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# USAID/TSHIP Routine Immunization Review in Bauchi and Sokoto States

## Review Report



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## Table of Contents

ACRONYMS.....	3
EXECUTIVE SUMMARY .....	5
INTRODUCTION .....	7
OVERVIEW OF USAID/TSHIP ROUTINE IMMUNIZATION REVIEW .....	8
SUMMARY OF KEY FINDINGS .....	9
National Level Key Findings with NPHCDA and Partners (WHO, UNICEF, PRRINN- MNCH, CHAI, CDC NSTOP, IVAC).....	9
State Level Key Findings with SPHCDA, MOLG and Partners.....	10
LGA, Health Facility, and Community Level Key Findings: Bauchi and Sokoto States	11
Planning and Management of Resources, including Partner Coordination, Advocacy, and Governance .....	12
Increasing Access .....	14
Monitoring for action .....	15
Supportive Supervision (SS).....	17
Community Linkages .....	18
Capacity Building .....	19
RECOMMENDATIONS BY THE REVIEW TEAM FOR USAID/TSHIP .....	20
CONCLUSIONS.....	23
ANNEXES.....	24



## ACRONYMS

<b>AD</b>	Auto-Disable Syringes
<b>AEFI</b>	Adverse Events Following Immunization
<b>CBHV</b>	Community-Based Health Volunteer
<b>CBO</b>	Community-Based Organization
<b>CBHV</b>	Community-Based Health Volunteers
<b>CDC NSTOP</b>	U.S. Centers for Disease Control and Prevention, National Stop Transmission of Polio Program
<b>CO</b>	Cold Chain Officer
<b>CHAI</b>	Clinton Health Access Initiative
<b>BCG</b>	Bacille Camette Guerin (vaccine)
<b>DHS</b>	Demographic and Health Survey
<b>DPHC</b>	Director, Primary Health Care
<b>DPT</b>	Diphtheria, Pertussis and Tetanus Vaccine
<b>DSNO</b>	Disease Surveillance and Notification Officer
<b>DQS</b>	Data Quality Self-assessment
<b>EEFO</b>	Early expiry, first out
<b>EPI</b>	Expanded Program on Immunization
<b>FOMWAN</b>	Federation of Muslim Women of Nigeria
<b>GAVI</b>	Global Alliance for Vaccines and Immunization
<b>GIVS</b>	Global Immunization Vision and Strategy
<b>HC</b>	Health Center
<b>HepB</b>	Hepatitis B
<b>HCW</b>	Health Care Worker
<b>HE</b>	Health Educator
<b>Hib</b>	<i>Haemophilus influenzae</i> type b
<b>HMIS</b>	Health Management Information System
<b>ICC</b>	Inter-Agency Coordinating Committee
<b>IPDs</b>	Immunization Plus Days
<b>IMMbasics</b>	USAID's IMMUNIZATIONbasics Project (2006-2009 In Nigeria)
<b>IVAC</b>	International Vaccine Access Center,
<b>JHU</b>	Johns Hopkins Bloomberg School of Public Health
<b>LGA</b>	Local Government Area
<b>LIM</b>	USAID/TSHIP Local Government Area Immunization Monitor
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MOH</b>	Ministry of Health
<b>MOLG</b>	Ministry of Local Government
<b>MOU</b>	Memorandum Of Understanding
<b>N</b>	Naira (Nigerian currency)

<b>NPHCDA</b>	National Primary Health Care Development Agency
<b>PCV</b>	Pneumococcal Conjugate vaccine
<b>PEO</b>	Polio Eradication Officer
<b>PHC</b>	Primary Health Care
<b>PIE</b>	Post Introduction Evaluation
<b>PRRINN-MNCH</b>	Partnership for Reviving Routine Immunization in Northern Nigeria; Maternal, Newborn, and Child Health Program (DFID funded)
<b>RED</b>	Reaching Every District
<b>REW</b>	Reaching Every Ward
<b>RI</b>	Routine Immunization
<b>SIO</b>	State Immunization Officer
<b>SMOH</b>	State Ministry of Health
<b>SMOLG</b>	State Ministry of Local Government
<b>SPHCDA</b>	State Primary Health Care Development Agency
<b>SS</b>	Supportive Supervision, a component of REW
<b>TBA</b>	Traditional Birth Attendant
<b>USAID/TSHIP</b>	USAID's Targeted States High Impact Project
<b>USAID</b>	United States Agency for International Development
<b>UNICEF</b>	United Nations Fund for Children
<b>VDC</b>	Village Development Committee
<b>VVM</b>	Vaccine Vial Monitor
<b>VPD</b>	Vaccine Preventable Disease
<b>WDC</b>	Ward Development Committee
<b>WHO</b>	World Health Organization



## EXECUTIVE SUMMARY

The five-year Targeted States High Impact Project (USAID/TSHIP) launched in Bauchi and Sokoto States in 2010. The project focuses on improving child survival interventions in the two states, with a major aim “to support introduction of new initiatives and interventions...to produce high-impact results within the timeframe of saving one million lives by 2015” (USAID/TSHIP PY5 Work Plan Oct. 2013 – Sept. 2014). With the project entering its 5th year, a team was asked to review the routine immunization (RI) component and advise on strengthening USAID/TSHIP’s plans for enhancing engagement at all levels in RI, in line with the Reaching Every Ward (REW) strategy.

This review focused primarily on documenting the achievements and remaining gaps for strengthening RI in Bauchi and Sokoto States, and involved record reviews, observations and interviews structured along major components of the REW approach: (1) planning and management of resources, (2) increasing access to services, (3) monitoring for action, (4) supportive supervision, and (5) community linkages; the team added capacity building.

The review team visited 6 LGAs and 12 health facilities (HFs) across Bauchi and Sokoto States, as well as interviewed national partners in Abuja. At national level, all partners interviewed were aware of the presence of USAID/TSHIP and its activities in both states. State officials were particularly appreciative of the role of USAID/TSHIP support for planning, improvement of infrastructure (buildings, cold chain equipment), strengthening provision of services, supportive supervision, reactivation of Ward Development Committees (WDCs) and Community Based Health Volunteers (CBHVs), and capacity building efforts. However, national partners noted concern over the two states being too small for a system strengthening project in a country as large as Nigeria, and also highlighted the lack of visibility of USAID/TSHIP at the national level—especially with the current increased focus on RI with the newly endorsed strategy.

In terms of findings in the two states with **governance**, there are varying degrees of political will and financial commitment, the latter being more evident in Bauchi. State task forces on immunization exist in both states, with terms of reference that include RI, although by far the focus of discussions remains on campaign-related activities. Importantly, accountability in terms of use of RI-related funds released remains an issue in both states.

In the area of **planning and management of resources**, all 6 LGAs and 12 HFs visited across both states demonstrated some planning as seen in either catchment area maps, immunization session plans, etc. But consolidated plans in the form of micro plans, and commensurate follow up on plans using data to guide decision making was found to be weak.

As part of efforts at **increasing access to immunization services**, Bauchi has shown a recent increase in the number of HFs providing RI services, while Sokoto has not shown an increase. Although administrative reports show RI coverage increasing, all partners at national level acknowledged data quality concerns, and lot quality assurance sampling done by USAID/TSHIP in the two states points to the likely coverage in both being less than 10% DPT3.

**Supportive supervision** visits are being carried out in both states, as sometimes evidenced by written feedback at the level of the supervisees, and at the HF level in Bauchi. However, supportive supervision is reported to be conducted infrequently by state-level officers unless partners are leading the process.

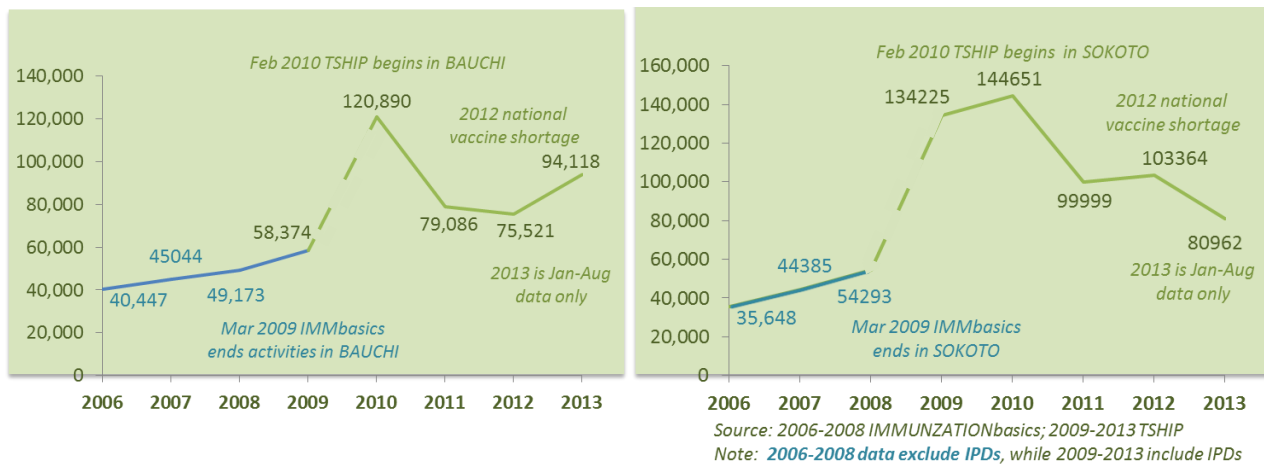
**Monitoring and use of data** is done, as seen by monitoring charts on display in all LGAs and all HFs visited during the review. However, the quality of the data was not only questionable, but there was also little evidence that the data was being used to solve local problems (e.g. examples include combining of DTP1 and DPT3 into one line on the chart, erroneous dropout rate calculations, many charts not fully updated).



Community structures such as WDCs, CBHVs and sub-grantees who are potentially key for **community linkages** with HFs were found in the two states, but the review team did not find evidence of strong community demand for RI services—as evidenced by chronically low numbers of children vaccinated and sub optimal attendance at existing sessions. Currently, financial incentives for engaging these structures is wholly supported by partners, with no evidence of a costing handover plan to the Ministry of Local Government (e.g. to align with financial incentive scheme as outlined in the WDC/VDC strategy).

The reviewers concluded that the weak RI system in Bauchi and Sokoto States revolves around: weak state and LGA ownership/poor governance, weak analysis and follow up of local problems little or no interpretation and use of data for action, less than adequate demand for RI service by the community (including sub optimal session attendance), weak supportive supervision structures, and challenges with human capacity in terms of quantity and quality. This figure illustrates that from 2009-2012, the number of children being vaccinated by DPT3 declined or stagnated, with Bauchi showing an increase in 2013 but Sokoto showing a decline.

*Figure: 2006-2013 trend by state (Bauchi left, Sokoto right) in **number of children vaccinated by DPT3**; 2013 data is Jan-Aug only; source: administrative data. Note: 2006-2008 data for Bauchi and 2006-2009 data for Sokoto excludes IPD data while 2010/2009 data includes IPD data, thus the spike in trend in 2010 Bauchi and 2009 Sokoto.*



The review team concludes that USAID/TSHIP, with only a short implementation time remaining, may not be able to tackle many of the issues adequately, and should focus attention on how to address persistent system operational gaps in close collaboration with the states and partners in the areas of governance, advocacy, supporting community structures, supportive supervision and capacity building—with a clear joint state-USAID/TSHIP handover strategy in place. On a continuous and consistent basis, USAID/TSHIP and partners should specifically be involved in high level advocacy to relevant arms of government. This includes working to strengthen ownership and sustainability of the RI program, supporting the government to establish a mechanism to ensure release and accountability for the use of RI funds, supporting community structures with emphasis on working with the community on creating demand, training and capacity building at all levels using appropriate and updated training modules, and making updated data tools available, working through regular and supportive supervision on improving data quality at all levels and building the capacity of health workers to analyze, interpret and use data they are generating for timely local action. Realistically, the plan to implement these recommendations should cover at least 20-24 months.

If we are to protect our children, born and yet unborn, against vaccine-preventable diseases, we must reconnect with the community to improve and hold their trust in immunization through better government ownership and self-reliance. This must involve working with the private sector and community-based organizations and working in collaboration within the context of a complete health system, using a step-by-step methodical process.

