

NIGERIA

SUMMARY DOCUMENT: MAKING “REACHING EVERY DISTRICT” OPERATIONAL



A step towards revitalizing
Primary Health Care
in Nigeria

2009



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ACRONYMS AND ABBREVIATIONS

BaSPHCDA	Bauchi State Primary Health Care Development Agency
DFID	United Kingdom's Department for International Development
DPT	Diphtheria-pertussis-tetanus vaccine
HF	Health facility
IMMbasics	IMMUNIZATIONbasics (USAID)
JRIST	Joint RI Strengthening Team
LGA	Local Government Area (a Nigerian administrative term, similar to a district)
MOLG	Ministry of Local Government
NPHCDA	National Primary Health Care Development Agency
PHC	Primary health care
RED	Reaching Every District
REW	Reaching Every Ward (the Nigerian adaptation of the RED approach)
RI	Routine immunization
SMOH	State Ministry of Health
USAID	United States Agency for International Development
VDC	Village development committee
WDC	Ward development committee
WHO	World Health Organization

INTRODUCTION

In 2002, the World Health Organization (WHO) and partners designed the Reaching Every District (RED) approach in response to the decline or stagnation in routine immunization coverage across the Africa region. This innovative method is designed to increase and sustain high levels of routine immunization (RI), *particularly* in the Africa region. In 2004, WHO's Africa regional office and its partners developed and disseminated a RED guide, encouraging countries to adapt it to their context. This guide was updated and revised in 2008, and includes a monitoring tool.¹ WHO's Africa regional office led the revision process, with UNICEF and USAID's IMMUNIZATIONbasics project partnering in the effort.

In December 2004 Nigeria adapted the Reaching Every District approach to its own country context as the "Reaching Every *Ward*" approach (REW) since a *ward* represents the lowest administrative level in the country. Nigeria defined its REW approach as *"a strategy aimed at the provision of regular, effective, quality and sustainable routine immunization activities in every ward, so as to improve immunization coverage."*² Nigeria used WHO's 2004 Africa region RED guide to develop its REW guide.

In 2006, Nigeria disseminated nationwide its REW guidelines and tools. The National Primary Health Care Development Agency (NPHCDA) and partners provided cascade training in all states and Local Government Areas (LGA) starting in 2007. However, a nationwide assessment of REW in 2008 revealed that less than half of the 774 LGAs and health facilities were practicing the principles of REW.

The lessons learned from adopting the RED approach in Nigeria **can and should be applied** within a broader, integrated context of maternal and child health. The seven steps outlined in this document can easily be adopted and applied **to benefit other primary health care interventions**.

In October 2006, the IMMUNIZATIONbasics (IMMbasics) project embarked on a two-and-a-half year effort in two states in Nigeria to put REW into action, and thereby strengthen routine immunization (RI) services. By April 2009, a review of the project concluded that IMMbasics had developed "a practical and affordable way forward for strengthening RI in Nigeria."

The role of IMMbasics centered on creating an approach for establishing a sustainable RI system, which would serve as a model for rebuilding RI within the context of the primary health care (PHC) system in Nigeria. The project applied participatory techniques at all levels. IMMbasics did not provide funds to

carry out new or supplemental activities, but rather contributed technical assistance to support the government for improving and making operational what was already in place in terms of: strategies, health facilities (including equipment and supplies), and staff. To address sustainable financing, the project and LGA health teams successfully advocated to LGA Chairmen for the release of sufficient government (LGA) funds to sustain RI activities on a regular basis.

While Nigeria's REW guide provides a comprehensive description of RED's five components and requirements, the following pages of this document summarize how two states in Nigeria are putting the requirements into action. The lessons learned from these experiences are relevant not only in the field of immunization but to other primary health care interventions as well. A more detailed document on this experience (intended for a Nigeria audience) is available online: ***Making REW Operational: A step towards revitalizing PHC in Nigeria***³.

¹ http://www.who.int/immunization_delivery/systems_policy/AFRO-RED_Aug2008.pdf

² "Reaching Every Ward Field Guide," Federal Government of Nigeria National Program on Immunization, January 2007, pages 5-6.

