and to achieve high coverage (Fig. 1). However, administrative coverage is not showing improvement in both districts. A discussion of the issues follows.

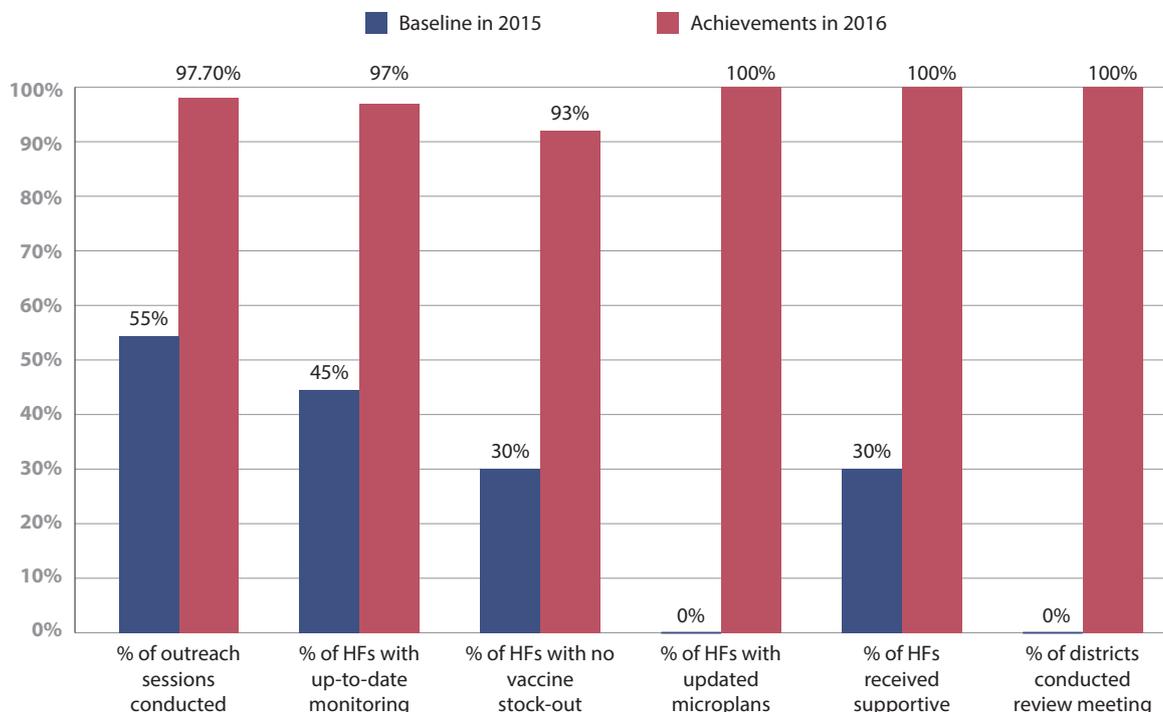


Figure 1 - Selected process indicators in two districts in 2015 and 2016

Similarly puzzling administrative coverage data are found in other districts in Malawi. The team, and other public health experts, tried to understand the situation. Although there is no definitive explanation, several hypotheses may be offered to explain data quality problems. One factor may be linked to a new and complex Under Two Register. It is difficult for HSAs to extract data from seven to nine registers in each HF by the end of the month. MCSP supported the MOH/EPI to re-introduce the immunization tally sheets which should address the problem. The DQSA conducted in 2016 revealed common under- and over-reporting in the two districts.

Several bits of evidence imply official target populations are too high, thus reducing reported coverage. FP acceptance increased rapidly, from 46% to 59% from 2010 to 2015 (DHS data), with a decline in the total fertility rate from 5.7% to 4.4%. The level of institutional deliveries is high nationally, at 91%. Using this level to estimate the number of live births in the two districts yields a number slightly more than half of the official target. National coverages for Penta 3 and first dose of measles vaccine were high: 93% and 91% in the 2015 DHS, respectively. In eight communities visited for this documentation, all 40 children studied were on track for vaccination (based on health passports). The district health team conducted mini community-based house-to-house surveys in 130 villages and the results indicated only 1.6% of infants had not commenced vaccination.

Given the conflicting information on coverage and the need to obtain reliable coverage data that shows the impact of the approach, the documentation team recommends that MCSP follow through with its plan to carry out coverage surveys or request that the MOH include the MCSP priority districts in their national survey. MCSP is confident that the MOH would include enough clusters to calculate district-specific coverage rates and indicators such as timeliness and valid doses in the national survey.