## INTRODUCTION

### ***Background on USAID/TSHIP***

The Targeted States High Impact Project (USAID/TSHIP) is a five-year, USAID-funded project which aims to strengthen healthcare delivery in in all 20 Local Government Areas (LGA) in Bauchi State and all 23 LGAs in Sokoto State. The overall objective of USAID/TSHIP is to increase the use of high impact integrated maternal, newborn and child health and family planning/reproductive health interventions. Using a tri-focus approach to improving community engagement, quality of healthcare services, and health system effectiveness, USAID/TSHIP partners with and builds the capacity of the Bauchi and Sokoto State Ministries of Health (SMOH), State Primary Health Care Development Agencies (SPHCDA), and the associated LGAs in order to improve health systems and management and quality service delivery in both states. Ultimately, USAID/TSHIP is working to establish strong and durable bonds between community institutions and a healthcare delivery system to improve household health practices and increase people's use of health services.

In September/October 2013, USAID/TSHIP engaged three external consultants to review its efforts in strengthening routine immunization to date, as well as its intensification plan to revitalize the Reaching Every Ward (REW) approach over the remaining months of the project. The purpose of the review was to examine adequacy and appropriateness of the current efforts and to advise on ways to strengthen the design, effectiveness and synergy of USAID/TSHIP support to on-going routine immunization (RI) efforts. For an overview of USAID/TSHIP personnel who work on routine immunization, see Table 1.

Table 1: ***RI-related USAID/TSHIP staff and approximate time spent on RI in Sokoto State***

Position	Approximate time spent on RI (%)
Senior MCH Advisors	~40%
Malaria & Child Health Specialists	~40%
3 LGA health Coordinators per state	~40%
PEOs	~40% initially and now 60% (since March 2013)
14 LGA Immunization Monitors per state	~30% initially and now 60% (since March 2013)
Assistant M&E Officers	~10%

### ***Reaching Every Ward - REW***

Page 11 of the National Routine Immunization Strategic Plan 2013-2015 (NRISP) cites the following: "Within the NRISP, the Strategic Framework enumerates strategies to improve the country's RI system. Three strategic focal areas have been identified to concentrate efforts to improve the system in practice; these strategies are already in place to varying extents and are recognizable by stakeholders at all levels in Nigeria. They are: Reaching Every Ward (REW), Accountability for RI Framework (AFRIN), and Health System Strengthening."

Given that REW is the foundation of Nigeria's routine immunization strategy, this review was structured around its components in order to assess strengths and weaknesses in operationalizing REW at LGA and below levels.

REW components include:

- 1) Planning and management of resources, including issues relating to governance
- 2) Improving access to immunization services
- 3) Monitoring for action
- 4) Supportive supervision
- 5) Linking services with community



In the Project Year 5, USAID/TSHIP plans to strengthen RI through the following, in line with the NRISP:

- Strengthening the capacities of the state ministries of Local Government and Health to effectively manage and implement the components of REW
- Advocating to decision makers at ward, LGA and State levels for effective governance on immunization and other child health interventions
- Promoting early commencement of immunization on the platform of chlorhexidine and community-based civic registration interventions
- Investing in preventive maintenance of cold chain equipment at LGAs and ward levels
- Tapping into existing community structures - WDCs, CBHVs/CDI volunteers, to create demand and monitor RI sessions.

## **OVERVIEW OF USAID/TSHIP ROUTINE IMMUNIZATION REVIEW**

### ***Purpose***

The USAID/TSHIP RI review was conducted between 2 and 20 September, 2013 in three phases. The first phase was in Sokoto from 2 to 10 September, the second phase was in Abuja from 11 to 13 September and the third phase was in Bauchi from 16-20 September.

The purpose of this exercise was to review the overall level of implementation of the project's process for strengthening both health workers' capacity and the RI system, and to advise the project's future plans in RI strengthening efforts. This was done in line with the Reaching Every Ward (REW) approach, with a view to reach every eligible child wherever that child may be, through the following components:.

- Planning and management of resources, including issues relating to governance
- Improving access to immunization services
- Monitoring for action
- Supportive supervision
- Linking services with community
- Capacity building

### ***Objectives of the RI review***

1. To review USAID/TSHIP's support to routine immunization in the context of the REW approach in Bauchi and Sokoto states, with feedback from national partners in Abuja
2. To learn how the RI system has been improved or otherwise in the each state
3. To gain insights on how RI can be further strengthened in the remaining period of the project and after project closure

### ***Methodology***

The RI review was carried out by a team consisting of three (3) consultants and USAID/TSHIP staff from both Bauchi and Sokoto states. The team was divided into three groups, and three Local Government Areas (LGAs)—one from each Senatorial zone of the state—were visited by a group. The LGAs were purposefully selected to include at least one with low performance in RI (e.g. high dropout), and also to include at least one urban situation. Based on these criteria, the following LGAs were selected: Gada, Sokoto South and Tureta LGAs in Sokoto State and Bauchi, Missau and Itas Gadau LGAs in Bauchi State. At the LGA level, government health staff such as Director PHC (DPHC), Local Immunization Officer (LIO), Cold Chain Officer (CCO),

Monitoring and Evaluation (M & E) officer and Health Educator were interviewed. Two health facilities providing RI services (one with a fridge and one without—especially in Sokoto State, only one HF without a fridge was selected in Bauchi State---both outside of the LGA headquarters but from different wards and have received USAID/TSHIP support in the past two years) were selected and visited in each LGA. At the health facilities, the officers in charge of the facility and or RI service providers were interviewed. Where RI sessions were taking place, services were observed and exit interviews done with two or three mothers who had brought their children for vaccination. Community groups such as Ward Development Committee (WDC) members and Community Based Health Volunteers (CBHVs) were also interviewed. At the state level, technical staff of the SPHCDA and the Ministry for Local Government (MOLG) were interviewed. Partners and USAID/TSHIP technical staff involved in RI were also interviewed during the process. A qualitative method in the form of In-depth Interviews and structured observations (e.g. RI data review) were employed for the review. Interviews were conducted using a tool adapted from previous similar reviews and pre-tested at a different LGA in each state. In Abuja, the National Primary Health Care Development Agency was interviewed, as well as WHO, UNICEF, PRRINN-MNCH, CHAI, CDC NSTOP and IVAC. For a full list of locations visited and people interviewed, see Annexes 3 and 4.

## **SUMMARY OF KEY FINDINGS**

The following summarizes key findings at national, state, LGA, health facility and community levels. National and state feedback are in different sections, while LGA, HF and community feedback are consolidated into a third section.

### ***National Level Key Findings with NPHCDA and Partners (WHO, UNICEF, PRRINN-MNCH, CHAI, CDC NSTOP, IVAC)***

#### ***Positive Findings***

- They know of the USAID/TSHIP structure and the presence of USAID/TSHIP in Bauchi and Sokoto States
- They are aware of USAID/TSHIP's efforts at the state and lower levels to support supervision, training and community structures
- All partners at the national level are now placing more emphasis on RI than previously, all in line with the new NRISP
- Vaccine shortage has improved in 2013 as opposed to the situation in 2011-2012
- Partners believe there are best practices in the states that can help inform national policy

#### ***Areas to strengthen***

- All partners felt that USAID/TSHIP has not been visible enough at the national level and so miss the opportunity to properly link operational activities to policy level
- One of those interviewed at the NPHCDA felt that two states are too few for USAID/TSHIP to support in a country like Nigeria
- Some partners expressed concern over poor RI data quality, noting that administrative data is likely lower than what is being reported (e.g. DPT3 containing antigen)



- There needs to be more examples of using someone like Dangote (a Nigerian entrepreneur who is funding RI in Kano State) as “RI Ambassadors”, particularly in the north
- Many partners emphasized the need for better governance and ownership, especially at state and lower levels
- Not much has been done to encourage exchange visits for states to learn from each other

## ***State Level Key Findings with SPHCDA, MOLG and Partners***

### ***Positive Findings***

- USAID/TSHIP was found to be collaborating in RI with Government (at all levels within the two states) as well as other partners such as NPHCDA, SPHCDA, WHO (general RI support), UNICEF (social mobilization, targeted community volunteers), CDC NSTOP (new born tracking and outreach services for nomadic population as well as LGA management training)
- The two states each have a State Task Force on Immunization; in the case of Sokoto it includes the Commissioner and Director (PHC) of the MOLG. However, topics mainly address polio/IPDs
- Even though there is no MOU between Bauchi State and USAID/TSHIP, this exists in Sokoto State, between MOLG and USAID/TSHIP in supporting RI services
- In Sokoto, both the Ministry of Agriculture and MOLG are involved with the Conditional Cash Transfer Project which is being tied to children’s education, routine immunization, and emergency obstetric care
- Both States have demonstrated, to different degrees, political will and financial commitment to RI. While MOLG in Sokoto advised every LGA to establish a budget line for RI into which a sum of N200,000 should be transferred monthly and used for RI activities, Bauchi provides a monthly allocation to both LGAs and HFs for supervision and outreach services respectively apart from dedicating 10% of funds for IPDs to RI
- Since January, there have been no major stockout of vaccines in either state at state level
- In Bauchi, there is no manpower shortage in most of the health facilities (HFs) visited
- USAID has expressed a renewed focus on RI, which will need to be capitalized upon to encourage a methodical step-by-step RI strengthening endeavor (not a focus on rapidly increasing coverage without major focus on system strengthening)
- Support from USAID/TSHIP
  - Development, in Bauchi, of ward Minimum Health Care package for the SPHCDA now being used for standards based management and recognition, and providing integrated supportive supervision monthly to 365 HFs including 23 general hospitals
  - Presence of USAID/TSHIP – with recruitment of staff - LGA Immunization Monitors (LIMs), Polio Eradication Officers (PEOs) with terms of reference changed recently to include more RI focus (now about 60% RI)
  - Provision of data tools, computers, DHIS software which is now used to collate data from HFs and HMIS tools 001 with data transmitted electronically by M&E officers each month
  - Supply of equipment/supplies e.g. cold chain equipment, data management tools in the two States and plastic sleeves for immunization cards in Sokoto State
  - Support for organizational development and capacity building at state (Bauchi and Sokoto) and national levels with some officers from Sokoto being trained at the Administrative Staff College of Nigeria (ASCON) in Lagos
  - Renovation of infrastructure support provided in both states (e.g. HF renovation)
  - Reactivation of WDCs, formation of CBHVs and supporting sub-grantees for RI
  - USAID/TSHIP: Monthly meeting of top management staff of two states

- USAID/TSHIP: interventions have a common goal of child survival and health systems strengthening

### ***Areas needing strengthening***

- Lack of partner coordination which translates to lack of joint planning across partners
- Meetings involving partners are convened primarily for IPDs
- Governance is not strong enough to enforce release and accountability on the use of funds
- In Bauchi State, MOLG has no budget line or an RI plan; in Sokoto, no mechanism in place to monitor the release and use of the N200,000 as directed
- Absence of supportive supervision (SS) from state to LGA and LGA to HFs without partner involvement (including absence of a uniform checklist); Sokoto SPHCDA confirmed N100,000 was budgeted monthly for SS but no visits being conducted on a routine basis, and Bauchi SPHCDA releases around N5,000 each for at least 3 people (LIO, CCO and HE) at the LGA (in 2013)
- Sokoto SPHCDA has no control over staff at LGA, although plans are under way for bringing PHC under "one roof" to ensure smoother collaboration across SMOH, SPHCDA, and MOLG
- Immunization coverage data from USAID/TSHIP's 2012 LQAS points to coverage less than 10% for DPT3 in both states, but administrative coverage reported at state and national level points to DPT3 at >60% in both States this year; while partners acknowledge many data quality problems, this large disparity in performance by source is something that USAID/TSHIP and others should focus on with the states;
- USAID/TSHIP: even though the opportunities exist and there is no management barrier, no regular USAID/TSHIP inter-state meetings or teleconferences for experience sharing and peer review occur; this hampers cross exchange of promising practices between Bauchi and Sokoto states
- USAID/TSHIP: uses an integrated supportive supervision approach implemented on the project's side by the M&E team on a quarterly basis, with little written feedback to the USAID/TSHIP technical team; there were no observed benefits during the review of how this system is helping to improve how RI services are managed or delivered
- USAID/TSHIP: no regular inter-state technical review meetings
- USAID/TSHIP: poor communication between USAID/TSHIP state teams and between program clusters within the States in areas of planning, implementation and monitoring of activities relating to RI

### ***LGA, Health Facility, and Community Level Key Findings: Bauchi and Sokoto States***

The following summarizes the RI review team's key findings at LGA, health facility, and community levels presented according to the major REW components: 1) planning and management of resources (with added focus on partner coordination, advocacy, and governance); 2) improving access to immunization service delivery; 3) monitoring for action; 4) supportive supervision; and 5) linking services with community and capacity building.