³ http://www.immunizationbasics.jsi.com/Docs/Making_REW_Operational.pdf

MAKING RED OPERATIONAL, Seven Steps

The Approach

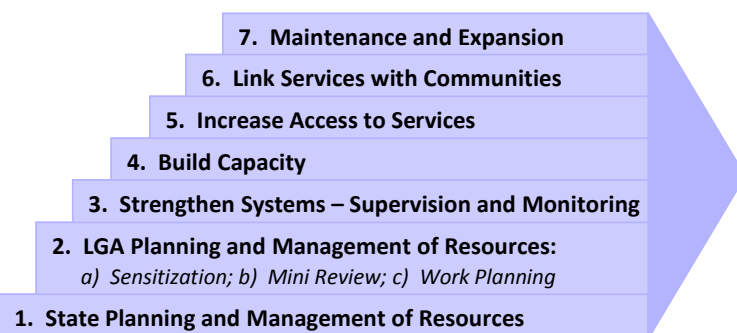
The health facility and the local administration levels serve as the frontline, and the most critical levels, for providing access to quality RI service. Consequently, IMMbasics concentrated efforts at these two levels. The project also actively worked with state health officials on both building capacity and promoting advocacy, and worked at the national level for coordination and advocacy with partners and stakeholders. The project's first priority centered on strengthening human resources and systems capacity. After the local health system was prepared for providing quality immunization services, the project then focused greater effort on promoting community involvement to expand access to the improved quality services and increase their utilization.

IMMbasics collaborated with state and LGA teams following a phased approach in Nigeria's Bauchi and Sokoto states. This process involved working with one "phase" of three LGAs per state at a time (one LGA was randomly selected from each of the three state senatorial zones). Approximately one phase was entered every quarter. This phased approach, as opposed to concurrent statewide or nationwide implementation, allows much needed attention on the LGA and the health facility during the crucial start up period. Concentrating on a few LGAs at a time also promotes participation and ownership.

The Seven Steps

The approach for implementing RED in Nigeria required two years of intensive work, beginning with the initial stage of developing and refining tools and techniques. The following briefly summarizes the steps which evolved from this careful developmental process. As with the five RED components, it is important to realize that these seven steps are not exclusive of one another, nor strictly sequential. Each depends on the other; certain steps may be ongoing with others.

Figure 1: The Seven Steps
used to implement the RED approach in Nigeria.



Step 1: State Planning and Management of Resources

The first step in making RED operational involves a statewide assessment. Before this assessment, a Joint RI Strengthening Team, or JRIST, was formed, consisting of either the State Ministry of Health (SMOH) or State Primary Health Care Development Agency (SPHCDA) —depending on the mechanism used in each respective state—the Ministry of Local Government (MOLG), LGAs and IMMbasics. This collaborative group, JRIST, visits the LGA chairmen to brief them about the RI strengthening process. The JRIST then reviews existing documents, such as monthly summaries of routine immunization data, health worker personnel lists and qualifications, and data on immunization coverage and access to immunization services. After collecting information from all of the LGAs, the JRIST collates and analyzes the data. Data entry, collation and analysis can be accomplished using Microsoft Excel, and if available SPSS 11. The state then works on revising its RI work plan in coordination with partners. Where a multi-year plan already exists, the SMOH/SPHCDA fine-tunes and updates their plans. The state continuously improves their plan through regular meetings. This participatory exercise helps the states realize the status of their RI services in terms of number and locations of the health facilities actually providing RI.

Step 2: LGA Planning and Management of Resources

The next step focuses on the service delivery level: the LGA and the health facilities. Step two involves a series of activities organized by the JRIST:

- **Sensitization** meeting held with 3 LGAs together to introduce LGA partners to the coming RI strengthening effort.
- **Mini-Review** to establish baseline information in each LGA and to expose everyone in a participatory manner to the full picture of the RI system in their LGA.
- **RI Planning** (or microplanning) in each LGA to identify objectives, targets, immediate next steps, schedules, and responsibilities for strengthening RI.

After an introductory **Sensitization Meeting in an LGA**, the RI **Mini-Review** takes place the following week. This Mini-Review takes from six to ten working days to complete, depending on the number of health facilities and the local terrain. A team composed of at least two LGA staff and one person from the State lead the Mini-Review. During this exercise, the JRIST puts together the necessary information for planning such as: a listing of all settlements, population counts, health facilities either providing or capable of providing RI services, and the cold chain status in each facility. A set of seven instruments are used for gathering information according to the RED guidelines. (These instruments can be found online in the document ***Making REW Operational***⁴.) Topics covered include:

1. LGA vaccine usage and coverage (using data from the previous full year),
2. LGA or LGA Zonal cold store,
3. vaccination equipment and supplies,
4. data management,
5. supportive supervision,
6. medical waste disposal, and
7. health staff distribution.

The third entry activity, **Work Planning**, uses the results and information gathered during the RI **Mini-Review** for developing an RI work plan which includes activities and schedules for strengthening RI (also called “microplans”). At the end of this process, the health team briefs the LGA Chairman and council members on the **Mini-Review** results, and the initial steps, work plan and budget developed for strengthening RI.

