Comprehensive training

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Participatory Approaches for Monitoring & Evaluation (for vaccination communications/demand)

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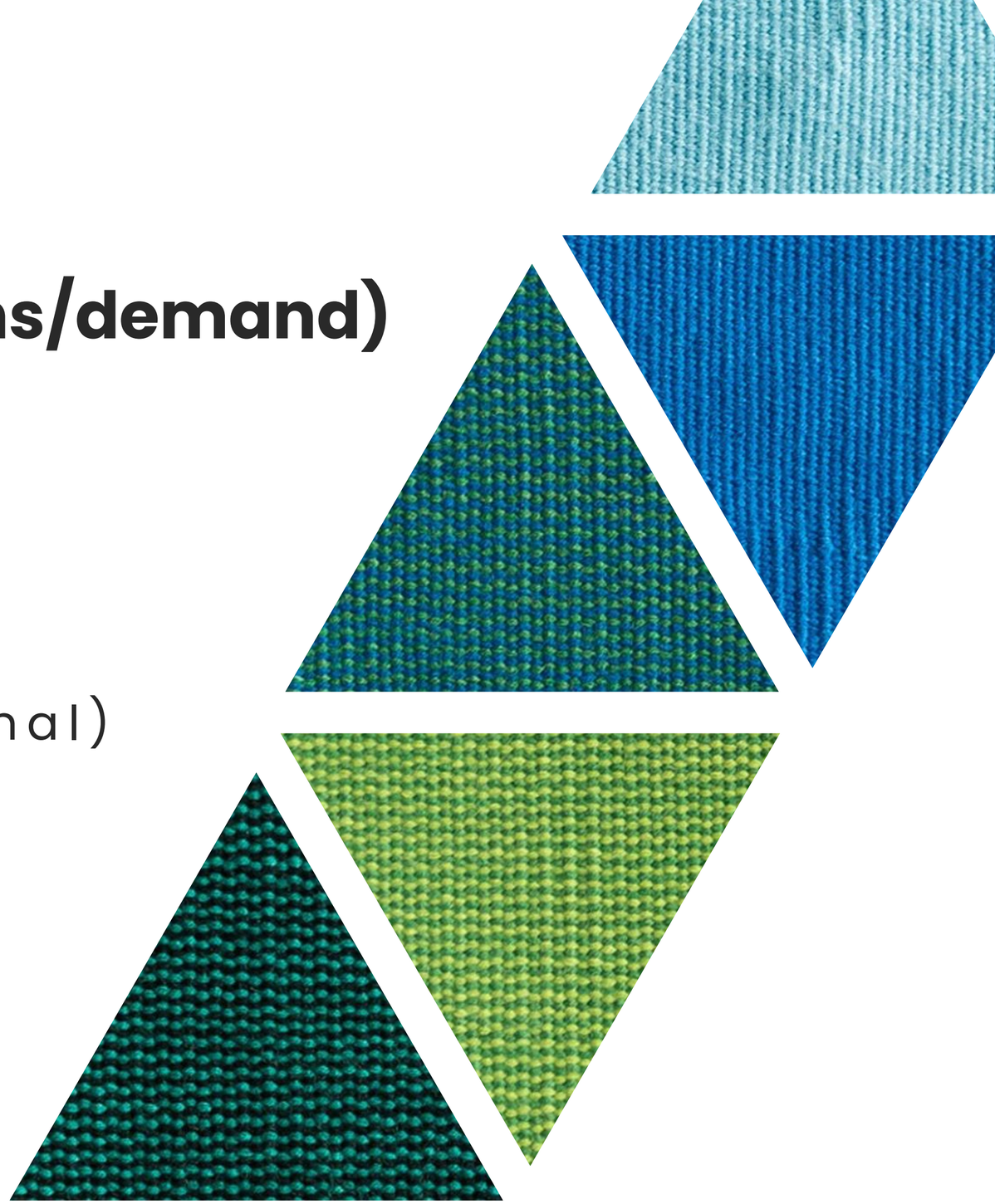