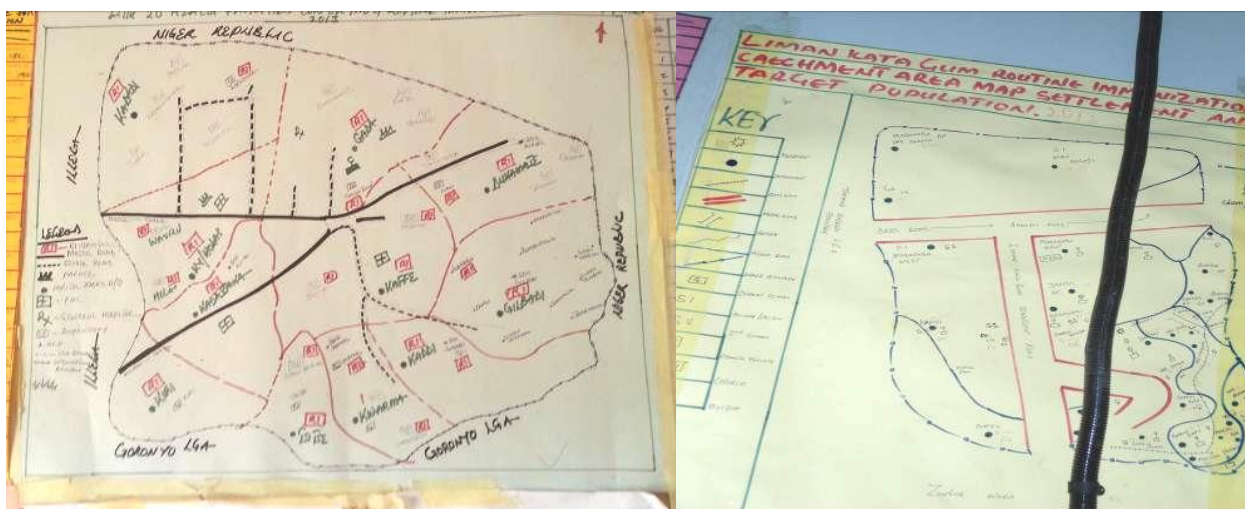


## Planning and Management of Resources, including Partner Coordination, Advocacy, and Governance

### Positive findings

- In Sokoto, LGA Chairmen give varying amounts monthly to support RI activities, up to N200,000; one LGA has seen an increase from N50,000/month in 2012 to N100,000/month in 2013; one LGA reported providing RI updates to the LGA Chairman on a monthly basis; in Bauchi, funds are regularly sent to the LGAs—about N5,000 each for LIO, CCO and HE for supportive supervision, and N5,200 to each HF providing RI services, especially for outreach services
- For LGA cold chain, the stores are connected to the national grid and where electricity was not working, the review team observed generators running or functional; but LGA teams in Sokoto State noted that funds to fuel generators throughout the month are inadequate—it should be noted that the RI review occurred just prior to IPDs, thus funds were available for generators; all 6 LGAs visited as well as the 1 pre-test LGA and the 1 IPDs LGA observed had sufficient functional cold chain equipment to support current RI services, and in all LGAs in both states a number of satellite cold stores had been set up through USAID/TSHIP support at HF level to improve regularity of RI services in rural locations; All HFs visited (except one HF in Itas Gadau LGA in Bauchi) reported having adequate cold chain equipment, ranging from cold store satellites to giostyle/rush vaccine carriers
- All 6 LGAs and 12 HFs visited had session plans displayed, including vaccine distribution plans (these plans were of varying quality as some did not show all supplies, responsible person or exact areas for outreach services), catchment area maps (with reports of using them to help identify hard to reach populations; see Figure 1)
- Availability of data tools varied among the two states. In Sokoto State, no LGAs reported stockout of RI monitoring tools or immunization cards, corroborated through observation of stock at hand- the situation was different in Bauchi where the data tools were not in stock
- Most HFs visited offer RI sessions at least on a monthly basis in Sokoto and on a weekly basis in Bauchi, and this was observed in the monthly forms and registers
- In relation to partner coordination in both states, WHO and USAID/TSHIP support all components of RI, while CDC's NSTOP supports outreach efforts with nomadic populations as well as LGA management training; UNICEF provides limited support with community mobilization, but is not currently active in technically supporting RI as it was in the past; the LGA PHC teams reported that all partners coordinate well with their team

Figure 1. Picture of a Sokoto LGA (left) and Bauchi HF catchment area map (right)



## ***Areas needing strengthening***

- While partner coordination is strong, LGA teams noted their dependence on partners for key activities, including in development of micro plans and all aspects of capacity building
- While it was stated that partners assist with micro plans, none of the six LGAs could produce consolidated micro plans, although they had many posters with various RI plans on the wall (e.g. RI session plans, vaccine distribution plans, supportive supervision plans); in Sokoto State, the LGA visited during pre-testing of tools did have a consolidated micro plan although it was not available through the LGA office, but shared in electronic form by a WHO colleague who was also visiting the LGA at the time of the pre-test
- While all 3 of the LGAs in Sokoto reported a monthly budget line for RI, how the funds were actually being used were not well tracked, nor had LIOs outlined budgets they had prepared that noted line item needs for supporting all aspects of RI; 1 of the 3 LGAs in the review provide N200,000 per month as per the MOLG directive, but through informal channels the review team found that of N200,000 given by the LGA Chairman in one LGA, only N8,000 reach the LIO
- In Bauchi, it was confirmed at the lower levels that funds are regularly received from The SPHCDA but there is no mechanism to monitor the effective use of these funds
- 2 LGAs in Sokoto reported adequate storage capacity for pentavalent vaccine introduction, scheduled for December 2013 (equivalent to 3 months of current storage requirements) In Bauchi which had already introduced the pentavalent vaccine in 2012, there would be challenges of storage were PCV to be introduced today.
- EPI monitoring charts were available in all LGAs visited, but were poorly drawn, with many not updated through August, and contradictions in what the data showed versus what LGA staff stated in coverage trends; overall, many LGA immunization staff were not able to adequately interpret their data, nor were they able to cite 2012 full year coverage
- Most LGAs were not delivering vaccines to HFs; HFs collect vaccines from the LGA cold store
- In both States, LGAs and HFs with refrigerators reported monitoring their fridge temperatures, and the vaccines although 2 LGAs visited did not have updated temperature charts, nor did they have functional thermometers in their fridges; 2 of the LGAs in Sokoto had vaccines in stage 2 on their VVMs (meaning reduced potency of vaccine), In Bauchi, Pentavalent vaccine already in Stage 2 and collected from the LGA the previous day was observed while a health worker at the same HF was seen using OPV with VVM stage 3; one of the LGAs visited noted that it did not have enough space for pentavalent vaccine introduction; as new "dollar" vaccines as opposed to traditional "cent" vaccines are introduced in the coming years (e.g. pneumococcal and rotavirus), **the issue of cold chain monitoring and vaccine management will become even more critical**
- There was no systematic plan for cold chain equipment maintenance
- The HF visited during IPDs in Sokoto State offered RI services only 4 months of the 8 months to date, with outreach conducted only once in the past 8 months (as per a review of the HF summary form Jan-Aug); most HFs report offering outreach once a month, but often not to the same site each month (one HF reported a "random selection" method, with it being unclear how communities know when RI sessions are being conducted...**pointing to the critical need to focus not just on reliable and regular RI services, but also optimal attendance at sessions**); when records were reviewed, one HF provided outreach only once in the last 6 months and another only once a quarter; all HFs noted a lack of funds to provide outreach services and some do outreach out of pocket; although USAID/TSHIP has been providing HFs with funds to conduct additional outreach sessions, since July most HFs have not been able to access these funds due to a recent internal change in how USAID/TSHIP manages fund disbursement
- In Bauchi, LGAs and HFs reported stockout of RI monitoring tools or immunization cards,

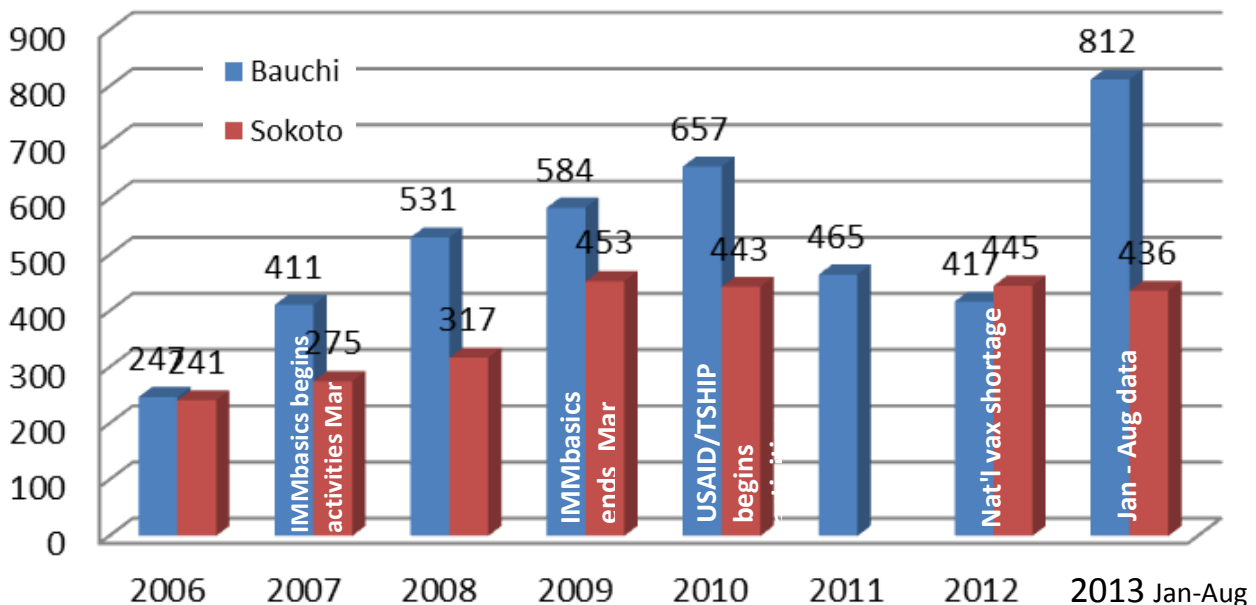
- **USAID/TSHIP focus at LGA level with RI support will need to be in close coordination with CDC NSTOP to ensure there is no duplication of effort**, as NSTOP is now expanding to all 43 LGAs in Bauchi and Sokoto

## Increasing Access

### Positive findings

- Reported increase in number of HFs providing RI in all the LGAs visited; e.g. from 13 to all the 20 health facilities in Tureta and from 16 to 20 in Gada LGAs In Bauchi LGA the number of HFs providing RI services increased from 74 in 2012 to 84 in 2013.
- Generally speaking the trend of HFs providing at least 4 immunization sessions per month tended to have been increasing especially in Bauchi (Figure 2) However, coverage data do not show corresponding increases (Figure 3).
- Increased number of cold chain equipment (Freezers, refrigerators, solar refrigerators) across LGAs and health facilities. In Bauchi, all the LGA cold stores are connected to the national grid with back-up generators
- Evidence of regular review meetings of LGA teams with health facilities to discuss RI performance of all facilities seen in all the LGAs visited
- RI session plan indicating both fixed and outreaches with catchment area maps seen in all the HFs visited
- All HFs visited in Bauchi report providing RI at least 2-4 times a month (one fixed and one outreach session), although HF summary form did not always corroborate with this
- Engagement of community structures (WDCs, CBHVs, TBAs & Town announcers) to create demand and mobilize mothers for RI services
- Mothers interviewed had their children’s immunizations cards and confirmed that they were not turned back without vaccinating their children due to lack of vaccines

Figure 2: Trend in **number of HFs providing RI services** in Bauchi and Sokoto States at least 4 times/year from 2006 – 2013; source: 2006-2008 IMMUNIZATIONbasics; 2008-2013 USAID/TSHIP



### Areas needing strengthening

- Outreach sessions not conducted according to existing national guidelines of 2 per month in all the LGAs visited (e.g. 1-2-3 strategy of 1 fixed, 2 outreach and 3 SS visits per month); hence not all communities will have at least one session a month
- Not clear how regular/reliable fixed sessions are (e.g. HF visited during IPDs showed fixed sessions occurring in only 4 of 8 months Jan-Aug in 2013)
- Inadequate transport/funds for some LGAs to push vaccines to the HFs in Sokoto State while the “pull” system in Bauchi State faced delays due to inadequate funds
- Inadequate data capture tools in Bauchi
- Inadequate transport and funding for the HFs to conduct outreaches
- From review of RI monitoring data in both states, **there is sub optimal attendance at existing sessions comparing the number of sessions and the coverage reported (Figure 3)**; undoubtedly there are major gaps in regular/reliable RI fixed and outreach services; thus the issue is less about community access to services (e.g. geographical, cultural/traditional or otherwise) than ensuring that planned sessions occur—basically failure to vaccinate as a health system issue rather than a caretaker/mother issue