*See case study in Annex C on **PLANNING AND MANAGEMENT**:
“A Little Planning and Management Go a Long Way”*

⁴ http://www.immunizationbasics.jsi.com/Docs/Making_REW_Operational.pdf

Step 3: Strengthen Systems: Supervision and Monitoring

Once the three initial activities (sensitization, mini-review, planning) in Step 2 are completed, the LGA staff prepare to strengthen supportive supervision. This first involves: **health facility RI task identification and standard setting**. The local staffs identify the key RI tasks and then they set standards for them. This is accomplished through a series of exercises lasting an average of two days each during which LGA staff identify, and prioritize their basic RI management tasks in the areas of:

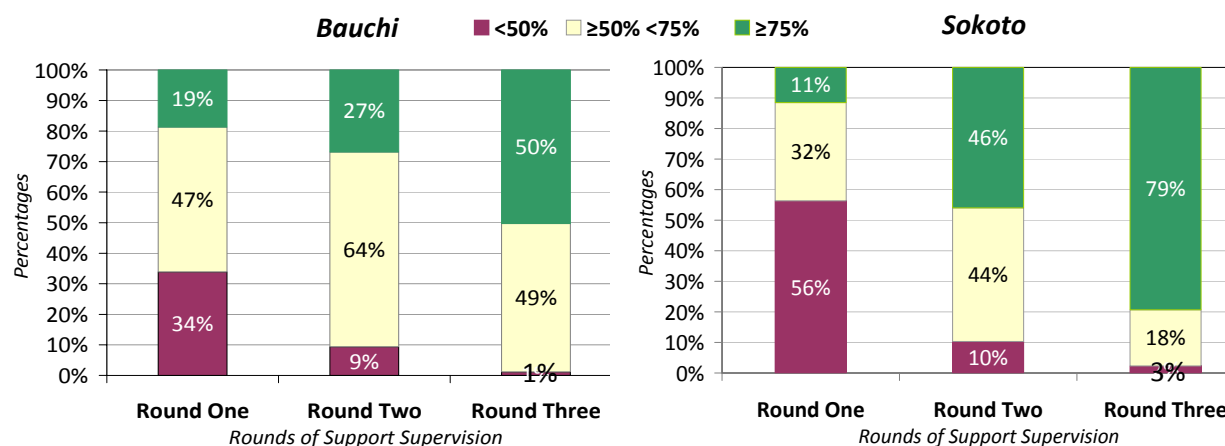
- vaccine supply management,
- regular vaccine distribution,
- supply management and distribution,
- data organization, analysis, use, and feedback, and
- supportive supervision.

Then the staff prepare an analytical checklist for both self-assessment (by LGAs and HFs) and supervision (by state and LGAs). (*See tools in Annex B.*) The Supervision Checklist provides a quantitative, measurable score (based on Yes/No questions) which reflects the number of tasks done correctly. The Self-assessment Checklist contains the same questions. Both scores are posted on a tracking sheet where progress on specific tasks is easily viewed. Self-assessment is encouraged at least monthly to promote self-learning and improved performance. It also serves as a bridge for maintaining best practice standards in places where supervision may not be regular or well-established.

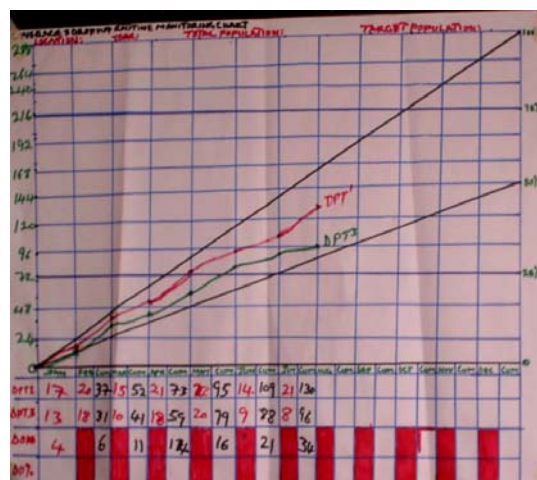
The next step for strengthening supervision and monitoring involves joint supportive supervision visits by the health team and “**peer motivators**.” Peer motivators are fellow health workers who have demonstrated a high level of competency in RI tasks, and have leadership and facilitative skills. At the end of each visit, on-the-job mentoring is carried out based on the identified knowledge and skills gaps. When under-performance is related to the LGA or state, the team conducts advocacy to the appropriate authorities in order to maintain standards. As documentation, each Support Supervision visit must leave behind both a completed analytical Supervision Checklist and a quantitative score that assesses the performance of the facility.