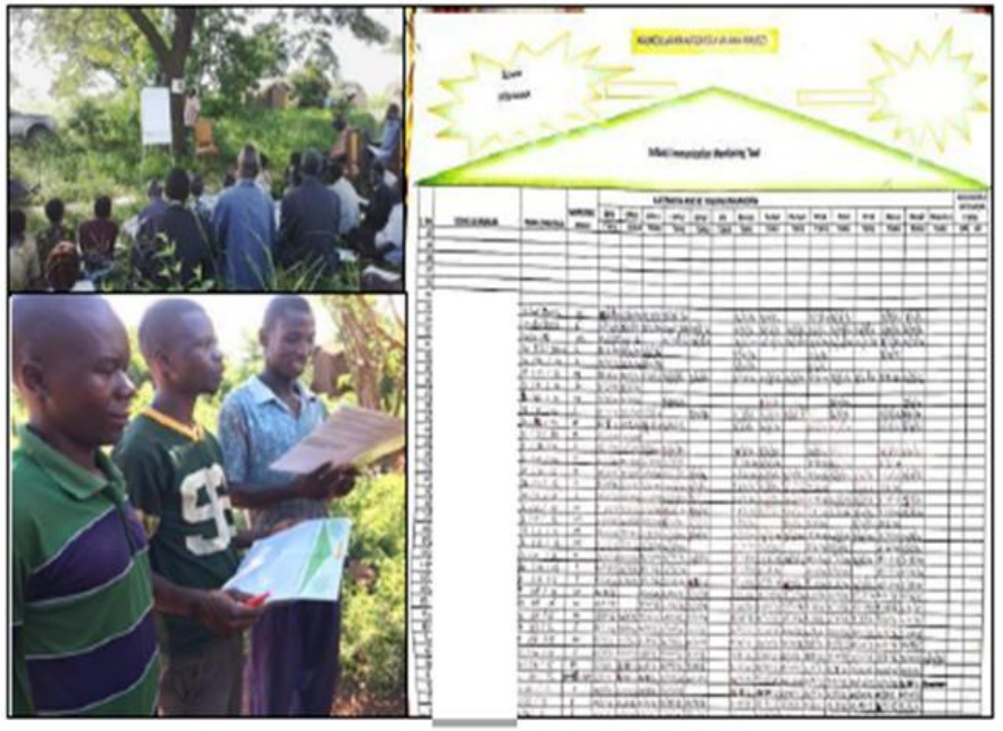
Outline

- Explanation of participatory monitoring and evaluation and how it applies for vaccination communications and demand
- Description of several participatory approaches in the immunization context
- Three country examples of different participatory M&E approaches
- Summary and ways to apply participatory M&E

Learning objectives

By the end of this session, participants will be able to…

- Describe at least 3 different participatory monitoring and evaluation approaches that can be used for vaccination communications
- Select participatory approaches that can be used for M&E with the immunization programs that they support
- Develop scenarios for participatory M&E based on examples



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

Definitions

Participatory	affording the opportunity for individual and group collaboration and engagement
Interactive	allowing a two way flow of information and exchange
Extractive	information or data gathering that can be misguidedly embedded in systems of power or hierarchy that often privilege technical and scientific knowledge over local and cultural knowledge
Quality Improvement	a systematic approach using specific methods to improve quality; achieving successful and sustained improvement

What do we mean by ‘participatory’ M&E for vaccination communications?

- Program monitoring and evaluation is participatory when it includes:
  - audience and recipient input,
  - perspectives and feedback that is sufficiently representative, and
  - contributes to measurement of outputs, outcomes, and impact of the activities/projects/initiatives for vaccination communication and demand

- Linkage of qualitative and quantitative data to assess the communication components and how they are assisting with achievement of health indicators (such as individuals confident in vaccination, attending vaccination services, and receiving expected vaccination services of accepted quality)

Why is participatory monitoring important?

Photo Credits: Karen Kasmauski/MCSP

- M&E often focuses disproportionately on extractive data for impact or results (such as numbers vaccinated or % coverage) but not on the *routine monitoring* that is beneficial for more rapid, frequent and local data analysis, use and decision-making

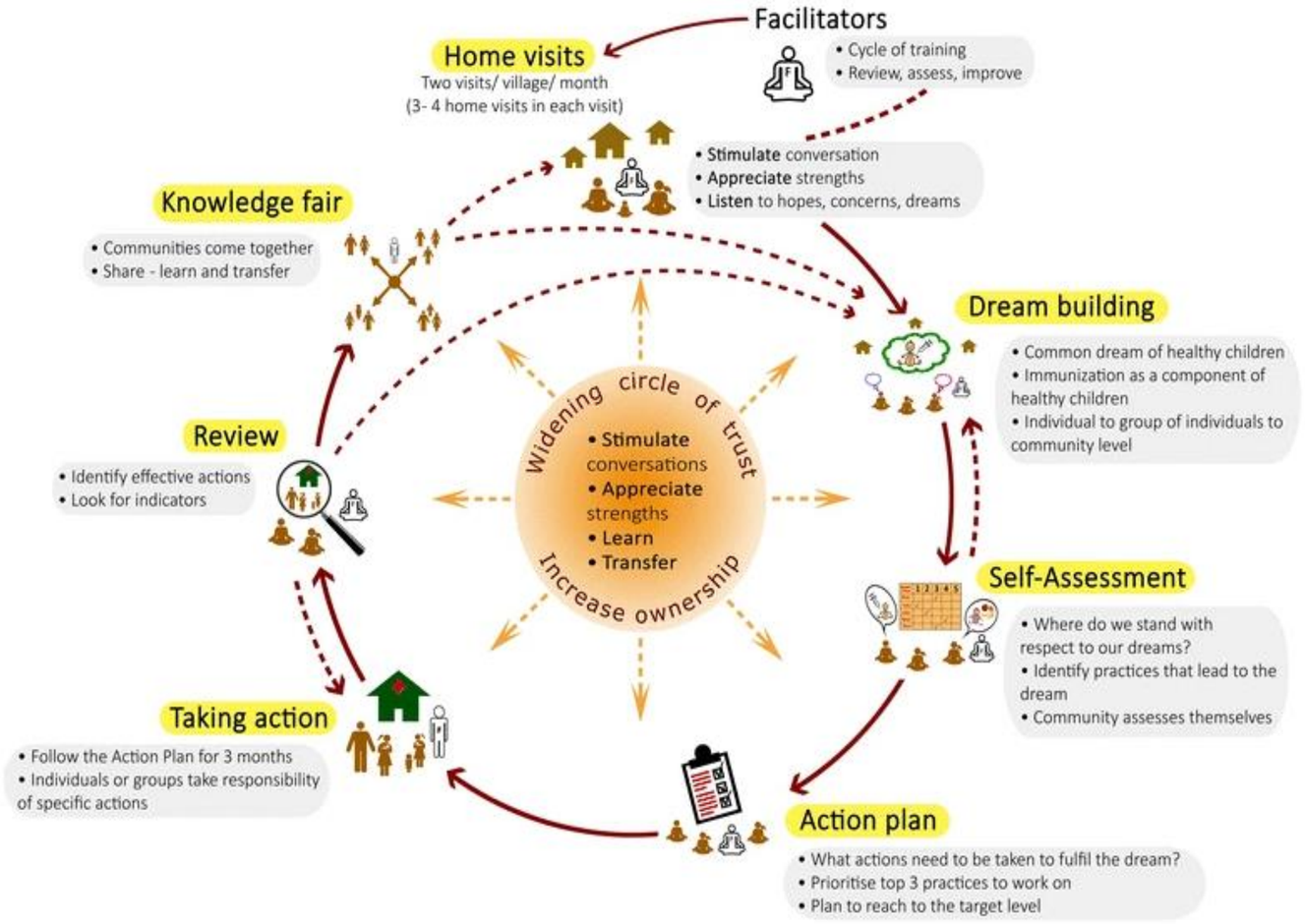
- Measuring *process* learning and cross-referencing qualitative and quantitative data through participatory approaches can contribute to:
  - Synthesizing evidence and 'telling the story' of how activity accomplishments are measured and achieved/not achieved
  - Making the learning accessible and digestible for quick, on-hand decision making (particularly for those gathering the data)
  - Collaboration on the use of the data with the people that were part of its collection (interactive feedback, joint review, and linking back with activity planning)