Findings and Suggestions for REC Components

Planning and Management

- Respondents felt the MP process, in conjunction with data improvements and review meetings, has made a significant contribution to making plans and services more data-driven, efficient, and effective. They offered no specific suggestions on improving the process.
- HSAs and community member representatives regularly participated in MP; but only some CSOs participated.
- The HF MPs are incorporated into the District Implementation Plan. Although this plan is budgeted, only a portion of committed government funding becomes available for implementation.
- During quarterly, two-day district review meetings, each HF brings its data, experiences, and solutions to compare with those of the previous quarter. Respondents consider the meetings to be valuable for sharing implementation status, strategies, and suggestions, as well as to update plans. Respondents felt quarterly review meetings were useful for building staff appreciation and use of data, as well as for establishing a sense of teamwork and common purpose among community representatives and formal health staff.
- Some HSAs work with VHS and volunteers to plan individual outreach sessions.
- HF in-charges appear to be focused on curative care and to be minimally engaged with immunization planning and management.
- DHMTs felt that the MLM training was useful.
- MCSP is considered an important collaborating partner at national level. The Program participates in the Technical Working Group, helped develop the cMYP (comprehensive Multi-Year Plan), and helped develop and participate in national-level supportive supervision in the districts.

Suggestions: Planning and Management

- MCSP should continue to provide technical and financial support for microplanning and review meetings, but gradually decrease support, encouraging district and HF staff to take the lead.
- Encourage national EPI and district teams to request HF in-charges to participate more in immunization planning and management, and to orient them as necessary.
- Suggest that costing be a routine part of HF microplanning.
- Encourage district staff to include more HWs and community collaborators in HF preparations for microplanning and review meetings.
- Propose that more local CSOs participate in microplanning, and encourage them to help sustain monitoring and mobilization activities in focus communities, as MCSP scales down support.
- Encourage DHMTs to engage more with District Executive Committees and Area Development Committees, which could assist with financing and sustainability.

Reaching the Target Population

- Outreach is important: 60% of vaccinations in the two districts are provided in outreach sessions.
- Demand for preventive and curative services appears to be high; HFs are heavily utilized, with swarms of clients appearing particularly during the morning hours.
- Respondents at all levels consider infant tracking to be an effective initiative, working well in most communities where it was introduced; it has been introduced in the majority of communities within the two districts.
- Immunization coverage appears to be nearly 100% in communities where infant tracking and monitoring using the MVMH tool is well implemented (an estimated 60 to 90% of communities).

- Due to improvements in cold chain, vaccine supply, and referral from other services, there are fewer canceled outreach sessions and missed opportunities.
- Most village heads and volunteers are effective, but some are not working as effectively. Some volunteers lack motivation and/or skills/training, sufficient literacy, or have not received sufficient support and encouragement from HSAs. Some VHs selected inappropriate volunteers who have not been very active.
- District and facility staff appreciated MCSP support procuring key commodities, including gas cylinders and petrol. Without support from MCSP, the DHMT would have more limited reach and coverage.



VHs and volunteers mobilizing and monitoring the immunization status of the infants in the villages (MCSP/PACHI)

Suggestions: Reaching the Target Population

- MCSP should encourage national partners to consider implementing community tracking and monitoring in other districts, based on MCSP experience; this should be rolled out gradually, with rapid assessments, to ensure acceptable quality and to provide feedback for any needed adjustments in introductory and maintenance support.
- Based on a needs assessment, MCSP should provide training to some existing HSAs, VHs, and volunteers.
- Based on an analysis of staff and coverage by area, MCSP should encourage the DHMTs to request more HSAs and volunteers.
- Evaluate and respond to the request of many HSAs and volunteers for bicycles or motorcycles for their transport needs.
- Evaluate and respond to the request of most VHs and volunteers for additional incentives.
- While MCSP should support essential costs on an emergency basis, the MOH and donors must strive either to increase district operational budgets and/or find more efficient ways to provide essential logistics. The system will lack sustainability if it consistently relies on donor support.
- DHMTs should develop minimum qualification standards to help recruit more competent volunteers.

Data Recording and Use

- Respondents noted a number of improvements in the availability and use of tools supported by MCSP, including introduction of the MVMH tool, c-Stock monitoring, and the re-introduction of tally sheets.
- MCSP has made it more likely that HWs will analyze and act on the basis of data, particularly in quarterly review meetings; however, the recording, tabulation, and use of data remain weak.
- Respondents mentioned (and the team observed) poor, incomplete use of the Under Two Register by many HWs because it is complex to use and/or a lack of planned training on its use.
- When a recent DQSA exercise compared the Under Two Register with reports, few came close to matching; under- and over-reporting was observed in equal measure.
- Return dates and other information are rarely written in child health passports (Figure 2). Return dates are

particularly important for children vaccinated in HFs; but perhaps not as important for communities that routinely attend a monthly outreach session.