Figure 3: 2006-2013 trend by state (Bauchi left, Sokoto right) in **number of children vaccinated by DPT3**; 2013 data is Jan-Aug only; source: administrative data; note: this data is denominator independent; also of importance is 2006-2008 data excludes IPD data while 2009-2013 includes IPD data, thus the spike in trend in 2010 (see Annex 2b for larger graphs)



### Monitoring for action

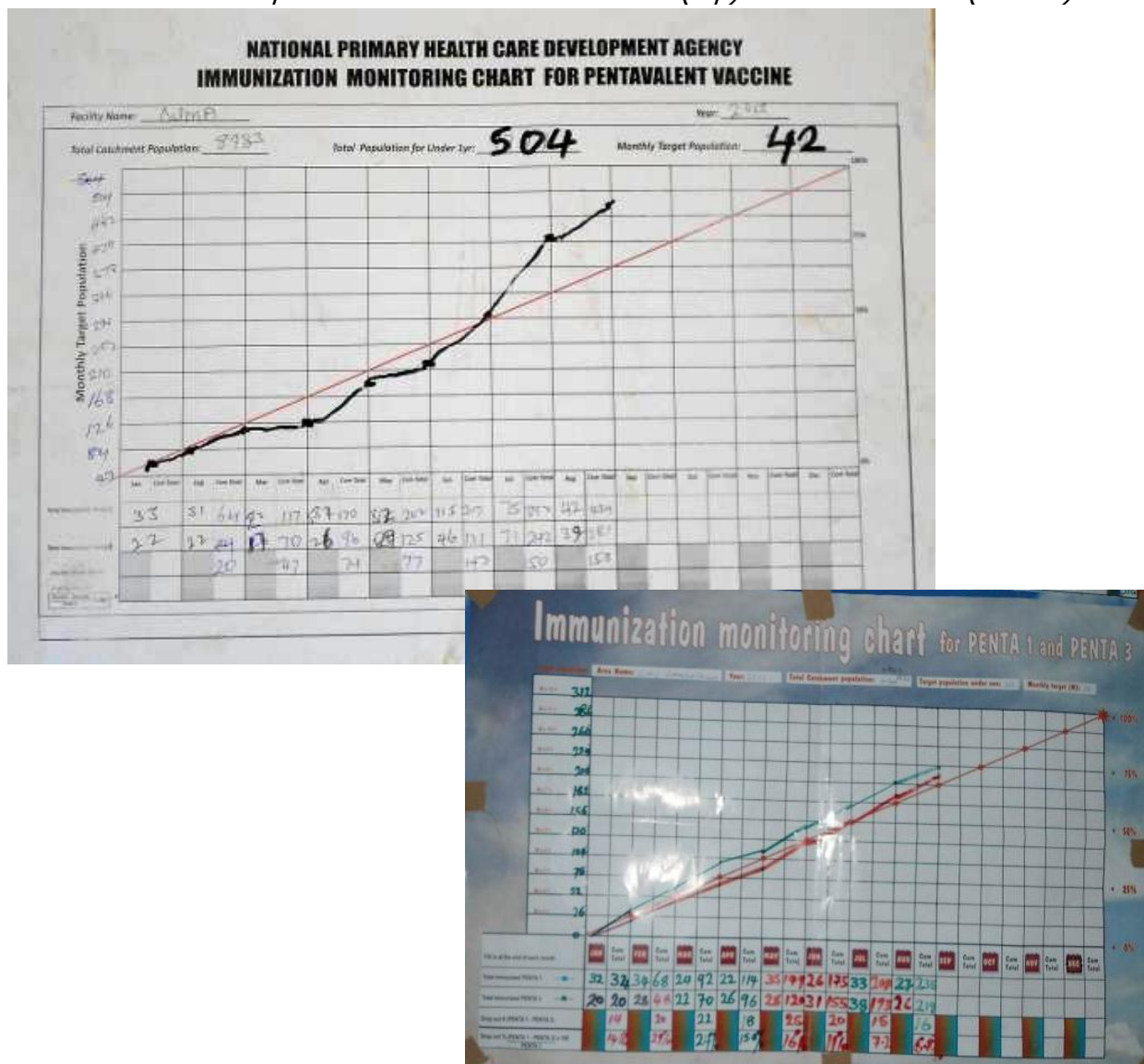
#### Positive findings

- Data tools available and in use at all levels in Sokoto, including EPI monitoring charts and catchment area maps indicating locations of HFs providing RI and outreach sites
- Data quality verification reported to be done by many LGAs and HFs; LGA staff recently trained on data management by USAID/TSHIP and partners, with computers also provided to feed into the HIMS
- LGAs hold regular monthly review meetings with service providers where RI performance is discussed (verified by reviewing minutes)
- Community groups such as WDCs and CBHVs actively involved in house to house counselling, education, referral of new-born, defaulter tracking, sensitization of community/caregivers on RI at worship sites and ceremonies

## Areas needing strengthening

- While EPI monitoring charts were widely available in all LGAs and HFs visited, RI staff could not adequately interpret them and some were not updated through August (e.g. couldn't describe coverage/negative dropout, calculation problems with dropout rates, didn't know target population; graphing errors such as combining DPT1 and DPT3 into one line); one HF combined DPT 1 and DPT3 on a single line on the monitoring chart (Figure 6); importantly, no LGA or HF could tell us their full 2012 DTP3 coverage
- Stockout of data tools in Bauchi
- Some HFs noted that they review data monthly to compare data quality; but evidence of this not seen and many data quality errors found with quick checks (e.g. monthly summary form not matching EPI monitoring chart)
- **A critical finding from this review is that use of data at all levels is weak to non-existent and that while partners have built capacity to enter/chart data and ensure RI monitoring tools are present, commensurate focus on interpreting and using the data for local decision making was not found;** USAID/TSHIP will need to build internal capacity of its staff to ensure that they are able in turn support LGAs and HFs in maximizing their active use of data over the long term

Figure 6. HF EPI monitoring charts, incorrectly combining DPT1 and DPT3 into one line graph and no cumulative dropout rates calculated each month (top) and a correct one (bottom)



## Supportive Supervision (SS)

“Supportive supervision promotes quality outcomes by feedback, focusing on problem-solving, facilitating teamwork and providing leadership and support to empower health providers to monitor and improve their own performance” (*REW Field Guide, 2006*). To be considered “supportive”, SS requires consistent use of a checklist and encourages written feedback with local on-the-job training and timely problem solving.

### Positive findings

- As seen by copies of filled-in checklists, SS visits happen from LGA to the HF level through partner support and including but not limited to LGA staff such as PHD Director, Deputy Director, LIO, CCO, Health Education officer, District Surveillance Nodal Officer
- All LGAs have supervisory plans on the walls (see Figure 7)
- Out of the 6 LGAs visited in the two States, only one LGA in Sokoto did we have a report of having motorcycles for supportive supervision
- SPHCDA in Sokoto **reported** that N100,000 is budgeted per month in 2013 for SS to LGAs while 4 persons per LGA **confirmed** being provided with funds for SS to HFs in Bauchi
- Evidence of both verbal and written feedback was seen in SS log books in the HFs

### Areas needing strengthening

- No evidence found of SS visits from state to lower levels or LGA to HFs without partner support; **claims of visits from a higher level but no written evidence such as checklists were found**, although visitors books had been signed (but with no written feedback or recommendations); **LGA teams noted an over-reliance on partners**
- SS reported to be hindered by lack of transport or funds
- In Sokoto State, we found no evidence of N100,000 funds at SPHCDA being used for SS to LGAs, with the SPHCDA reporting that it has not been able to enforce regular SS visits by its own staff
- In Bauchi, there were confirmed reports of funds being released by the SPHCDA to State and LGA for SS but we did not find **documented evidence** of the visits especially from the state level at LGA or HF level

GROUP LGA THIRD QUARTER RI SUPERVISORY PLAN  
SCHEDULE OF SUPERVISION AND ROUTINE IMMUNIZATION PLANNED, JULY TO SEPTEMBER 2013  
(LGA HQ OFFICE)

S/N	LGA	HEALTH FACILITY	NO. OF VISITS	SCHEDULE OF VISIT	JULY			AUGUST			SEPTEMBER			RESPONSIBLE OFFICER
					1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	
1	DUNAMBE	PHC DUNAMBE	2	1 <sup>st</sup> WED, WEDNESDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
2	GAZALI	PHC DUSGAMBE	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
3	GAZALI	GAZALI HOSPITAL	2	EVERY TUESDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
4	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
5	GAZALI	PHC KADUNA I	2	1 <sup>st</sup> WED, TUESDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
6	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
7	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, WEDNESDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
8	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
9	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, TUESDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
10	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
11	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
12	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
13	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
14	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
15	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
16	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
17	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
18	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
19	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
20	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
21	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
22	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	
23	GAZALI	GAZALI DISPENSARY	2	1 <sup>st</sup> WED, MONDAY	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	3/2	

LGA NAME: GAZALI  
DATE: 30/06/2013

Figure 7. Supportive Supervision plan from an LGA

## Community Linkages

### ***Positive findings***

- Community structures such as TBAs, WDCs and CBHVs, mostly reactivated by USAID/TSHIP, were present in all communities, and reported to be involved in RI; they work with HFs to announce days for fixed and outreach sessions; they are also involved in house to house mobilization and referral of children for immunization; other community structures reported in Bauchi State include Miyetti Allah, Federation of Muslim Women of Nigeria (FOMWAN) and Nigerian Union of Road Transport Workers
- Regular meetings are held between service providers and community structures; WDCs/CBHVs discuss issues on RI and HFs provide feedback to communities through these structures
- In Bauchi, USAID/TSHIP works with sub-grantees to support community structures
- Health education materials were printed and provided at HFs, but usefulness not clear in the light of low female literacy level in the communities
- Communities have started asking for more services and personnel to be deployed to their facilities although the HFs are currently not optimally utilized

### ***Areas needing strengthening***

- Inadequate communication (IPC, or inter-personal communication) with mothers on key information on RI such as when to return for the next vaccine and importance of keeping the immunization card at RI sessions; weak feedback to communities from HF in relation to RI
- Low engagement and ownership of community structures by the state and LGAs; thus sustainability of the gains of their involvement not clear (e.g. USAID/TSHIP provides WDCs and CBHVs with N2,000/month as per national guidelines for states, but states do not provide any support)
- In Bauchi, many of the LGAs visited were not aware of the existence of the sub-grantees

*Quote: "RI partners should advocate with SMOH and MOLG to own the community structures if we are to improve routine immunization in a sustainable manner" LIO*

*Figure 8. Community interview in Sokoto (left) and Bauchi (right)*



## Capacity Building

### *Positive findings*

- Multiple partners are assisting the state with RI related training including:
  - LGA level training included cold chain maintenance training by USAID/TSHIP for all CCOs (March 2013); LGA used to hire technician to fix cold chain, but they are now able to use CCOs
  - USAID/TSHIP conducted training in Bauchi prior to PCV introduction in 2012, while in Sokoto a 5 day training was conducted for select HF and LGA staff using the old RI Basic Guide
  - CDC conducted vaccine management training in both states
  - Officials were trained on organizational management in both states
- Existence of experienced and committed staff providing RI services at the HFs

### *Areas needing strengthening*

- All levels reported a **critically weak supportive supervision system**, with no time for on-job training to boost skills/knowledge learned during training or to orient newly transferred staff; with no written feedback given, and little follow up on recommendations from one visit to the next, capacity issues persistently remain unresolved—as illustrated by poor use of existing tools/data and many errors in RI data tracking tools
- Frequent turn-over of qualified staff at all levels reported as a common challenge at all levels (more in Sokoto) which translates to some of the service providers being not yet formally trained
- Capacity building efforts such as supportive supervision with use of checklist and training are mostly done by partners; **LGAs noted over dependence on partners for capacity building**
- Inadequate skills of CCO in vaccine management documentation and cold chain maintenance
- Capacity building done by partners appears to focus exclusively on training, with little evidence of other methods used
- **USAID/TSHIP: follow up after the 5 day RI training done by USAID/TSHIP reported as weak** with no evidence of cascading to lower levels, and with a poor supervision system it is unclear how new skills/knowledge are being reinforced post-training
- Key areas noted to be improved by interviewees (which matched review findings) include **immunization monitoring chart use, vaccine distribution, and linking with communities**