Examples of participatory approaches for M&E

- Exit interviews, key informant interviews, intercept interviews
  - For larger settings: Snowball sampling – building and accumulating information from continuous sources
- **Most significant change methodology** (narrative-based; conducted with people impacted by a program and systematic analysis of trends)
- **Interactive case studies, narratives, personas** – used in group settings or with different audiences
- **Action reviews** – participatory feedback and analysis around agreed upon indicators and/or tools for anticipated activities and results
  - Review meetings (e.g. monthly, quarterly)
  - Quality improvement methodology (Plan, Do, Study, Act cycles for small tests of change)
  - My Village, My Home (MVMH)
  - Tailoring Immunization Programmes (TIPs)
  - Collaborative community checklists and collective measurement (Champion Community Approach; scorecards)
- Digital interactive
  - App-based learning with built-in survey or metrics (such as quizzes, periodic assessment to move to next level)
  - Community video
  - Rapid online feedback/input: Mentimeter (https://www.mentimeter.com)
  - Online surveys: SurveyMonkey (https://www.surveymonkey.com)
  - Interactive voice response (automated messaging and reply with audiences for input/feedback)

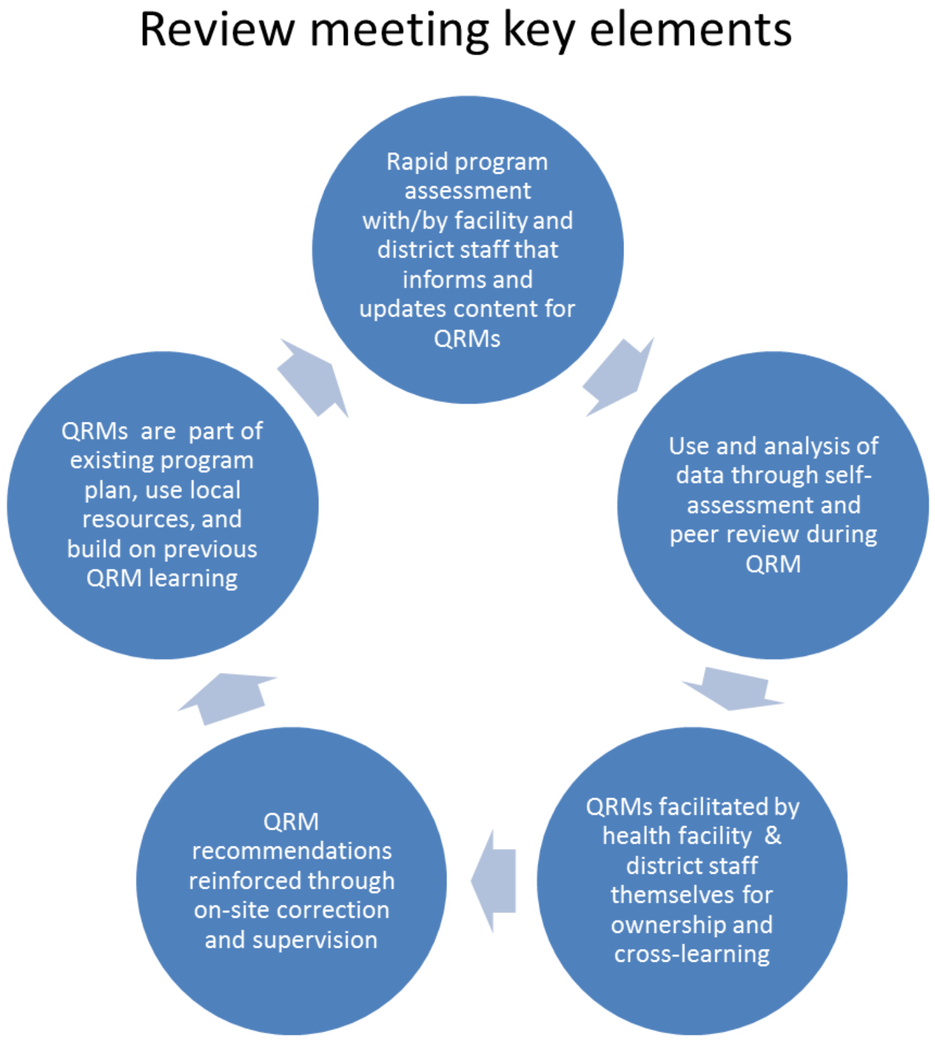
What does this look like in practice?