Analytical monitoring of service delivery performance scores can be accomplished through hand drawn or computerized graphs showing comparisons of individual health facility performance scores over time. Summary graphs (such as those below) provide managers with visual evidence on performance improvement, and serve as encouragement for continued progress.

Figure 2: Supportive Supervision Check List Scores in 258 HFs (171-Bauchi, 87-Sokoto) that completed at least 3 rounds of RI supervision from Nov 2007 to April 2009. After each round of regular supportive supervision, note the increase in the number of facilities shaded in “green”- indicating scores of 75% or above.



In addition to the use of self-designed support supervision checklists and the tracking of support supervision scores, the **immunization coverage and drop-out monitoring chart** (pictured below) provides another valuable monitoring tool. It enables health workers and supervisors to readily assess the health facilities immunization coverage and drop-out rate status, as well to judge health facility capacity for effectively monitoring their own performance. Since performance is charted monthly, actions can be planned to address suboptimal performance in subsequent months. The immunization monitoring chart has also been successfully used as an advocacy tool with LGA Chairmen and their executive councils to encourage their regular support for routine immunization.



A low-cost hand-drawn immunization monitoring chart displayed on the wall of a health facility is just the beginning. Is the data on the chart understood and being used regularly by staff to improve services?

Photo credits: Akeem Ganiyu.

A unique feature about this approach to supportive supervision is that:

The supportive supervision system is put in place before the formal training of health workers.

This sequence of setting up supervision before conducting formal training adds to the impact from training by providing immediate, continuous follow-up and on-the-job reinforcement by supervisors long after the classroom training.

In addition, monthly LGA review meetings also provide a type of “reverse” supervision. These meetings offer opportunities to further develop health worker skills, allow for follow-up on topics covered during supervision, provide friendly competition and peer learning among health facilities, and other added benefits such as recognition for good performance. State level monthly review meetings also provide similar benefits to LGA staff. Many of these meetings capitalize on opportunities where staff are already coming to the LGA or state (to pick up supplies, salaries, etc.), and offer vital cost-saving ways to ensure that the health system does not miss any opportunity to advance the knowledge and skills of its staff—particularly important in the context of a weak primary health care system where supervision remains fragile.

See case study in Annex D on **SUPPORTIVE SUPERVISION**:
“Support Supervision is Becoming a Reality”
 and case study in Annex E on **MONITORING FOR ACTION**:
“Good Data Save Lives”

Step 4: Build Capacity

Making RED operational and strengthening RI services centers on the concept that:

Capacity building and training is a continuous process, requiring on-the-job reinforcement and active participation.

Only when the strengthening of planning, and monitoring and supervision systems are well under way, do the health workers receive formal training during a five-day work shop. Topics include:

- EPI target diseases and vaccines;
- organizing a vaccination session;
- injection safety and medical waste disposal;
- data management and tools, including vaccination coverage and drop out monitoring chart;
- involving the community; and
- the cold chain.

Throughout training, participants are encouraged to actively participate. Examples of the participatory techniques used include: drawing out the participant's knowledge of the subject matter very early in the training and continuing this throughout the session, assigning roles and responsibilities so that everyone is encouraged to contribute, and keeping the training classes small to ensure two-way interaction between facilitators and all participants. Participants had not experienced this kind of attention or detailed hands-on training before—where the facilitators presented the message using various methods in a friendly manner. This method increased active participation and “learning by doing,” as can be seen in the picture to the right where a health worker practices proper injection technique on a doll.



Adults are particularly responsive to action-oriented learning approaches, as seen by the health worker practicing injection technique on a doll during an RI training session.

-Photo credit: Halima Abubakar.

*See case study in Annex F on **CAPACITY BUILDING:**
“Reaching Every Health Worker: Capacity Building and Training”*

Step 5: Increase Access to Services

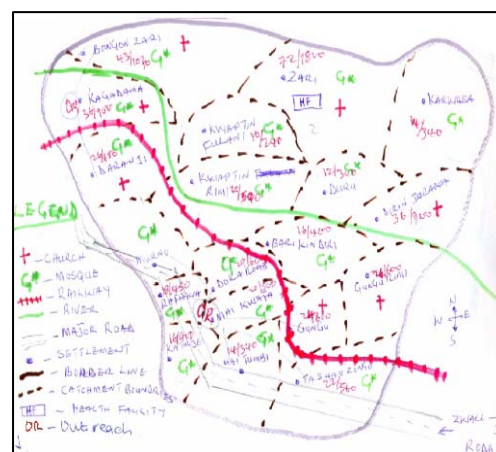
Once the preliminary implementation steps 1 through 4 are in process, the local RI program is mature enough to initiate expansion to additional service delivery points, first fixed and later outreach. The requirements for planning expansion, which are already available from the LGA **Mini-Review**, and from the planning and capacity building activities, include the following:

- Vaccine and supply distribution systems are established;
- Staff are trained;
- Health facility catchment area is clearly mapped;
- Data management tools and basic vaccination equipment are available;
- LGA approval and financial support are sought.