- Respondents considered IIP training for HSAs practical and useful for providing immunization service.
- Many, but not all, HSAs are said to meet with VHs and volunteers at the end of outreach to transfer data, plan, and discuss defaulter follow-up.
- The Ntchisi DHMT felt they had initiated action on eight of nine DQSA recommendations, and that at least three were fully implemented.

IMMUNISATION RECORD

Protected at Birth (PAB) Yes No

AGE	VACCINE	DATE GIVEN (DD/MM/YYYY)	BATCH NUMBER	INITIALS	DATE OF NEXT VISIT
At birth	BCG	6/01/16			Scar seen Yes <input type="checkbox"/> No <input type="checkbox"/>
If no scar seen after 12 weeks, repeat dose. Date dose repeat given: / /					
0 - 14 days	OPV 0	3/2/16			
At 6 weeks	OPV 1	3/2/16			
	Rota 1	3/2/16			
	DPT - HepB-Hib 1	3/2/16			
	PCV 1	3/2/16			
1 month after 1 st dose	OPV 2	16/3/16			
	Rota 2	16/3/16			
	DPT - HepB-Hib 2	16/3/16			
	PCV 2	16/3/16			
1 month after 2 nd dose	OPV 3	15/4/16			
	DPT - HepB-Hib 3	15/4/16			
	PCV 3	15/4/16			
At 14 weeks	IPV				
9 - 11 months	Measles 1	16/9/16			
15 - 23 months	Measles 2				

free xref issued

Figure 2 - Child Health Passport; often no information was entered in the last three columns

Suggestions: Data Recording and Use

- Support continued capacity-building via quarterly review meetings, supportive supervision (mentoring), training of HWs, and exchange visits (among HWs and VHs and volunteers).
- Suggest that DHMTs encourage and require data exchanges and discussions at the end of every outreach session; HSAs should compare MVMH names and information with register/tally sheets.
- Suggest that DHMTs require in-charge and environmental health officer to review and approve all immunization reports before submission.

Community Engagement

- HF and district staff interviewed were enthusiastic about the infant tracking initiative. They value having more accurate target population lists, and the high coverage in many MVMH communities. Interestingly, most respondents describe MVMH primarily as a defaulter-tracking tool; but, in fact, there are few defaulters in communities where the VH actively promotes immunization.
- MCSP has facilitated significant progress in this area: hundreds of communities, 700 in Ntchisi alone, are using infant tracking and monitoring using MVMH tools, mostly as intended.
- A minority of volunteers and HSAs are not supporting the initiative as expected; some volunteers were not performing, indicating a problem with recruitment.
- Most VHs leverage their prestige and authority to convince families to have children vaccinated. A number of VHs, with community consent, have issued bylaws providing for financial or in-kind penalties (such as giving up a chicken), for not immunizing. Coverage is near 100% in many MVMH communities.
- VHs and volunteers feel proud of their community coverage; they also feel responsible for ensuring children in their community are fully vaccinated.

- More experienced VHs and volunteers collaborate more often and more effectively with HSAs.
- Many VHs and volunteers educate about vaccination, and answer questions in outreach sessions and home visits; many mothers are well-informed about vaccination and vaccine-preventable diseases.
- Mothers claim that most fathers both encourage and remind about vaccination; some husbands purchase beauty aids for their wives when attending outreach sessions.
- Community members say that FP acceptance is high in villages; some methods are offered.
- Some mothers felt families are embarrassed by defaulter tracing visits, so they try to avoid such visits by keeping current children's vaccinations.
- VHs and volunteers want more training and more incentives.

Suggestions: Community Engagement

- MCSP should ask DHMTs to encourage and support HSAs to go into each of their communities at least quarterly to encourage the VHs and volunteers, and to speak with families.
- MCSP should assess DHMTs' interest in preparing a plan for incentives for VHs and volunteers every six months. A plan of incentives may include small gifts given each quarter, such as a photo ID card or a bar of soap. The plan might include support from private companies, community support of volunteers (such as helping harvest crops), and honoring the most active volunteers and VHs at district events.
- MCSP and DHMTs should expand infant tracking into populations without MVMH; this may require dividing some communities into MVMH zones, as respondents claimed some communities are too large for one volunteer and one MVMH.
- Many respondents suggested revising the selection process and criteria for volunteers to reduce the chance of recruiting low-performing volunteers.
- MCSP should discuss with national partners the idea of supporting the introduction of some form of infant tracking by communities in additional districts to reach every child in the villages and trace defaulters.
- MCSP should follow through on its proposal to make a video of the entire community tracking process for other districts and countries.