From: Impact evaluation of a community engagement intervention in improving childhood immunization coverage: a cluster randomized controlled trial in Assam, India



Pictorial illustration of different steps of SALT intervention

Participatory M&E via regular reviews (e.g quarterly meetings – QRM)



Immunization review meetings: "Low Hanging Fruit" for capacity building and data quality improvement (panafrican-med-journal.com)

Example 1: Quality Improvement Methodology

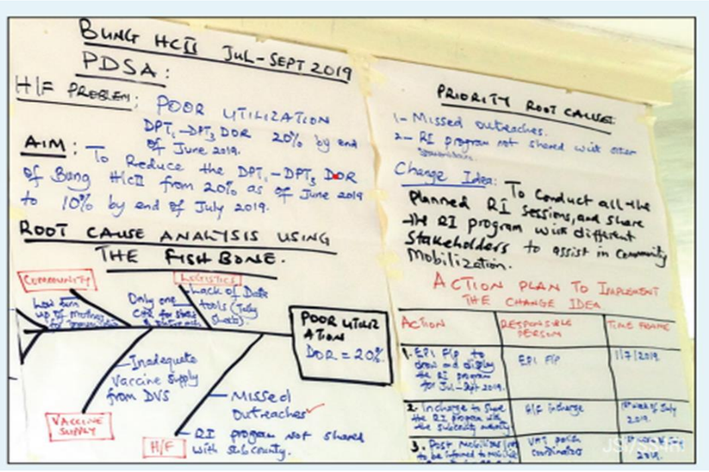
Engage communities in microplanning and monthly data and activity plan reviews

1. *Agree upon measurement of simple, easy-to-measure indicators*
   - Examples:
     - # of vaccination sessions held per plan each month;
     - # of caregivers/adults informed about vaccination sessions compared with the # that then attended the sessions

2. *Participatory action reviews as a regular monitoring process (incorporating performance, output and outcome indicators that can be measured collectively)*
   - Example: reviews with community contacts to assess their interactions with caregivers of newborns – Do they inform and encourage caregivers to vaccinate the infants (which, how many)? Are their activities linked with tracking of the caregivers that then attend vaccination sessions?

UIFHS snapshot

https://youtu.be/xR6vlif6GqY

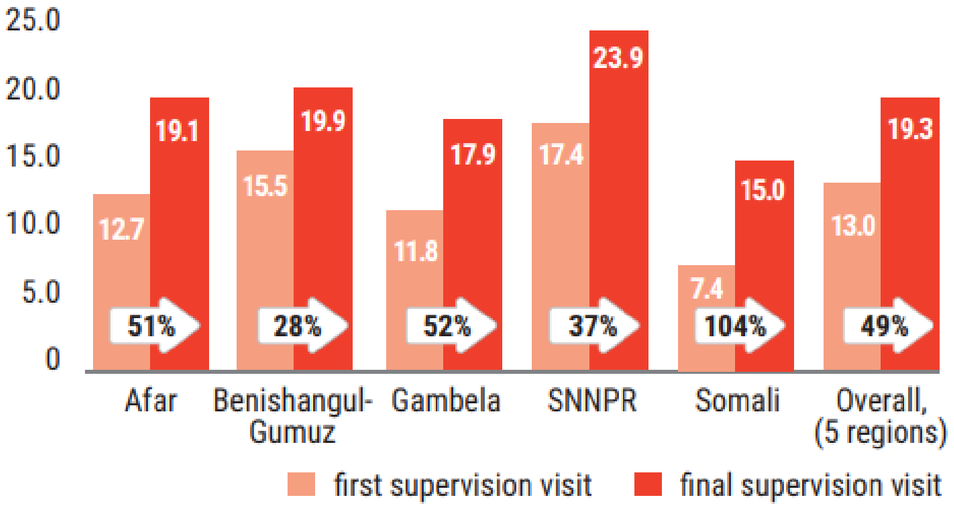


Example 1: Results of Quality Improvement for Immunization in Ethiopia

HEALTH STAFF WITH GREATER CAPACITY TO PROVIDE AND MANAGE SERVICES

Supportive supervision data showed woredas in all five regions demonstrated improvement in microplanning, vaccine management, community involvement,and data quality, management, and use.

Average district level scores and percent change over time on EPI-specific supervision checklist, for facilities with ≥ 3 supervision visits



IMPROVED DATA QUALITY AND USE

More health facilities reported consistent immunization coverage across three immunization reporting tools, suggesting greater accountability from health workers for quality data.

Facilities with consistent pentavalent3 data across all reporting tools		
	Baseline	Endline
WoHO level (n=10)	50%	80%
HC level (n=19)	21%	84%
HP level (n=35)	26%	43%

Example 2: My Village My Home Tool and Home-Based Records

How does this work?