Health Facility Catchment Area Mapping

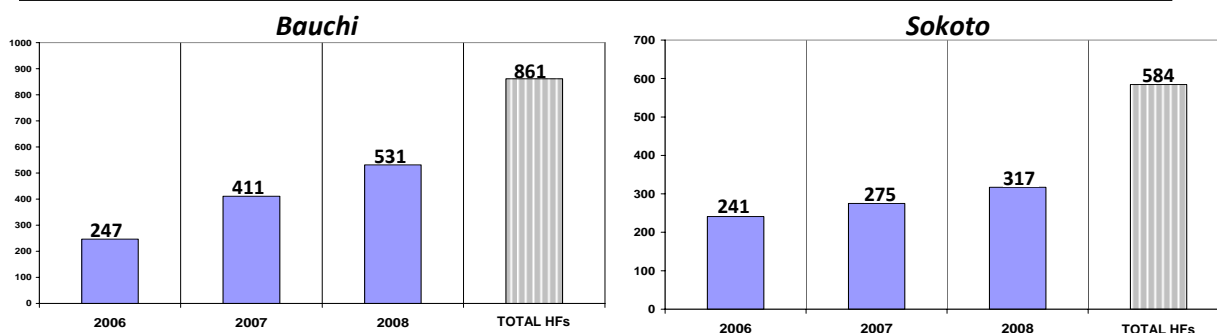
Among the activities for expanding access to RI, one of the most critical yet often neglected actions is identifying or updating the **health facility catchment area map**. This low-tech tool defines the communities “belonging” to the health facility, and therefore helps the health facility plan and monitor immunization services for the community⁵. A completed map is usually hand-drawn by the health workers, and will show important details such as geographical boundaries, roads, distances, outreach sites and target populations for each settlement or community. This tool is part of RED’s microplanning process, under the “Planning and Management of Resources” component, but when done in a participatory way it also boosts community engagement with health facilities (*more on the Bauchi experience in Step 6*).

Figure 3: A sample hand-drawn health facility catchment area map



Increasing access to routine immunization services is an ongoing process. The requirements for expanding quality services cannot be met rapidly. The graphs below show the steady increase in access to RI services in two states in Nigeria over a three year period.

Figure 4. Health facilities in Bauchi and Sokoto states providing RI at least 4 times per year, Jan 2006 – Dec 2008.



See case study in Annex G on **INCREASING ACCESS TO SERVICES:**
“Reaching People and Increasing Their Access to Services”

⁵ For more information on this participatory mapping process, please reference “A Practical Guide on Health Facility Catchment Area Mapping,” USAID, IMMUNIZATIONbasics and BaSPHCDA, Dec, 2008.
http://www.immunizationbasics.jsi.com/Docs/Practical_HFCAM.pdf

Step 6: Link Services with Communities

Long before initiating a formal process to strengthen **Community Linkages**, the RI team should always encourage routine contact between community leadership and health facility staff by:

- exchanging feedback and reviewing progress;
- listening to the concerns and suggestions of each;
- planning ways to overcome local obstacles to health service utilization; and
- seeking mutual support.

The key is to look for any opportunity which will involve community members in the community's health care.

There are many ways in which the community can contribute to the primary health care system, and thus increase community buy-in. One way in which the local administration and health workers can initiate these links is by inviting traditional leaders to participate in key meetings and events. In addition, training for service providers should include guidance on how to plan and link with community structures. Community members can be involved in updating birth registers as part of traditional child naming ceremonies, since maintaining an accurate birth register is fundamental to address issues of unimmunized children and routine immunization system drop-outs. Once a birth register is updated, the community can continue to help by following up on children to ensure that they are fully immunized before their first birthday. Other examples where community members can participate in the delivery of health care services include: planning of outreach visits, delivering public announcements that the outreach team has arrived in the village, transporting the health worker and vaccines to visit the community for scheduled outreach, and building burn and bury sites for safe injection waste disposal.

In 2007, Bauchi State conducted a participatory health facility catchment area planning exercise as part of RED's "**Planning and Management of Resources**" component. This process involved a series of interactive advocacy meetings at the state, LGA, district, and ward or village levels. During this exercise the traditional leaders from the Emirate system actively participated in catchment area mapping. State Ministry of Health and Ministry of Local Government officials, emirs, district and ward heads, LGA PHC officials, and health workers also participated. Participants prepared ward catchment area maps during community meetings. In addition to mapping, these meetings served as a platform for communicating key immunization messages and for communities to become regularly engaged with health facility staff in the PHC issues affecting them. Whenever possible, this important step in planning should be conducted with the involvement of community leaders.