## RECOMMENDATIONS BY THE REVIEW TEAM FOR USAID/TSHIP

### ***National-level***

- USAID/TSHIP should establish presence at RI meetings in Abuja to link on-ground successes with implementation to policy decisions, which USAID/TSHIP is well placed to provide
- USAID/TSHIP can help organize **peer exchange visits** to provide a forum to share promising practices
- Partners advised that USAID/TSHIP ensure that all future RI interventions should continue to be in line with the new National RI Strategy Paper recently agreed on by National Council for Health; USAID/TSHIP participated in the zonal RI strategy discussions in NEZ

### ***State-related, including partner relations***

- Use remaining implementation time to **focus on high level advocacy for ownership and governance of RI program**, including in Sokoto encouraging “PHC under one roof” with follow up support to maximize coordination across SMOH, SPHCDA, and MOLG
- Work closely with the states- in Sokoto to establish mechanism to monitor the release and use of the N200,000, in tandem with LGA efforts to improve budgeting and reporting of fund expenditures to LGA Chairmen in Sokoto and in Bauchi to establish a mechanism for monitoring use of funds released for RI
- Establish a joint supervisory team comprising of government and partners using a uniform supervision checklist, with **focus on building state capacity to conduct SS without partners present**
- USAID/TSHIP internal: encourage regular staff communication between Bauchi and Sokoto states
- USAID/TSHIP internal: improve quality of intra-state and inter-cluster technical meetings to ensure that the whole team considers its activities through a health systems approach; currently it seems that each intervention area does not fully maximize collaboration with others (e.g. service improvement facilitators reported to focus more on reproductive health without assisting with other areas, including RI)
- USAID/TSHIP internal: review the current system whereby integrated SS is done only by the program learning team on a quarterly basis only and with no systematic written feedback to technical staff for timely site-specific follow up

### ***LGA/HF/Community: Planning, Management, Partner Relations and Governance***

- **USAID/TSHIP/partners should work together in resolving persistent overdependence by state and LGA on partners;** in order to do this, USAID/TSHIP may need to take some calculated risks in reducing financial dependence of the state on such things as training, supervision visits, and community linkages work (WDC/CBHV monthly payments); failure for USAID/TSHIP and partners to take consolidated action will lead to continued low ownership and governance of key state and LGA health decision makers
- In fostering stronger local ownership and governance, the **SPHCDA should advocate with MOLG, Task Force/Partners and LGA health teams to ensure LGA Chairmen release monthly funds for RI according to the N200,000 minimum circulated by MOLG in Sokoto;** LGA teams should then work with HFs to rationalize/prioritize affordable plans for regular outreach; “Model LGAs” where adequate funding is being given should be used as **peer examples**. An example of a model LGA should include: receiving at least N200,000/month RI financial support from the LGA as per MOLG circular, good team work,

and significant expansion of access to regular RI services (following minimum national standard of 1 fixed and 2 outreach sessions per month as part of the 1-2-3 strategy).

- Partners should support **SPHCDA in Bauchi to monitor the efficient use of funds being released monthly to LGAs and HFs** for supervision and outreach services respectively
- LGA & Local Government Service Commission need to continue recruiting and ensure equitable distribution of HWs; partners may be able to play an advocacy role in this issue
- Encourage LGAs to improve on logistics support (transport and funding) to ensure adequate vaccine distribution to health facilities and outreach sites
- USAID/TSHIP internal: project should dedicate 1 staff full time to RI at state level in each state to ensure focused attention on building state capacity of RI, to oversee work in LGAs, and ensure focus remains on the RI system

### ***LGA/HF/Community: Increasing Access***

- Encourage HFs to **increase frequency and optimal attendance of RI sessions** both fixed and outreaches in line with 1-2-3 strategy and local budget allocation
- **Training and retraining of service providers on data management and use** including strengthening supportive supervision to provide on the job training and follow up
- SPHCDA, LGAs, and HFs should institute specific planned actions to address the high number of left outs and drop outs from the RI system
- To make full use of scarce resources, HFs should work to increase and maximize attendance at RI sessions (e.g. by conducting sessions according to plan, ensuring communities are well aware of when sessions are taking place, improving friendliness of services that meet community needs)

### ***LGA/HF/Community: Monitoring and Use of Data***

- Now that data tools are present at all levels in Sokoto and as soon as data are made available in Bauchi, the focus by SPHCDA, LGAs, HFs, and partners should be **maximizing use of tools to make more evidence based tailored local decisions**, as data is largely not being used at any level; this includes more specific planned actions are needed for changing the high drop out and left outs
- The SPHCDA should take over the task of routinely producing and disseminating summary charts showing the ranking of LGAs according to coverage, drop out, and quality of immunization services; **data analysis should be housed in SPCHDA and not overly rely on partners as has persistently been the case in Sokoto State**
- USAID/TSHIP internal: project needs a dedicated M&E staff focusing on RI in each state, since RI includes many data for action needs (especially feeding back data)

### ***LGA/HF/Community: Supportive Supervision***

- A formal supervisory structure involving government and partners should be put in place at state level, where state is chairing the process, including **SS visits conducted without partner presence and with consistent use of checklists** with log/visitors' books used to document findings and recommended follow-up actions
- Supervision should be done during RI sessions to enable on-the-job training
- USAID/TSHIP internal: provide timely feedback of SS visit results to technical team to enable them to provide needed follow up on specific issues
- USAID/TSHIP internal: current use of a standards-based SS method, even in abridged format, may not be appropriate for such a weak health system as in Sokoto; in order to better build on the local context and to foster stronger ownership, USAID/TSHIP and the state should explore returning to a more bottom-up approach to developing supervision

checklists, such as the task identification approach where HF and LGA staff jointly developed their own checklists, and agree to hold themselves accountable to 10-15 points; in the past, this approach ensured local ownership as well as room for progressing according to a limited set of standards; but this method takes time and focused attention to put in place

### ***LGA/HF/Community: Community Linkages***

- Train and retrain RI service providers on IPC, to deliver key information on RI such as when to come for the next vaccine, common side effects and importance of keeping immunization card including written messages in *Hausa and Ajami* as appropriate
- Engage Government –State and the LGAs to **take over ownership of the community structures for sustainability**, starting with cost sharing of the incentives initially and gradually exiting from N2,000/month to WDC members and CBHVs before end of project
- Explore how best to address governance/ownership issues given current low level with this issue, and how to get “power players”, including cultural/traditional, to take lead

### ***LGA/HF/Community: Capacity Building***

- In order to address weak knowledge/skills of health staff, frequent turnover of staff, and plans not being well implemented, a **supportive supervision system with sufficient time for on-the-job training should be strengthened** so that, at minimum, the state and LGAs conduct at least 1 visit to each site per quarter without partner assistance by USAID/TSHIP close-out, using a checklist and providing written feedback to those being supervised
- While LGA and HF staff suggested that additional and frequent RI training was needed—particularly to address high turnover issues—the reviewers observe that **a system in place to follow up after training is first needed before there is a focus on training**; failure to build a locally owned structure to ensure follow up will result in training with no support to assist LGAs and HFs in implementing the new skills/knowledge learned
- While the RI review found many plans in place, the **lack of consolidated microplans and the lack of follow up on RI session plans** means that much of the planning capacity stops and reinforces poor management/follow up and low health worker morale
- Frequent turn-over of qualified staff at all levels means that capacity building efforts are lost unless a **strong on-job-training system is in place** (e.g. SS system) for new staff to be oriented in a timely fashion; more attention from supportive supervision with on-job training will also help build HF understanding and capacity to use their own data to address local problems



## CONCLUSIONS

Findings from this review point to widespread and systematic weaknesses in the public health system to manage and deliver regular and quality RI services to communities in Bauchi and Sokoto States.

The role of government and partners working collaboratively to improve the RI system is essential. Even though the overall findings suggest that the RI system in Bauchi is stronger than that in Sokoto, the systems in both states are still faced with critically weak state ownership and governance in relation to the RI system, and large disparities exist in immunization performance data by source (e.g. >60% DPT3 coverage based on administrative reports in 2013 to date; USAID/TSHIP 2012 LQAS of DPT3 coverage <10% in both states).

At LGA level in both states, large gaps remain in management (including financing), government-led supportive supervision with use of checklists and on-job-training, and active use of data to maximize utilization of scarce resources. There is a critical need to increase the quality and quantity of RI sessions because health facilities, while operational, were rarely found to be conducting fixed and outreach sessions according to plans and in ways that optimized attendance.

Even though health managers and health workers seem to understand the principles of the REW approach, their practices still need much improvement. A very concerning finding is the issue of weak data management and use at all levels. The involvement with community structures in relation to RI also needs to be strengthened, as this may facilitate the linking of civil registration to newborn tracking with immunization, as well as improve defaulter tracking. Behind all of the above issues, is the need for a regular and supportive supervision system that can provide LGAs and health workers with routine support and feedback, on-job-training, review of local data, and discussions on how to jointly solve persistent problems. All of the recommendations in this report revolve about these key highlights.

Both states require continued system-strengthening support from partners, but need to provide support in ways that foster increased ownership and maturation of processes, so that every eligible woman and child are reached by timely vaccination services with all required antigens.

USAID/TSHIP may not be able to address all the issues at once and alone, but it plays a major role in areas which touch on RI management and service delivery issues. In the coming year, USAID/TSHIP will need to work in close coordination and collaboration with CDC NSTOP as CDC expands to focus on RI support to all LGAs in Sokoto and Bauchi for FY2014.

A May 2009 end of project review report for USAID/IMMUNIZATIONbasics noted that: *"the two-and-one-half year's lifespan of this project was not sufficient for all of the five REW components to achieve full maturity in the two states. More work remains to effectively consolidate the process in these two states, and to expand the effort to other States. The Team encourages the Federal Government of Nigeria, USAID and other partners to continue to support the effort to strengthening RI in Sokoto and Bauchi States, as well as to utilize the tools, methods and approaches developed by the IMMUNIZATIONbasics Nigeria project on a national scale, for strengthening both RI and PHC in Nigeria"*<sup>1</sup>.

Given that USAID/TSHIP has just entered its fifth year of implementation, it may be difficult for the project to consolidate gains and focus on RI system strengthening with sufficient time to ensure that a minimal level of maturity and state ownership of RI processes is in place before its end date. To work towards this goal, the project will require internal resolve in paying sufficient and focused attention, time, and resources (staff and financial) specifically to the RI system. Its current annual plan notes a focus area will be on RI.

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<sup>1</sup> [http://www.immunizationbasics.jsi.com/Docs/IMMbasics\\_Nigeria\\_EOP\\_Review\\_Report\\_May2009.pdf](http://www.immunizationbasics.jsi.com/Docs/IMMbasics_Nigeria_EOP_Review_Report_May2009.pdf), page 18

## ANNEXES

### Annex 1a: Review Team members -Sokoto

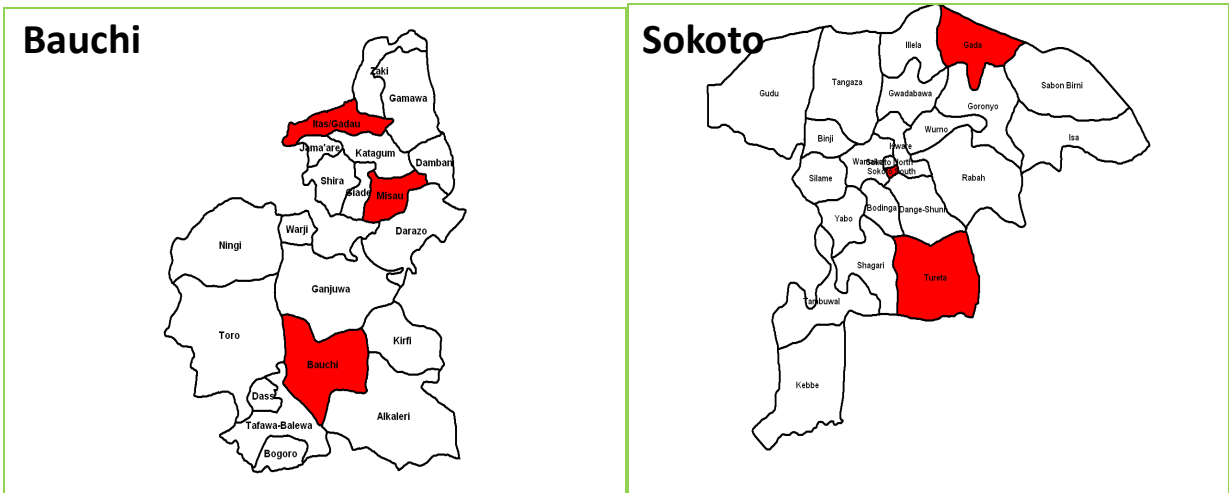
<b>Names</b>	<b>Organization</b>
Dr. Auwal Gajida	Consultant
Dr. Femi Oyewole	Consultant
Jenny Sequeira	JSI
Dr. Amos Bassi	USAID/TSHIP
Dr. Mohammed Auwal	USAID/TSHIP
Dr. Zainab Mohammed	USAID/TSHIP
Ibrahim Ahmed Na'ya	USAID/TSHIP
Buhari Shehu	USAID/TSHIP
Hafsat Bukar	USAID/TSHIP
Abdullahi Aliyu	USAID/TSHIP
Alima Abubakar	USAID/TSHIP
Aliyu Abdullahi	USAID/TSHIP