My Village My Home in Action

Village Health Workers (VHWs) and village heads (VHs) link with nurses from the health centers where children are vaccinated

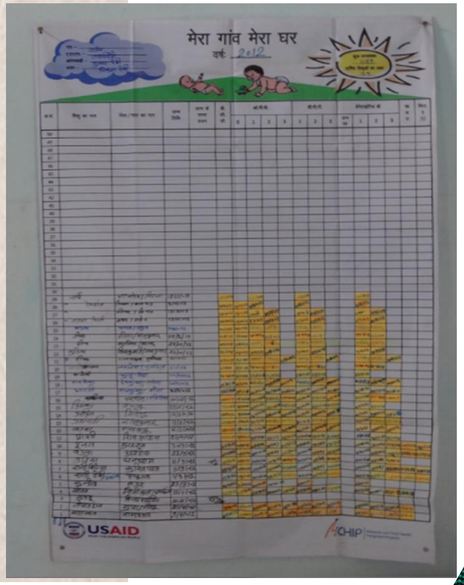
VHWs update registers for children under two years of age by comparing with the health facility register

VHWs check the child health cards and update the MVMH tool

Charts are displayed at the homes of the VHs and also taken to village meetings

VHs and VHWs review the charts to identify rows with missing bricks

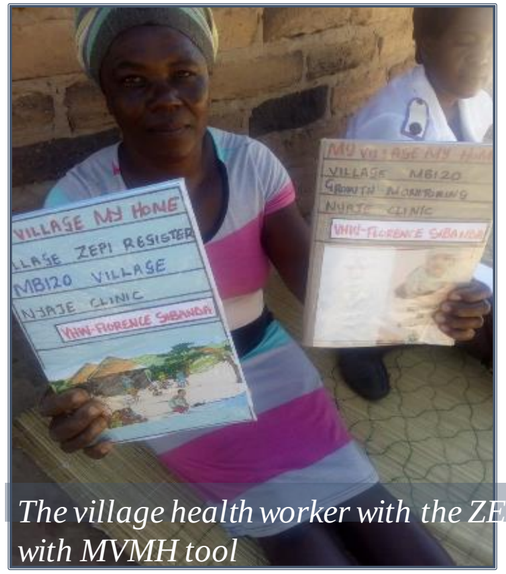
The VH encourages the VHW to follow-up at the child's home to remind the caregiver of the missing vaccine



Example 2: Zimbabwe MVMH and HBR Intervention

- 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**



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

Example 2: Zimbabwe MVMH and HBR 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	

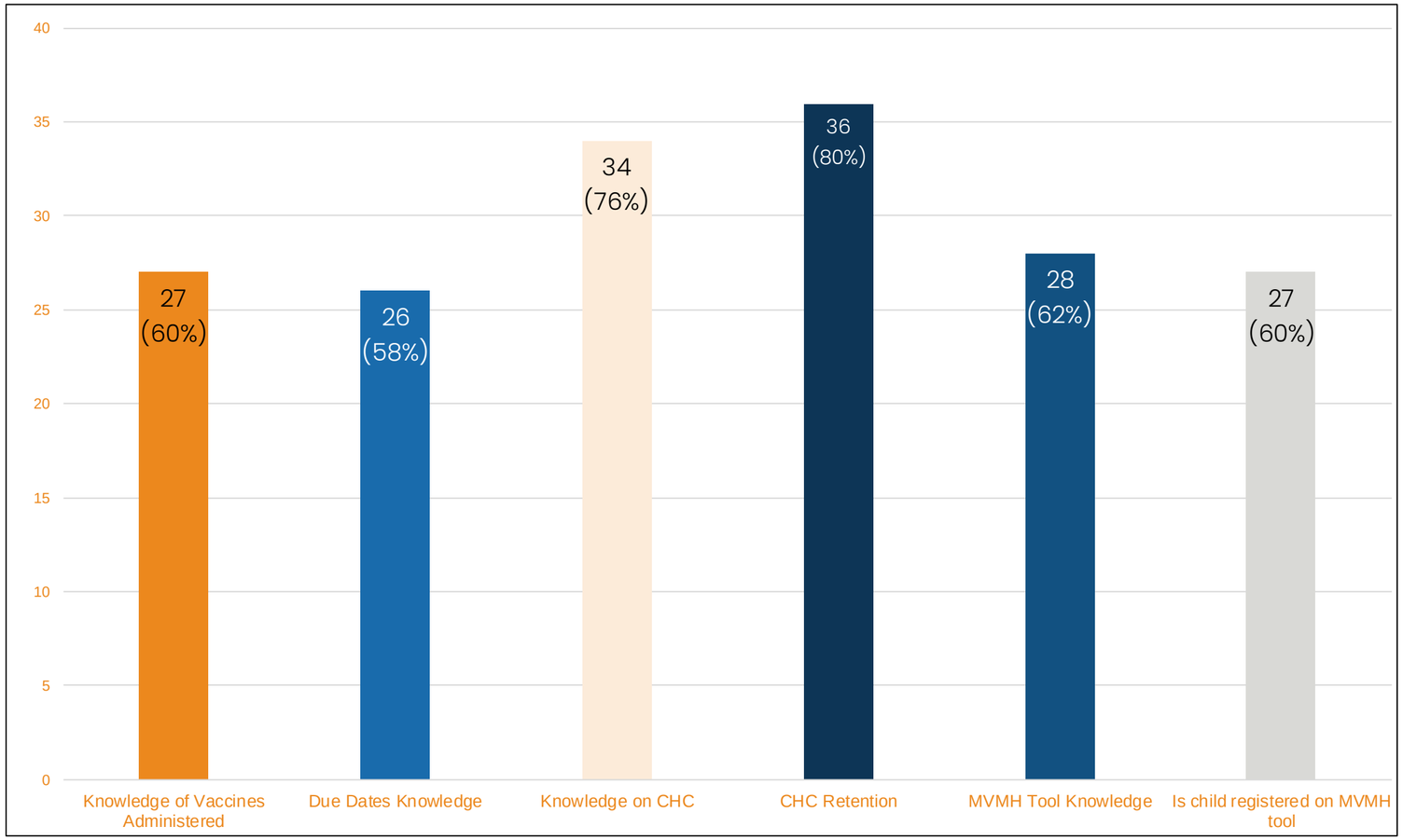
- **Location:** Matabeleland South and Midlands provinces in 2 randomly selected districts: Bulilima and Gokwe South
- **Timeline:** 4 – 10 November 2019
- **Approach:**
  - 10 randomly selected rural health centres (5 per district)
  - Exit interviews with caregivers
  - In-depth interviews conducted with staff from the selected facilities, VHWs, and VHs
  - Evaluators examined completeness and use of the VHW register