*See case study in Annex H on
LINKING SERVICES WITH COMMUNITIES:
"Getting and Keeping Communities Involved in Health"*

Step 7: Maintenance and Expansion

These first six steps for making RED operational are only the beginning of a long process. The steps are never “completed”, but rather must be continually renewed. Updating plans, keeping health workers trained, revising tools according to developing needs, expanding access to routine immunization as well as utilizing the approach in other primary health care interventions are necessary ongoing steps.

In addition, RED cannot be sustained in isolation. Any effort to strengthen routine immunization or other primary health care interventions will not last unless:

- the government adequately supports service delivery, logistics, supervision, and capacity building;
- the government establishes a structure for training and retraining health workers;
- health officials periodically review and revise their RI strengthening approach, performance, and tools; and
- RI is included within the broader context of primary health care.

Inadequate government funding for routine immunization is often the biggest obstacle to improved and expanded health services. One fundamental reason for this lies in the lack of awareness by the local, district, or state administrations on the exact funding requirements for RI. However, the steps for making RED operational not only provide accurate information for budgeting, but also can lead to more cost-effective health services through evidence-based planning and better resource allocation.

Health workers cannot acquire and maintain a level of skill necessary to provide quality primary health care services from a single workshop. Everyone needs continuous on-the-job reinforcement through support supervision, monthly review meetings, and refresher training from established in-service training. Strengthening routine immunization and revitalizing primary health care ultimately requires a government-driven structure which provides low-cost training for health workers, periodically and continuously.

Every approach and tool needs periodic review and revision to keep up-to-date with evolving needs. In addition, routine tasks ultimately lose value and become tedious when performed over and over for months and for years. Like capacity building, keeping monitoring and supervision effective requires a long-term government-driven structure for reviewing and updating methods and tools.

KEY POINTS for strengthening RI and other primary health care interventions

Fundamental Principles

- Rebuilding a health care system involves an ongoing effort, with strong partner collaboration and continuous capacity building. There are no short cuts. The process requires years of concentrated efforts and maintaining a functional system lasts forever.
- All levels of the health care system- health facility, ward, LGA, state, district, and national-must understand and apply the concepts of RED. In addition to building capacity, continuous advocacy is required to guarantee that the system is adequately funded at all levels.
- A firm foundation with the capacity for supportive supervision must be in place first even before health workers are trained.

Ownership and Participation

- Participatory planning and tools development promotes ownership and commitment. LGA and health facility staff can assist in collecting baseline information or health staff can set their own standards by which to be supervised.

Planning and Management of Resources

- It is imperative to entrench a planning culture. One way to accomplish this involves using a recognition approach. There are other motivators besides money—recognition among peers can be used as motivation and encouragement for others to adopt good management practices.
- Local management teams also must realize that they play a critical role in both the political and the technical aspects of health care, and that their actions (or inactions) affect other levels as well.

Supportive Supervision

- Supportive supervision and training go hand-in-hand, providing the much needed reinforcement training through continuous on-the-job coaching and mentoring.
- Routine use of an analytical supervision check list with quantifiable scores documents the visit, measures performance, and creates accountability.

Monitoring for Action

- Health workers need and want training on how to analyze and use their own data; not just on filling in forms and reporting. Simple, hand-drawn charts and graphs can be used; a computer is not necessary. When staff understand the value of their own data, data quality improves.

Building Capacity

- Long-term structures must be put into place for training future staff or for refresher trainings. A government-driven structure for capacity building and for maintaining standards is essential for sustaining any health service. Participatory and practical training should be built into a long term structure for continuous capacity building.

Increasing Access to Immunization Services


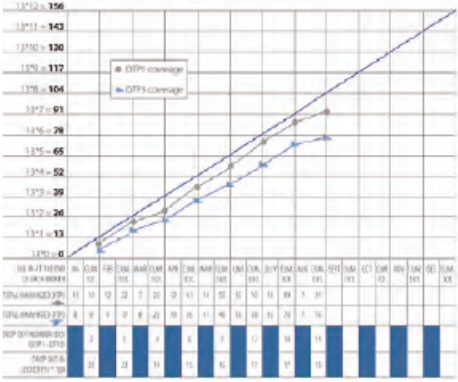
- All fixed service points must be fully functional and friendly, with enough trained health workers with good interpersonal communication skills and a clean working environment, before outreach.
- The health facility catchment area must be clearly defined. This allows for easier implementation and more accurate monitoring, and also for better linkage with the community.