Supportive Supervision

- District staff usually conduct monthly supportive supervision visits in each HF. Every third visit uses a checklist and includes feedback from staff and jointly planned action points. The next two visits review progress on action points.
- MCSP and the DHMTs analyze performance scores at the district level (although not as immediately and thoroughly as possible) to identify weaker HFs and indicators.
- Round to round, scores for most, but not all, SS indicators have improved (Figure 3); a few have not.
- It appears there is no systematic, in-house supervision of immunization by HF in-charges, who appear to be more focused on providing curative care.
- MCSP worked with UNICEF and other national partners to develop a supportive supervision checklist.
- MCSP works with partners to help fund and bring national supportive supervision visits into districts. Respondents considered these helpful, but noted that many action points are not implemented.

Suggestions: Supportive Supervision

- MCSP should refresh district supervisors on SS skills and technical issues and explore with DHMTs the feasibility of HF in-charges providing in-house SS and support of immunization.
- DHMTs should analyze SS findings sooner and more thoroughly, and use findings to target weak areas through mentoring, job aids, or even staffing changes (as a final option).
- The national EPI or partners should find additional funding to help low-performing districts to implement the improvements agreed to in SS.
- For national SS, after several months, supervisors should revisit the weakest districts to assess progress in implementing action points.

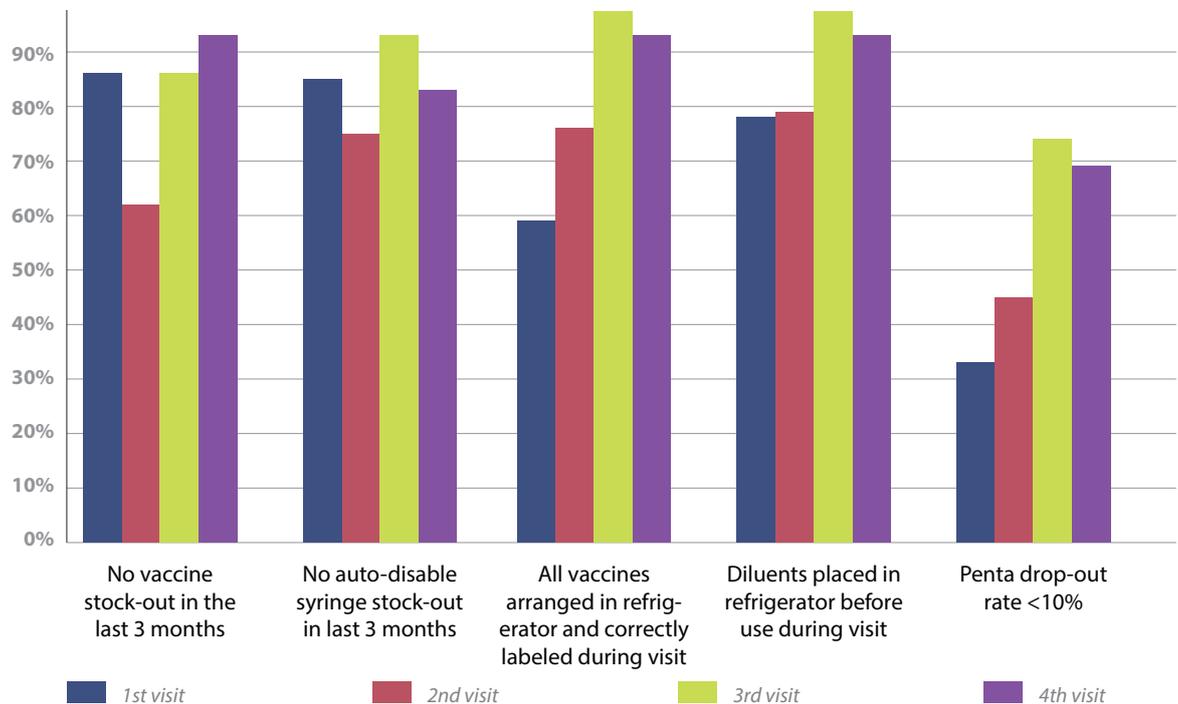


Figure 3 - HF's Performance on a Sample of Indicators during Four Supportive Supervision Rounds in 2016