Example 2: Summary of Participatory Evaluation Findings

Caregiver Knowledge : CHC Importance, Vaccines and Due Dates

(n=45)

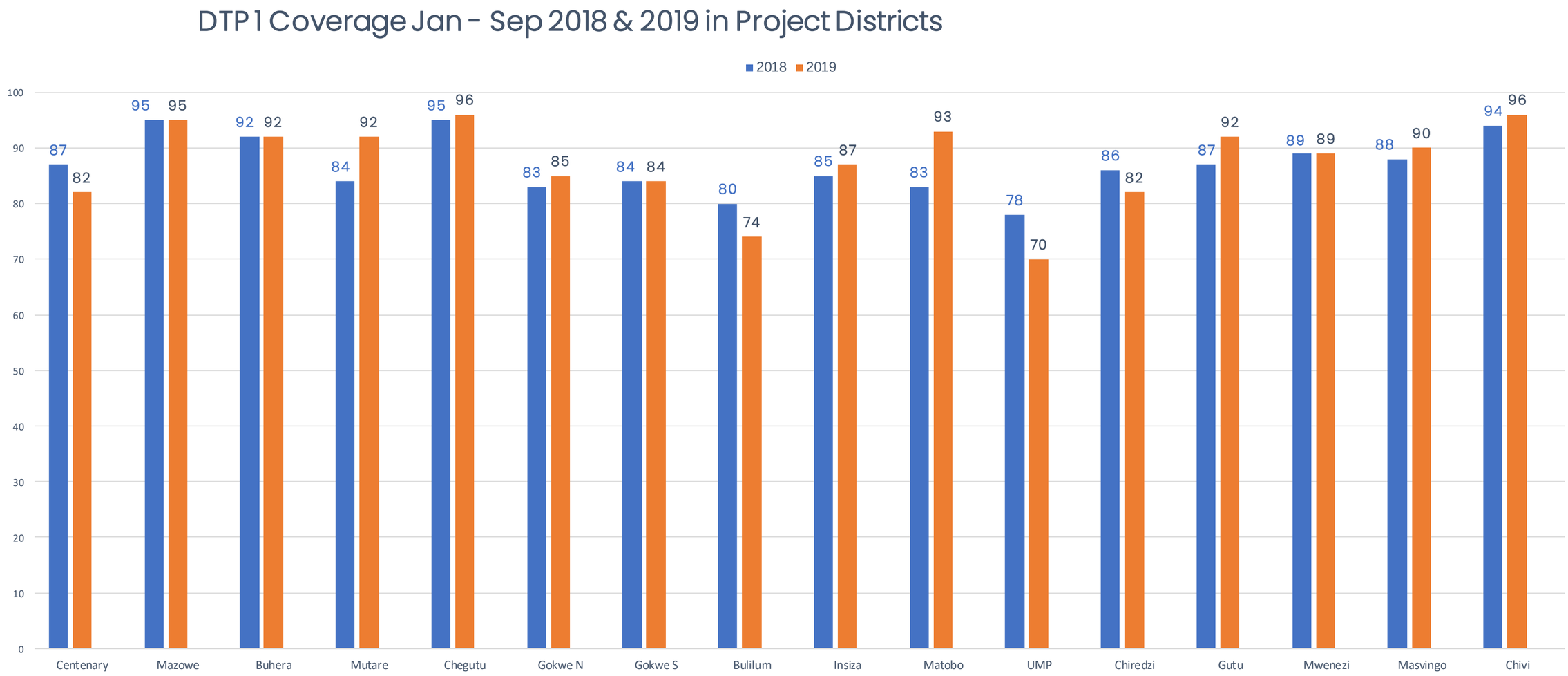
Improved understanding of card, but more HW communication needed on due dates and vaccines received



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

Example 2: Link with improving zero dose coverage



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

Example 2: Community perceptions on health services and vaccination in four countries (Burkina Faso, Ghana, Mali and Nigeria)

Interactive Voice Response surveys, Dec 2021 Platform used: https://viamo.io/

1. **Why**: To learn more about community member perceptions on: 1) access to health services; 2) Views on routine immunization; 3) Views on COVID vaccination; 4) Willingness to promote vaccination.
2. **What**: Interactive Voice Response surveys via Viamo "3-2-1" service platform, in collaboration with mobile telephone network operators (MNOs) in four countries.
3. **Where**: Burkina Faso, Ghana, Mali and Nigeria. Countries chosen for the survey in collaboration with UNICEF country offices, based on availability of Viamo/MNO "3-2-1" service in their country and capacity to conduct surveys in multiple languages.