Linking Services with Communities

- Community members and health facility staff must interact regularly for guaranteeing joint commitment toward more effective and more efficient health services.

By implementing these lessons learned from the Nigeria RED experience, partners and governments can help improve the quality of other primary health care services systematically and sustainably.

ANNEX A: RED Quick Reference⁶

<p>1. Planning and Management of Resources (Human, material and financial)</p> <p>At the district and facility levels, planning should identify what resources are needed to reach all target populations in a way that can be managed well and thus maintained. Good planning involves: (a) understanding the district/health facility catchment area (situational analysis); (b) prioritizing problems and designing microplans that address key gaps; (c) as part of microplanning, developing a budget that realistically reflects the human, material and financial resources available; and (d) regularly revising, updating and costing microplans to address changing needs.</p>	<p>2. Reaching the Target Populations</p> <p>“Reaching the target populations” is a process to improve access and use of immunisation and other health services in a cost-effective manner through a mix of service delivery strategies that meet the needs of target populations.</p> 
<p>3. Linking Services with Communities</p> <p>This RED component encourages health staff to partner with communities in managing and implementing immunization and other health services. Through regular meetings, district health teams and health facility staff engage with communities to make sure that immunization and other health services are meeting their needs.</p>	<p>4. Supportive Supervision (Regular on-site teaching, feedback, and follow-up with health staff)</p> <p>Supportive supervision focuses on promoting quality services by periodically assessing and strengthening service providers' skills, attitudes and working conditions. It includes regular on-site teaching, feedback and follow-up with health staff.</p>
<p>5. Monitoring for Action (Self-monitoring, feedback and tools)</p>  <p>District health teams and health facility staff need a continuous flow of information that tells them whether health services are of high quality and accessible to the target population, who is and is not being reached, whether resources are being used efficiently and whether strategies are meeting objectives. Monitoring health information involves observing, collecting, and examining programme data. “Monitoring for Action” takes this one step further, by not only analyzing data but by using the data at all levels to direct the programme in measuring progress, identifying areas needing specific interventions and making practical revisions to plans.</p>	

⁶ Taken from Annex 5 of the 2008 RED guide: http://www.who.int/immunization_delivery/systems_policy/AFRO-RED_Aug2008.pdf

ANNEX B: Sample Supportive Supervision Checklists

Annex B-1: Sample LGA Level Supportive Supervision Checklist

LGA LEVEL ROUTINE IMMUNIZATION MANAGEMENT CHECKLIST

N/S	MANAGEMENT ISSUES	YES	NO	COMMENTS (please continue on the back of the page))
1	Is there a vaccine temperature chart placed on each refrigerator and being monitored twice daily?			
2	Are there functional thermometers in each refrigerator with vaccines?			
3	Do all vaccines have readable labels?			
4	Is there a correct and up-to-date vaccine ledger?			
5	Is there a functional stand-by generator?			
6	Are all vaccines for RI available in the cold store?			
7	Are there corresponding diluents equal to reconstitution vaccines?			
8	Are there frozen ice packs for vaccines/distributions?			
9	Does the vaccine balance in the ledger correspond to the physical stock?			
10	Is the dry store available and spacious?			
11	Is there a separate ledger for dry materials with correct and up-to-date entries?			
12	Are items in the dry store arranged by category and type?			
13	Are there equal numbers of syringes equivalent to injectable vaccines?			
14	Are there at least two safety boxes for each HF providing RI?			
15	Is there a burn and bury site for used immunization materials and is it being put to use?			
16	Are there HF monthly summary RI reports for all HF providing RI?			
17	Did the reports from the HF tally with monthly reports sent to the state for the last three months?			
18	Is there a DPT coverage/dropout monitoring chart with correct/up-to-date entries and pasted on the wall in the cold store?			
19	Is there a poster-size LGA map showing all HFs (indicating those HFs providing RI) as well as major geographical features?			
20	Is there a supportive supervision workplan pasted on the wall at the cold store?			
21	Is there an updated vaccine use rate monitoring chart pasted on the wall at the cold store?			
22	Is there an updated report receipt monitoring chart pasted on the wall at the cold store?			
23	Is there a vaccine distribution plan (indicating HFs, target pop, vaccine, giostyle, icepacks requirement, delivery days, and responsible officer) pasted on the wall at the cold store?			
24	Is there an LGA immunization session schedule pasted on the wall at the cold store ?			
25	Is there an updated DPT coverage/dropout monitoring chart pasted on the wall of the LGA Chairman's office?			
	TOTAL YES			
	% YES			