### Annex 1b: Review Team members -Bauchi

<b>Names</b>	<b>Organization</b>
Dr. Auwal Gajida	Consultant
Dr. Femi Oyewole	Consultant
Dr. Amos Bassi	USAID/TSHIP
Adamu Abdullahi	USAID/TSHIP
Mohammed Umar Sakwa	USAID/TSHIP
Ibrahim Ahmed Na'ya	USAID/TSHIP
Buhari Shehu	USAID/TSHIP
Bello Kilgori	USAID/TSHIP
Kawule Ya'u	USAID/TSHIP
Murtala Ahmed	USAID/TSHIP
Ibrahim Baba Mustapha	USAID/TSHIP

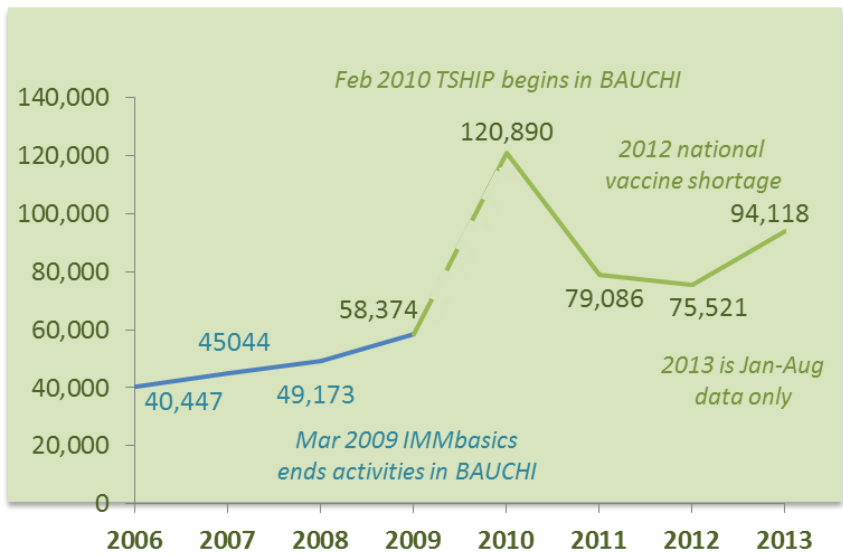


ANNEX 2a: Maps of Bauchi and Sokoto State Maps indicating the LGAs visited

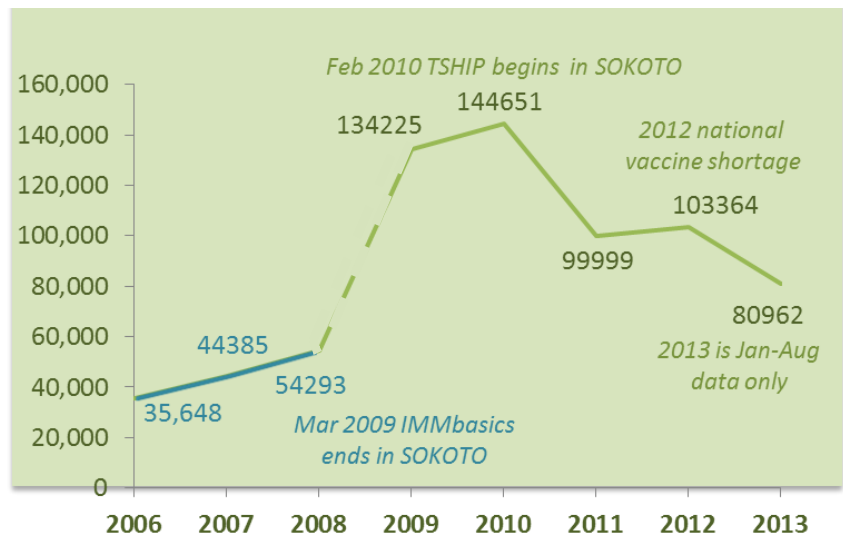


ANNEX 2b: 2006-2013 trend by state in **number of children vaccinated by DPT3**; 2013 data is Jan-Aug only; source: administrative data; note: this data is denominator independent; also of importance is 2006-2008 data excludes IPD data while 2009-2013 includes IPD data, thus the spike in trend in 2010

**Bauchi State**



**Sokoto State**



Source: 2006-2008 IMMUNZATIONbasics; 2009-2013 TSHIP  
 Note: 2006-2008 data exclude IPDs, while 2009-2013 include IPDs

### ANNEX 3: LGAs and Health Facilities Visited During the Review

	S/No	LGA	WARD	HEALTH FACILITY
<b>SOKOTO</b>	1.	Gada	Kadassaka	Kadassaka Dispensary
			Kaffe	Kaffe Primary Health Center
	2.	Sokoto South	Gagi B	Mabera Mujaya Dispensary
			Gagi C	Mabera PHC
	3.	Tureta	Duma/Bimasa	Duma upgraded PHC
			Tsamiya	Model PHC Tsamiya
<b>BAUCHI</b>	4	Itas Gadau	Itas	Area Health Office, Itas
			Mashema	Mashema PHC
	5	Bauchi	Birshi	Yelwa Domiciliary Dispensary
			Zungur	Liman Katagum PHC
	6	Missau	Kuka Dige	Area health office
			Zadawa	Zadawa Maternity

### ANNEX 4: List of People Seen During the Review

#### National level

Organization	Name	Designation
NPHCDA	Pharmacist Mohammed Sani ADAMU	Logistician
	Dr Mahmoud	Director, Routine Immunization
	Alhaji Ado Abdullahi	Head, Social Mobilization
	Dr David Malgwi	Director, Special Duties
	Dr E. Abanida	Director
UNICEF	Dr Abubakar Kampo	Head of Health
	Dr Boubacar Dieng	Routine Immunization
CDC	Dr Hashim Elmousad	Routine Immunization
	Ms Lisa Esapa	
	Dr Adamu Sule	N-STOP
CHAI	Dr Garba Abdu	Head
WHO	Dr Daniel Ali	Routine Immunization
PRRINN-MNCH	Mr Wahab	Team Leader
	Mr Solomon Mengiste	

#### Sokoto State

##### State Level and Partners

Person Interviewed	Organization	Designation
Amin Shehu	SPHCDA	Dir Disease Control & Immunization
Danmalam Maichede	SPHCDA	Dir PHC
Lema Sani	SPHCDA	SIO
Hassan Mohd Galadanchi	SPHCDA	SCCO
Alhaji Jinaiudu Mohammed	MOLG	Dir Local Government matters
Mekonnen Tesfaye	UNICEF	
Shaheed Gidado	CDC - NSTOP	
Halimatu Bolatito	CDC – NSTOP	
Aliyu Abubakar Abdullahi	WHO	National Immunization Officer
Abubakar Maishanu	USAID/TSHIP	Deputy Chief of Party, Sokoto
Yusuf Muaazu Jatau	USAID/TSHIP	LGA Immunization Monitor
Aliyu Abubakar	USAID/TSHIP	LGA Immunization Monitor
Malami Magaji	USAID/TSHIP	LGA Immunization Monitor
Aisha M Bello	USAID/TSHIP	LGA Immunization Monitor
Abah Stella	USAID/TSHIP	LGA Immunization Monitor
Mohammed Auwal Ibrahim	USAID/TSHIP	Senior MCH advisor
Zainab Mohammed	USAID/TSHIP	Malaria & Child Health specialist

Halima Abubakar	USAID/TSHIP	LGA Health Coordinator
Hafsatu Bukar	USAID/TSHIP	LGA Health Coordinator
Abdullahi Aliyu	USAID/TSHIP	LGA Health Coordinator
Yusuf Umar Sanura	USAID/TSHIP	Polio Eradication Officer
Buhari Shehu	USAID/TSHIP	Polio Eradication Officer
Nurudeen Lawal	USAID/TSHIP	Policy and Research Specialist

### Sokoto LGA Level

LGA	Person interviewed	Designation
Gada	Mohammed Magaji	LIO
Gada	Aminu Abdullahi	Health Educator
Gada	Umar S Gobir	CDC – NSLO
Gada	Mohammed Ladan	USAID/TSHIP – LIM
Sokoto South	Muslim Adamu	Director PHC
Sokoto South	Umar A Shehu	Health Educator
Sokoto South	Lawwali Isyaku	CCO
Sokoto South	Usman A Shehu	LIO
Sokoto South	Umar Dange	LGA Facilitator WHO
Tureta	Hassan Shehu Kamba	Director PHC
Tureta	Ladan Sulaiman	LIO
Tureta	Shehu Abubakar Danchadi	M & E Officer
Tureta	Abubakar Jabbi	CCO
Tureta	Idris B Ibrahim	Head Educator

### Sokoto Health Facility Level

LGA	Health Facility	Person Interviewed	Designation
Gada	PHC Kaffe	Ibrahim Abdullahi	I/C
Gada	PHC Kaffe	Garba Abdullahi	Staff
Gada	PHC Kaffe	Jamilu Bala	RI Focal Person
Sokoto South	Mabera Mujaya Dispensary	Saadatu Usman	I/C
Sokoto South	Mabera Mujaya Dispensary	Sakina Sarkin Fawa	RI Focal Person
Sokoto South	Mabera Mujaya Dispensary	Maryam Bawa	Staff
Sokoto South			
Sokoto South			
Tureta	Tsamiya Model PHC	Ahmed Mohd Buda	I/C
Tureta	Duma Upgraded PHC	Alh Bawa Dange	I/C

### Bauchi State

#### State level and partners

Person Interviewed	Organization	Designation
Dr A. I. Ningi	WHO	State Coordinator
Pharm Katugwa Emmanuel	WHO	Logistician
Zwane Alison	UNICEF	
Auta A. Kawo	UNICEF	
Moji Afolabi	WHO	Immunization Officer
Goni Abba Ngaga	WHO	
Hassan Gunda	WHO	
Luka Mangveep Ibrahim	CDC N-STOP	
Dr Nasser Ali Umar	Bauchi SPHCDA	Executive Secretary
Hajja Yaya Tijjani	Bauchi SPHCDA	Director PHC
Mr Bakoji Ahmed	Bauchi SPHCDA	
Musa A Mohammed	Bauchi SPHCDA	
Ahmed Mustapha Abdul	Bauchi SPHCDA	
Mohammed B. Mustapha	Bauchi Min of Local Government Affairs	Director PHC

Rufai Ibrahim Yahaya	USAID/TSHIP	
Toyin Akomolafe	USAID/TSHIP	M&E
Kelvin	USAID/TSHIP	M&E
Aminu Sadiq	USAID/TSHIP	
Daniel Yerima	USAID/TSHIP	
Amina Aliyu	USAID/TSHIP	
Dr Sadauki	USAID/TSHIP	DCOP
Dr Bassi	USAID/TSHIP	Senior Advisor
N. Ibrahim	USAID/TSHIP	Immunization Officer
Adamu Abdullahi	USAID/TSHIP	Poilo Officer
,Murtala Ahmed	USAID/TSHIP	
Baba M Ibrahim	USAID/TSHIP	
Yahu Abdullahi Bukachua	USAID/TSHIP	
Ezenwa Nwizugbe	USAID/TSHIP	
Musa A Umar	USAID/TSHIP	
Elijah B Kidachau	USAID/TSHIP	
Anna B Turaki	USAID/TSHIP	
Willaim Sambisa	USAID/TSHIP	M&E
Masduk Abdulkarim	USAID/TSHIP	M&E
Abubakar U Jaja	Bauchi Min of Local Government Affairs	

#### Bauchi LGA level

Person interviewed	LGA	Position
Alhaji Mudi Ari	Bauchi LGA	Director, PHC
Alhaji Ahmad Ibrahim	, Bauchi LGA	LIO
Alhaji Mohammed Rasheed Aliyu	, Bauchi LGA	Health Educator
Alhaji Musa danladi	Bauchi LGA	CCO,
Shehu Imam	Itas Gadau	Deputy Director PHC
Mohammed Danasabe Abba	Itas Gadau	LIO
Alhaji Magaji Gambo	Itas Gadau	M&E Officer
Gambo Ahmed	Itas Gadau	CCO
Magaji Dauda	Itas Gadau	Health Educator
Hadiza Ibrahim	Itas Gadau	MCH Coordinator

#### Bauchi Health Facility Level

Person Interviewed	LGA	HF	Designation
Hailiru Adamu	Bauchi	Liman Katagum	Officer-in-charge RI
Usman Mohammed	bauchi	Liman Katagum	Deputy Officer-in-charge RI
Dauda M. Shuaibu	Bauchi	Liman Katagum	Officer-in-charge HF
Mohd Ishyaku	Missau	Area health office, Missau	i/c
Rufa'i Shehu	Missau	Area health office	JCHEW
Ibrahim Musa	Missau	Area health office	E H A
Salisu Yahaya	Missau	Area health office	
Sani Ahmad	Missau	Zadawa Maternity	E H T



## ANNEX 5: **Review Tools** (*reformatted to take minimal space in this report*)

### **USAID/TSHIP RI Review INTRODUCTION SHEET and INTERVIEW GUIDANCE**

#### *INTRODUCTION and TEAM MEMBER GUIDANCE*

This is a review of USAID/TSHIP's routine immunization-related support. It is not a formal evaluation of the overall immunization program in each state. The review is essentially a qualitative one but with some quantitative components. The emphasis is to learn how the RI system has been improved or not, and insights on how it can be further strengthened in the next 2 years and after project closure.