Example 3: Results from Interactive Voice Responses

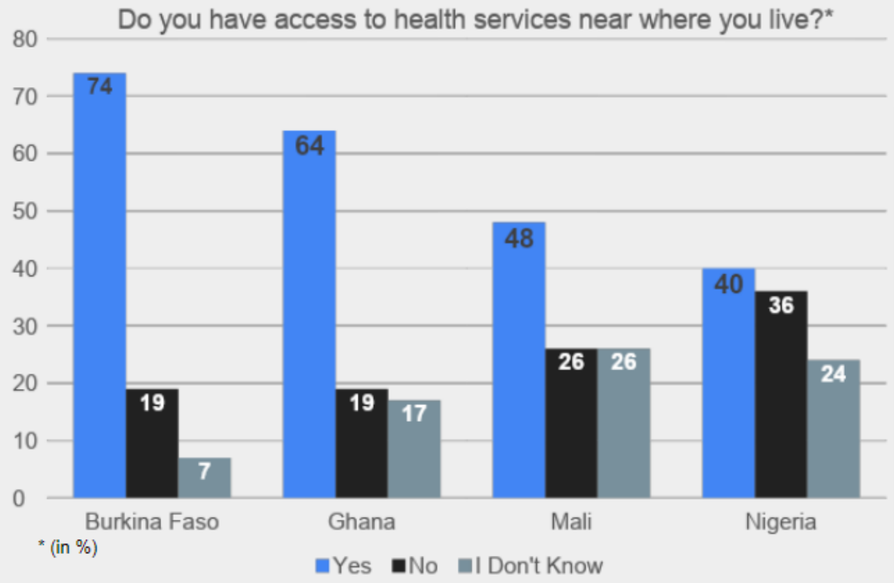
Access to health services

BURKINA FASO
Responses 10,176
Yes: 7,120
No: 1,828
Don't know: 673

GHANA
Responses 2,022
Yes: 1,168
No: 347
Don't Know: 310

MALI
Responses 61,985
Yes: 20,406
No: 11,053
No: 11,053

NIGERIA
Responses 10,221
Yes: 3,644
No: 3,279
Don't Know 2,186



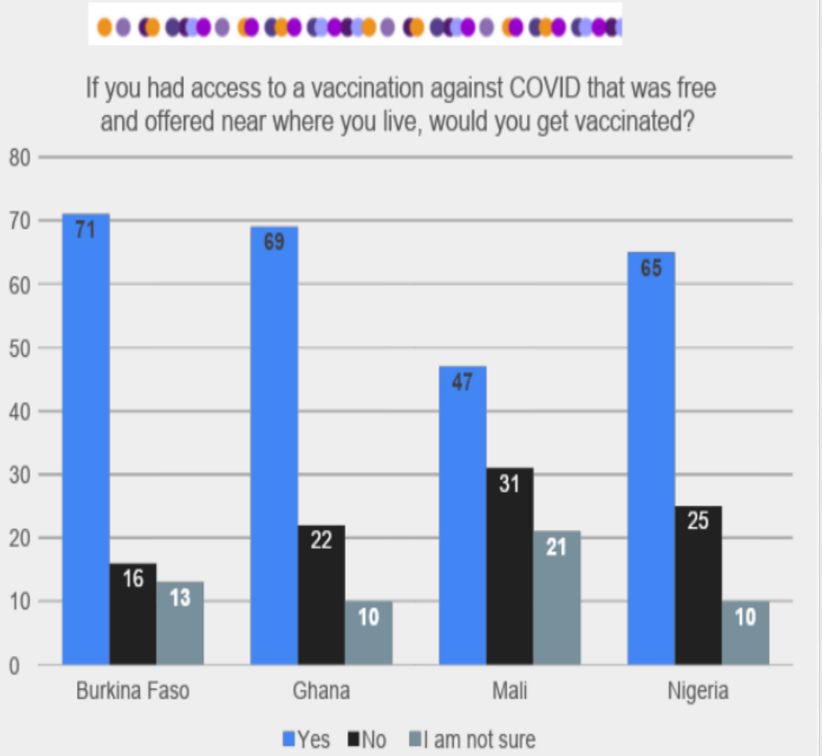
Perceptions of COVID vaccination

BURKINA FASO
Responses 9,784
Yes: 6,947
No: 1,565
No Sure: 1,272

GHANA
Responses 1,874
Yes: 1,293
No: 412
Not Sure: 187

MALI
Responses 45,682
Yes: 21,471
No: 14,161
Not Sure: 9,593

NIGERIA
Responses 9,371
Yes: 6,091
No: 2,343
Not Sure: 937



Example 3: Applying the results from the IVR

- Invite community-led action, even if we're not sure people will step up to help (What does it hurt to ask?)
- Question: "How do we know if people are 'hesitant'? (Is there data, or is it just a "feeling"?)
- Question: "When you say "low uptake," do you mean low vaccination rates? Because perhaps it's not a demand problem - it could be a low supply or service-related challenge
- Let's try to brief our health colleagues about the need to "go beyond raising awareness" –
- this is part of the "shift" to Social and Behavior Change - going beyond communication. Let's help reduce obstacles and barriers to action.