Immunization/FP Integration

- FP acceptance has increased from 46% to 59% nationally (DHS 2010 and 2015).
- The training of many HSAs in FP has had a positive impact; they offer immunization and some FP methods in outreaches and refer for other methods that need higher-level skills.
- Respondents in infant tracking and monitoring communities claimed most women were using FP; if true, this may be contributing to overestimating the target number of infants for vaccination.
- All respondents liked the idea of intra-service referrals and expressed positive attitudes towards both immunization and FP interventions.
- MCSP's referral forms appear to be used in some HFs / settings but not in others. Women are normally alerted to other services regardless of whether the form is used.
- In many HFs, a HW screens incoming mothers; at outreach sessions all available services are mentioned in the introductory health talk. Services are provided in the same location, sometimes by the same HSA.
- Providers like the FP counseling materials and find them useful.
- There are some referrals from FP to immunization, but their impact on timeliness and coverage is unclear, and is likely to be minimal.

Suggestions: Immunization/FP Integration

- MCSP and DHMTs should continue to encourage and expand integrated immunization and FP services.
- MCSP should assess the utility of referral forms, possibly limiting use to HFs where immunization and FP are offered in different locations, and where clients are not screened and directed to services on entry.
- Consider more simple methods to count any needed referrals (e.g. tick mark in existing register).
- MCSP should continue training, supervision, and reporting of this initiative.

Expansion and Sustainability

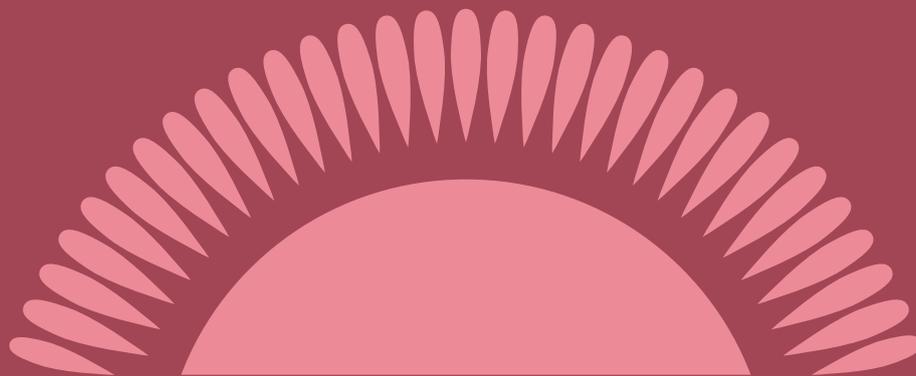
In the two priority districts, MCSP made significant contributions to staff skills; community engagement; improved planning and use of data for management; and reliability of fixed and outreach services (e.g. 93% of outreaches planned conducted in Ntchisi). Problems and challenges remain: there is a shortage of HSAs; a lack of staff skills in data recording, collection, and consistent use; a desire for more incentives for VHs and volunteers; and the need to improve the quality of infant tracking in some communities. Nevertheless, there has been clear progress that is appreciated by district staff at all levels.

Sustainability is always a challenge for resource-challenged MOHs that rely almost entirely on donor funding. There is never a guarantee of sustainability, but strategies correlating with endurance of improvements are known. MCSP has done a solid job in three areas: (1) supporting community engagement; (2) focusing on multiple methods of capacity-building; and (3) promoting integrated services. Still, it is unlikely that useful activities such as training, supportive supervision, and quarterly data review meetings can continue at the same frequency without donor funding.

The national EPI manager has asked MCSP to consider expanding support to additional districts. MCSP forwarded this suggestion to USAID, which will discuss and specify next steps. To manage expansion, should it occur, MCSP proposes to move current district staff to new districts, ideally in the central region. First, there would be a period of at least three months during which they would work with DHMTs in Dowa and Ntchisi to decrease intensity of some activities (such as SS) and increase district leadership. After the transition period, MCSP national staff would continue to provide periodic support to Dowa and Ntchisi.

Conclusion

The USAID-funded MCHIP and MCSP projects have supported the Malawi immunization program since end of 2011, including successful introduction of new vaccines and capacity building of HW at all levels. At the request from MOH/EPI, MCSP has been supporting two under-performing districts, Dowa and Ntchisi, in strengthening routine immunization. This documentation exercise revealed that the immunization system is strong in the two districts. Almost all villages have trained and empowered VHs and volunteers to track and monitor immunization and other primary health care services. Mini-surveys conducted by district supervisors indicated over 98% of infants were reached with immunization services. In addition, the contacts were used to counsel postpartum women for FP services, for which utilization has improved significantly. The review team concluded that the MCSP support might now be gradually scaled down in these districts and that USAID and the MOH should consider replicating REC and infant tracking support in other low performing districts.



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