As such, the questionnaires are designed with mostly open-ended questions. It is up to you to create an open and friendly environment that puts the respondents at ease and encourages them to do most of the talking. The team leader introduces the team members and the purpose of the interview. Each team will assign a member to be the interviewer and 2 members to be note takers. Don't bombard the respondents with too many questions or try to find fault. You are there to listen and observe, not to make corrections. Ask them to explain what they are doing and how they are trying to improve the routine immunization program and services.

Allow the conversation to flow naturally without forcing the respondent to strictly follow the order of the questionnaire. This may require you to move into other thematic areas on the questionnaire. When the conversation allows, be sure to return later to any unanswered questions. Avoid questions that can be replied with a "yes" or "no"; instead ask probing questions such as "how did you do that?" or "why do you think that?" In other words, probe and keep them talking. Remember to thank the respondent at the end of the interview.

You will use a daily personal log to structure your important observations and capture your key findings. This is not to be submitted. Each evening, the team will discuss the day's findings and prepare a daily team summary (in bullet format which quantifies observations from LGAs and health facilities where appropriate). A template will be provided for this daily summary. Each team will use this summary as you de-brief with the state team and prepare the overall state report. Each team has a leader. In consultation with team members, the leader is responsible for the overall direction, quality of the work, keeping things on track, ensuring participation by all team members, guiding the field work, following the review methods, responding to any team concerns and solving problems that may arise. Each evening, the team leader facilitates a discussion and recording of the day's key findings and suggestions and ensures that all interviews are typed up and shared. At the state level, a consolidated report and PPT slide set along REW thematic areas will be presented.

#### *METHODOLOGY OVERVIEW PER STATE*

- USAID/TSHIP staff interviews: technical staff involved in RI
- State interviews: SPHCDA, MOLG, partners
- 3 LGAs: 1 per zone, Sokoto South (central), Gada (east), Tambuwal (south); 1 urban/semi, 2 rural; at least one low performing
- 2 HFs per LGA: one with fridge, one without; both outside LGA headquarters; mix of good and low performers; must be from different wards and have received USAID/TSHIP support in past 2 years
- 1 WDC/CBHV per LGA: interview as a group
- 1 RI session observation per LGA: at least 3 exit interviews with mothers with children attending RI session
- Field testing: 3 interview teams during week 1: about 4 members per team (9 USAID/TSHIP staff, 3 consultants)
- 1 team during week 2: Gajida + USAID/TSHIP



## USAID/TSHIP RI REVIEW: STATE LEVEL GUIDE

General questions for USAID/TSHIP technical staff in the state

Questions	Whom to interview
<ol style="list-style-type: none"> <li>1. What are USAID/TSHIP’s greatest contributions to date in PHC strengthening in this state?</li> <li>2. What are USAID/TSHIP’s greatest contributions specifically in RI strengthening in this state?</li> <li>3. Do the USAID/TSHIP states have joint program review meetings? If so, how often? In general, describe how each state learns from the other?</li> <li>4. Which LGAs have the biggest successes in RI progress to date and why? Please be very specific.</li> <li>5. Which LGAs have the biggest challenges in RI progress to date in relation to USAID/TSHIP support and why? Please be very specific.</li> <li>6. What could USAID/TSHIP do better in relation to RI system strengthening?</li> <li>7. Briefly, what is USAID/TSHIP’s vision in relation to RI?</li> <li>8. What can be done in general to encourage the State and LGAs to continue the activities which you have helped to implement (planning, SS, capacity building, monitoring, etc.)?</li> </ol>	Select technical staff who have played any role relating to RI (this includes data quality strengthening)

Questions for State PHC staff

*Italicized text is for interviewer to note/probe, not ask directly*

Partner Coordination (SPHCDA/SMOH, MOLG, WHO, UNICEF, OTHERS)	Whom to Interview
<ol style="list-style-type: none"> <li>1. Please describe collaboration between USAID/TSHIP and your organization/agency exclusively in relation to RI, not in relation to IPDs or campaigns. <i>(probe: content, frequency, results? describe any difference seen in the last six months).</i></li> <li>2. What can you recommend to improve collaboration between your organization/agency and USAID/TSHIP?</li> <li>3. What needs to be done to strengthen RI in the context of REW in the state in a sustainable manner? <i>(probe planning &amp; management of resources, increasing access, monitoring for action, supportive supervision, community links)</i> How do you think USAID/TSHIP can help?</li> <li>4. Can you describe the involvement of MOLG in strengthening RI activities in last 12 months? <i>(Probe interaction between USAID/TSHIP project and MOLG)</i></li> </ol>	<p>State coord, Prog Officer, SPM, MOLG DirPHC SPHCDA, Dir Dz Control &amp; EPI, WHO, UNICEF, CDC NSTOP, GAVI (only ask these to partners)</p> <p>MOLG only</p>
<p>Planning and management of resources – interview all SPHCDA and MOLG staff as per above, but not partners</p>	
<ol style="list-style-type: none"> <li>1. Who are the key RI partners in this state and how do you work with each? <i>Probe for details who does what, what do they do, etc.</i></li> <li>2. Do you have an annual plan/microplan specific to RI for the state? If so, can we see it? <i>(If available: take a picture of summary pages of the plan).</i> <ul style="list-style-type: none"> <li>○ Who influenced the development this annual RI plan? What have you been able to accomplish so far? <i>(Probe: ask for specific names of partners who were involved in the state annual plan/microplan development; look for evidence of active use of the State plan for RI activities? e.g. state map, quantified resources, support supervision plan for LGAs; probe understanding of LGA’s planning and management of HF supervision, vaccine distribution plan, activities operational in the last quarter.)</i></li> <li>○ What have been the constraints, challenges in implementing the plan?</li> </ul> </li> <li>3. Do you have a budget line for RI? If so, is there a dedicated amount there? Are these funds released on time specifically for RI activities?</li> </ol>	
<p>Increasing access to immunization services &amp; using data– interview all SPHCDA and MOLG staff as per above, but not partners</p>	

For below, look for evidence of data analysis e.g. disaggregating of RI and IPD data, EPI monitoring charts, prioritization of LGAs, appropriate filing of data, charts/results of supervision, including feedback to LGA policy makers, service providers & communities

1. Please describe your DPT3 and dropout trends over the past 3 years.
2. Which LGAs in your state have the poorest access (e.g. DPT1); how do you know/decide? *(probe for data, is this documented or only the interviewees impression?)*
  - What have you tried over the past 3 years to improve access; what worked, what didn't work; what barriers do you face?
3. What partners work with the state in improving RI data quality (RI specific, not including campaigns or IPDs)?
4. Describe the number of review meetings you have had in this state over the past year, and what normally happens during these meetings, who attends, etc. *Probe for agenda, attendance, minutes, etc.*

RI Supportive Supervision – interview all SPHCDA and MOLG staff as per above, but not partners

1. What partners do you collaborate with, if any, in SS relating to RI?
2. Describe the current State-to-LGA supervision system as it relates to RI. *(probe for use of checklist, oral and written feedback; if written feedback is given, ask to see a copy of the last feedback given; NOTE: answer to this question may fill in points below)*
  - How many supervisory visits were planned and how many were conducted in the last six months? What are the barriers?
3. How many supervision visits were conducted without USAID/TSHIP support? *(Probe for evidence to show that supportive supervision is conducted by the state to each LGA at least quarterly, try to quantify according to information on file)*
4. In what ways can the State to LGA support supervision process be improved?
5. In what ways can LGA to HF support supervision process be improved?

Strengthening Community Linkages– interview all SPHCDA and MOLG staff as per above, but not partners

1. Which community structures do you work with, and how do you work with them in relation to routine immunization? Please give specific examples.
2. What have been USAID/TSHIP's main contributions in strengthening community linkages in relation to RI?
3. Can you suggest specific ways of strengthening community linkages for RI?

Capacity Building – interview all SPHCDA and MOLG staff as per above, but not partners

Describe what key areas in RI, if any, you think capacity has been built by USAID/TSHIP? What has been done in the last 2 years in capacity building (e.g. training, on-job-training) and how do you think you and the state have benefited from it? What could be done better?

Do you have any questions for us? Thank you for your comments and time.



## USAID/TSHIP RI REVIEW: LGA LEVEL GUIDE

Date: \_\_\_\_\_

Names of interviewers: \_\_\_\_\_

Names and position of those being interviewed: \_\_\_\_\_

Questions for LGA health staff

*Italicized text is for interviewer to note/probe, not ask directly*

*Whom to interview:* PHC Dir, Councilor Health, LIO, CCO, M&E, Health Educator

*Interviewer ask LIO to bring microplan before interview starts.*

### Planning and management of resources

1. Who are the key RI partners working with this LGA and how do you work with each?
2. Do you have an annual plan/microplan specific to RI for the LGA? If so, can we see it? *(If available: take a picture of summary pages of the plan).* Who influenced the development this annual RI plan?
  - What have you been able to accomplish so far? *(Probe: ask for specific names of partners who were involved in the LGA annual plan/microplan development; look for evidence of active use of the LGA plan for RI activities? e.g. LGA map, quantified resources, support supervision plan for HFs; probe understanding of LGA's planning and management of HF supervision, vaccine distribution plan, activities operational in the last quarter.)*
  - What have been the constraints and challenges in implementing the plan?
3. Do you have a budget line for RI? If so, is there a dedicated amount there? Are these funds released timely for specific RI activities? Is the MOLG circular for LGA Chairmen to give 200,000 per month for RI followed in this LGA? If not, why not? *Probe to make sure 200,000 is for RI not IPDs.*

### COLD CHAIN/LOGISTICS

4. What is the source of power supply for your cold chain? *Probe for availability of backup/standby generator and fueling. probe for national grid, etc.*
5. Can you keep your vaccines for one month in your LGA store?
6. What kind of cold chain equipment are you using?
7. What is the maintenance plan for cold chain equipment?
8. How do HFs get their vaccines? *Probe push/pull, etc.*
9. Have you run out of any vaccines in the last 6 months? *If yes, probe length of stockout. Ask to see vaccine ledger and further probe from there.*
10. *Do you have adequate cold chain capacity to accommodate Pentavalent vaccine introduction?*

### Increasing access to immunization services

1. How many HFs do you have in your LGA? How many of these HFs are providing RI services?
2. Have there been any changes in the number of HFs providing monthly fixed routine immunization services in the past 2 years? How do you know? What has been done?
3. Which HF in your LGA has the poorest access (e.g. DPT1 coverage)? which ward is this in?
  - How do you know/decide? *(probe for data, is this documented or only the interviewees impression?)*
4. What are the recommended frequencies for fixed and outreach sessions? Do you have any guide for how HFs should conduct outreach? If so, what is the guidance? *Prompt 1-2-3 national strategy (minimum of 1 fixed per week, 2 outreaches per month, 3 SS visits per month)*

### Monitoring and Use of Data for Action *(explain their own data and how they use it)*

*For below, look for evidence of data analysis e.g. disaggregating of RI and IPD data, EPI monitoring charts, prioritization of LGAs, appropriate filing of data, charts/results of supervision, including feedback to LGA policy makers, service providers & communities*

1. Please describe your DPT3 and dropout trends over the past 2 years. *If LIO is newly appointed, only ask for recent information.*
2. What partners work with this LGA in improving data quality?