3 Truths from the field

1. Do not come with a pre-determined solution: involve and foster participation by the recipients and implementers of the intervention in the planning and M&E
2. Utilize appropriate technology that is accessible and easy for your intervention team to customize and use for M&E
3. M&E is not understood by everyone, so be prepared to adapt and facilitate the learning and data culture (with local problem solving and planning; self-monitoring and mentoring)

3 Best practices

1. Engage the recipients and implementers in the M&E design process for the intervention from the conceptual stage
2. Ensure that the participatory M&E approach includes a sufficiently representative sample/grouping of the populations with whom you are interacting
3. Acknowledge limitations and potential response bias
    - Rapid insight gathering, intercept interviews, KIIs will have some bias (as the respondents may be purposefully selected or already represent experts or people who have chosen vaccination)
    - Participatory approaches for M&E often need to be triangulated with other data to ‘paint the complete picture’.

Actions You Can Take to Address Participatory M&E in Different Operating Environments

- Design with the recipients and implementers so that they can help to determine the most appropriate participatory M&E methods based on local human, financial and technology resources
- Use methodologies that do not require intensive resources
  - local interviewers; simple checklists or easy surveys like mentimeter during existing review meetings/supervision; SMS or mobile technology that doesn't require much data minutes

- Incorporate the same approaches as for 'Mountain Bike', and consider adding more monitoring and evaluation components or frequency
  - such as applying 2-3 participatory methods; conducting the monitoring activities quarterly and then doing an annual evaluation

- Bring on an M&E team to help with applying several participatory methods and to facilitate the learning and implementation of recommendations after each round of M&E
- Consider adding more electronic methods for M&E (such as a more comprehensive e-survey that can be administered at least twice per year)

Bigger vehicle = larger toolbox of interventions, more ways of promoting vaccine demand and mitigating the infodemic

Resources

- Tailoring Immunization Programmes Guide and evaluation: The WHO Tailoring Immunization Programmes (TIP) approach: Review of implementation to date – ScienceDirect
- Review meetings (experience from 4 countries)
- https://www.mentimeter.com, https://www.surveymonkey.com, https://viamo.io/

Community-based participatory research/implementation

- Notes from the field: Health System and Community Partnerships (ARISE) and Drivers of Routine Immunization System Performance at the District Level (netdna-ssl.com)
- Collaborative Community Checklists for Immunisation: A Feasibility and Acceptability Study in Rural Myanmar
- My Village, My Home (www.jsi.com – search "MVMH" for various resources across several countries)
- Coordination and Implementation of Child Health Record Redesigns (Home-Based Records) – JSI
- Champion Community Approach
- UIFHS (plan, do, study, act)
- Using participatory action research to improve immunization utilization in areas with pockets of unimmunized children in Nigeria | Health Research Policy and Systems | Full Text (biomedcentral.com)

Participatory approaches

- KIT-Working-Paper_final.pdf
- https://www.participatorymethods.org/page/about-participatory-methods
- Impact evaluation of a community engagement intervention in improving childhood immunization coverage: a cluster randomized controlled trial in Assam, India | BMC Public Health | Full Text (biomedcentral.com)
- https://busaracenter.org/our-work/more-insights/

Extra slides

Group work

Case study: Applying participatory M&E approaches for vaccination communication

Peri-urban District X has lower DPT1 coverage than neighboring districts and has struggled to have DPT3 coverage above 80%. There are 10 health facilities in the district that have the lowest DPT1 coverage. An immunization situational analysis and data review were conducted with those health facilities and a few local community leaders. A key finding was that there are CSOs doing household visits for reproductive and maternal health in the district, but they have not been engaged with immunization services.

In the last year, the district was able to use microplanning resources to engage 4 of these CSOs with immunization and also to provide perdiems for community mobilizers. They focused particularly in (1) several new dense urban settlements and (2) with 3 more remote facilities that have outreach sites that are 10 km away but have struggled with funding to conduct all planned sessions.

The facilities conducted interactive one day trainings with CSOs and community mobilizers on the vaccination schedule and how to understand vaccination cards and provide reminders. They also reviewed their community registers (each mobilizer is responsible for 50-100 households). The facilities committed to monthly one hour review meetings with the CSOs and community mobilizers, including comparing their household and pregnant women registers with the immunization registers. Several of the community mobilizers only have basic mobile phones. They have communicated via SMS, but neither the mobilizers nor the health facilities have funding for data minutes.

In the last 9 months, the health facilities that had the lowest DPT1 coverage (including the 3 more remote facilities) are now seeing increases in their monthly attendance at vaccination sessions. They need to be able to demonstrate that the community and CSO engagement is contributing to this, so that they can continue to advocate for these resources to ensure better coverage in the coming years.

In your breakout group, discuss and respond in Slido to the following questions:

1. What **participatory activities** have been used in District X to address the immunization challenges?
2. What are some **low resource participatory M&E approaches** that could be used by District X **in the next 6 months** to help them demonstrate the contributions of the communications and community engagement to increased vaccination attendance/uptake?
3. How could District X incorporate some **digital monitoring** into their activities, given limitations with funding data minutes? What could they suggest in their microplanning to advocate for additional resources for digital M&E and **to support M&E** for these activities for **at least 2 more years**?