3. How is data compiled, analyzed, used, and shared at LGA level? Describe in detail. *Probe for EPI monitoring chart shared with LGA Chairman, etc. Take photo of the LGA monitoring chart.*
4. What efforts have been made to address data quality? What changes have you observed since you started making efforts to improve? *(Probe if data quality spot checks done in health facilities?)*
5. Does the LGA have a functional LGA map (current map, when last was it updated?); if yes, how is the LGA using it? *(sight the map; should show all wards and HFs, indicating those providing RI; if possible, take photo of the map)*
6. Describe the number of review meetings you have had in this LGA over the past year, and what normally happens during these meetings, who attends, etc. *Probe for agenda, attendance, minutes, etc.*

**RI Supportive Supervision**

1. How many times has a team from the State visited you during the past 6 months for RI supervision? Has this increased or decreased over the past 2 years? What kind of feedback do they give? *Probe for evidence such as log book, SS checklist, etc. Take photo if possible.*
  - o How many visits were conducted without USAID/TSHIP support in the past 6 months? *Probe support from other partners*
2. In what ways can the State to LGA support supervision process be improved?
3. Can we see your LGA to HF SS plan? How many times in the last 6 months have you made visits to HFs?
4. Can we see a completed SS checklist that the LGA did with one of its HFs?
5. How do you give feedback to the HFs on support supervision results? *Probe for verbal, site registers, SMS, graphical, other* How do LGA supervisors follow up on recommendations from the last visit when they go on the next visit? *Probe especially the cases where different people go out.*
6. In what ways can LGA to HF support supervision process be improved?

**Strengthening Community Linkages**

1. Which community groups do you work with, and how do you work with them in relation to routine immunization? Please give specific examples.
2. What have been USAID/TSHIP’s main contributions in strengthening community linkages in relation to RI?
3. Have any community groups taken any RI issues to the LGA for action?
4. Can you suggest specific ways of strengthening community linkages in relation to RI?

**Capacity Building**

1. Have you had any training or on-job-training in relation to RI in the past 2 years? If so, please describe briefly.
2. Did you participate in any training supported by USAID/TSHIP relating to RI? *If yes: in what ways, if any, did it help you in your job?*
  - o Was the duration of the training adequate in relation to the content?
  - o What gaps were there in the training? *(probe: content and process areas)*
  - o How was follow up done, including any step-down training?
3. What key areas do you think capacity has been built by USAID/TSHIP?
  - o What has been done in the last six months and how do you think you and the LGA have benefited from it?
  - o What are the remaining gaps in capacity?
4. What do you think USAID/TSHIP can support to sustainably improve RI services?
5. What have been some of the strengths and weaknesses of capacity building efforts in RI?

Do you have any questions for us? Thank you for your comments and time.

**LGA OBSERVATIONS TO QUANTIFY DURING YOUR VISIT**

Observations	Comments on this LGA
Vaccine distribution plans on the wall	
Consistent financial support in past 6 months for: support supervision, vaccine distribution, generator, and outreach	



(quantify for each area)	
Funding increased or decreased for RI over past year (probe for figure in Naira)	
Number of support supervision visits to the LGA where checklist was used during previous 6 months compared to total number of support supervision visits	
No stockout of immunization cards or other RI monitoring tools	
EPI monitoring chart on wall and updated	
Temperature monitoring chart updated	
Temperature inside fridge within 2 to 8 degree C range; comment on functional thermometer	
Supportive supervision plan on wall (for 2013)	
Completed SS checklist seen and photo taken	
Minutes of monthly/quarterly review meeting seen	

### USAID/TSHIP RI REVIEW: HF LEVEL GUIDE

Date: \_\_\_\_\_

Names of interviewers:

Names and position of those being interviewed:

Questions for health facility staff

*Italicized text is for interviewer to note/probe, not ask directly*

Whom to interview: Health facility I/C, RI service provider

<b>Planning and Management of Resources</b>
<ol style="list-style-type: none"> <li>How long have you been providing RI at this HF?</li> <li>Describe the personnel in this HF working on RI. <i>Probe for adequacy, etc.</i></li> <li>Please tell us about the RI micro planning process for your HF (<i>clarify that the plans are for RI not SIAs/IPDs; use of catchment area map, target population, list of settlements, community involvement</i>) <ul style="list-style-type: none"> <li>Target population:</li> <li>How have you used your plans?</li> <li>What kind of resources and challenges for implementation of the RI micro plan were identified? <i>Probe for financial and material resource challenges</i></li> </ul> </li> </ol> <p><b>COLD CHAIN/LOGISTICS</b></p> <p>For HF with fridge:</p> <ol style="list-style-type: none"> <li>What is the source of power supply for your cold chain?</li> <li>What kind of cold chain equipment are you using?</li> </ol> <p>For HF without fridge:</p> <ol style="list-style-type: none"> <li>What kind of cold chain equipment are you using? <i>Probe for giostyle cold box, etc.</i></li> </ol>
<b>Increasing access to Immunization services</b>
<ol style="list-style-type: none"> <li>Can we see your RI session plan? <i>Take photo if possible.</i></li> <li>How many times do you provide RI services per month? <ul style="list-style-type: none"> <li>Describe fixed vs. outreach. <i>Probe reasons for not conducting sessions according to fixed and outreach plans.</i></li> <li>How many times were RI services provided in the last six months? (<i>outside of IPDs, record on tally sheet</i>)</li> </ul> </li> <li>What have you tried to improve access (e.g. DPT1) and attendance at RI sessions; what worked, what didn't work; what barriers are you facing? (<i>probe for outreaches, planned vs. conducted</i>)</li> </ol>



4. Are there settlements that you are not reaching; how are you or do you plan to reach them?  
*(probe: why aren't they being reached)*

Monitoring and use of data for action *(purpose is to determine whether they can explain their own data and how they use it)*

*Look for evidence of data analysis, e.g. EPI monitoring charts, appropriate filing of data, charts/results of supportive supervision; as well as functional catchment area map*

1. Can we see your immunization card and other RI monitoring tool stocks? *(Probe: specifically ask about cards, tally sheets booklet, VM-1, etc.)*
2. Do you have an up to date monitoring data and a catchment area map displayed or on file in the health facility? *(record the most recent month data are available)*
3. What is your RI coverage? *(ask for 2012 calendar cumulative, 2013 April-June quarter cumulative, compare with same April-June quarter period in 2012)*
  - How have you used this information?
4. Has RI coverage been going up or down over the past 6 months? How do you know? *(From own impression or from data)?* How do you use your monitoring information and map?
5. Has dropout gone up or down over the past year? How do you know? *(From own impression or from data)?* Have you done any special activities to reduce drop out? If so, describe. How do you do defaulter tracing?
6. What do you need to do to increase coverage? *(probe: role of DPT1, DO, left out, defaulter tracing)*
7. What efforts have been made to improve data quality? *(Probe if data quality spot checks done in health facilities, flow of information, look at EPI tally sheets, registers, summary report and archived availability of reports)*

RI Supportive Supervision

1. Describe what happens during an RI supervision visit from the LGA/state *(probe when the process started, anything new in how it is being done, use of checklist; NOTE: answer to this question may fill in points below)*
  - What do you think of this approach? Has it helped you? How? In what ways is the approach different? *(probe for use of checklist, ; NOTE: answer to this question may fill in points below)*
2. What has been the trend in supervision visit frequency from the LGA in the last 2 years? Increased or decreased? How have these visits affected your performance?
3. How do you receive feedback from the LGA on support supervision results?
  - What kind of feedback do you prefer? *(probe method, format; take pictures of any written documentation from last visit, including if in a log book)*
4. What ways can the LGA to HF support supervision process be improved?

Strengthening community linkages

1. Which community groups do you work with, and how do you work with them in relation to routine immunization? Please give specific examples.
2. What activities do you carry out that link RI with communities?
3. Have any community structures taken any RI issues to the HF for action?
4. What feedback do you provide feedback to communities?
  - How do you provide feedback? *Probe details such as method, frequency, etc.*
5. What have been USAID/TSHIP's main contributions in strengthening community linkages in relation to RI?
6. Can you suggest specific ways of strengthening community linkages in relation to RI?

Capacity building

1. Did you participate in any training supported by USAID/TSHIP in relation to RI? *If yes: in what ways, if any, did it help you in your job? Was the duration of the training adequate in relation to the content? What were the gaps in the training (probe: content and process areas) How was follow up done, including any step-down training? IF NOT participated, how long have they been there...probe capacity level, attrition rates, etc.)*  
*IF USAID/TSHIP SUPPORT IS IN RI IN THIS HF: What key areas do you think capacity has been built by*



USAID/TSHIP? What has been done in the last six months and how do you think you and the HF have benefited from it? What are the remaining gaps in RI capacity?  
 3. What do you think USAID/TSHIP can support to sustainably improve RI services?  
 2. In general, what do you like about existing training efforts in RI? What are some things you don't like in training in RI?

Do you have any questions for us? Thank you for your comments and time.

**HF observations to quantify during your field visits**

Observations	Comments on this HF
Vaccine session at least monthly so far in 2013?	
RI session plan on the wall?	
Active involvement of the community in RI during the past 6 months? (“active involvement” means: monthly community meetings with RI discussed, session monitoring, client tracking, community awareness raising for RI)	
Outreach provided at minimum once a month in past 6 months	
Supervision log book in use in last 3 months	
Number of support supervision visits to the HF where checklist was used during previous 6 months compared to total number of support supervision visits	
No stockout of immunization cards or other RI monitoring tools	
EPI monitoring chart on wall and updated	
If fridge: temperature monitoring chart updated	
If fridge: temperature inside fridge within 2 to 8 degree C range; comment on functional thermometer	

**COMMUNITY VOLUNTEER/WDC LEVEL GUIDE**

*Italicized text is for interviewer to note/probe, not ask directly*

**SELECTION CRITERIA:** communities where USAID/TSHIP has conducted/supported specific community linkages activities; at least 2 members of WDC, no more than 4, and at least 1 CBHV/HF visited; can do CBHV and WDC as one group

1. Are you aware of USAID/TSHIP as a project?
2. How can we improve the relationship between USAID/TSHIP and community groups?
3. Can you describe how your community/group collaborates with the HF in relation to routine immunization, not with IPDs or campaigns? *Probe if they are involved with health education, messages, announcements, etc., probe specifically in areas relating to:*
  - a. *their role, if any, in HF developing its annual plan*
  - b. *their role, if any, in sharing information/updates with the HF, and how this is done...for example, probe defaulter tracking, new deliveries, migrant populations*
  - c. *their role, if any, in sharing information with community, including awareness creation*
4. What have the community based health volunteers been doing in relation to RI?
5. What recommendations do you have for future projects to improve your community's/group's capacity so that more children in this community are vaccinated?
6. Describe immunization card stocks and how you keep your cards. *Probe availability/retention.*
7. *IF VISITING A BORDER LGA:* where do people go to for RI services? *Probe for communities accessing services in Niger, other LGA, etc.*

Do you have any questions for us? Thank you for your comments and time.

**IF RI SESSION IS TAKING PLACE: MOTHERS/CARETAKERS LEVEL GUIDE (INDIVIDUALLY OR IN GROUP)**

*Exit interview with at least 3 mothers whose children attended RI session*

1. What is your experience with immunization for your children?
  - a. How old is your youngest child?

- b. Can we see your child's immunization card? *Look at it, see what vaccines were given today, take photo*
  - c. Were you told when to return for vaccinating your child? If so, when? Who told you?
  - d. Whom do you get most of your RI information from?
  - e. Why do people want to immunize their children?
  - f. What stops people from immunizing their children?
  - g. Do you know someone who changed their mind--at first they did not have their child immunized and then decided to do? What were the reasons that they changed their mind?
2. Let's talk about the immunization services and activities managed by the health staff.
- a. What kind of services do they offer at this HF?
  - b. Has there been any change in the kinds of routine immunization services in the past few years?
  - c. What activities related to routine immunization services are most appreciated by the community?

Is there anything else you would like to say that you have not had a chance to say as of yet?  
*Thank you for your comments and time.*