Name of reviewer: _____
Signature: _____

Date of Review: _____

Annex B-2: Sample HF Level Supportive Supervision Checklist
HEALTH FACILITY LEVEL ROUTINE IMMUNIZATION SERVICE DELIVERY CHECKLIST

S/N	MANAGEMENT ISSUES	YES	NO	COMMENTS (may continue on back of page)
1	Is there an Immunization session schedule in Hausa pasted inside and outside the HF?			
2	Does the HF have at least two benches for the clients?			
3	Did the service provider record the clients' information in 3 places? (Immunization register, tally sheet and card)			
4	Is there a child immunization register with correct and up-to-date entries?			
5	Is the officer entering the date of next visit on the card correctly and explaining to the caretaker the date of next appointment?			
6	Does the number of children registered correspond with the tally sheet and monthly facility summary report for last month?			
7	Did the HF operate and maintain an immunization supply exercise book?			
8	Is there a vaccine stock exercise book updated and correctly filled?			
9	Does each Geostyles vaccine carrier contain four conditioned ice packs?			
10	Are the antigens in the Geostyles v/c with correct number diluents?			
11	Do all the antigens have readable labels and are not expired?			
12	Is the VVM for all the vaccines on stage one or two?			
13	Does the officer wash his/her hands before handling the vaccines?			
14	Does the service provider use correct diluents for reconstituting vaccines?			
15	Is the form pad in the vaccine carrier used for holding vaccines while in session?			
16	Does the service provider use sterile syringes and needles for reconstituting each vial of BCG, Measles and yellow fever vaccines?			
17	Is the officer using one sterile syringe and needle for each dose of vaccine?			
18	Is the officer giving the vaccine at the correct dose, site, and route?			
19	Did the officer avoid recapping the needles after use during the session?			
20	Is there a safety box used for discarding used syringes and needles?			
21	Are all syringes and needles discarded into the safety box immediately?			
22	Does the facility have a site for burning and burying used immunization materials and is it being used regularly?			
23	Did the service provider disseminate the five immunization messages to caretakers?			
24	Is there a catchment area map of the HF (developed with the community) and pasted on the wall?			
25	Is there any evidence or minutes of a meeting with the community held last month?			
	Total "Yes"			
	% "Yes"			

Name of reviewer: _____

Date of Review: _____

Signature: _____

Annex B-3: Sample HF Level Supportive Supervision Checklist (Filled)

HEALTH FACILITY LEVEL SUPPORTIVE SUPERVISION CHECKLIST FOR SHIRA LGA				
Health Facility Name: <u>Ardo/Buol ASSP</u> Supervisor Name: <u>MUSE M. FACH</u> Date: <u>19/11/2018</u> Sign: <u>[Signature]</u>				
ISSUES	YES	NO	COMMENTS (use extra sheet if needed)	
1 Is there a HF catchments area map with all the required features pasted on the wall?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Boundary map not indicated supported and corrected	
2 Did the HF have an RI poster pasted on the wall for clients to see?	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
3 Did the HF have an RI immunization session schedule pasted on the wall?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	adjusted RI session schedule to be twice a month not every week	
4 Are the vaccines in the Geostyle having readable label, not expired, with batch number and VVM in stage 1/2?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not supervised on the clinic day	
5 Is the HF having an extra Geostyle with frozen ice packs for replenishment?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	advise to start replenish RI to be conducted	
6 Did the HF have at least a place for 20 clients to sit while waiting for immunization?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	will forward the issues to LGA	
7 Are the opened vaccine vials in used placed in the Geostyle foam pad slit?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	supported & corrected the sp.	
8 Did the Service Provider wash his/her hands before and after giving immunization?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	advise the sp to wash hand during & after imm.	
9 Did the Service Provider administer the vaccine correctly according to dose, route, site and age?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	supported & corrected	
10 Did the Service Provider use a sterile syringe and needle for each antigen, each dose, and each client?	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
11 Did the Service Provider discard the used syringe and needle in the safety box without recapping?	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
12 Is there an up to date immunization monitoring chart pasted on the wall.	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
13 Are the data tools (Register, tally sheet, child immunization card and facility summary book) available?	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
14 Did the Service Provider enter correctly the information into the register DOB?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	supported & corrected	
15 Did the number of children immunized in the tally sheet correspond with that in the register and HF summary?	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
16 Is there available an up to date vaccine/supply book in the HF?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	advise to purchase one by next visit	
17 Is there available record for self assessment and supportive supervision conducted in the HF?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	just recently started	
18 Did the HF have a functional burn and bury pit and a person assign to manage it?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	advise to dig by line	
19 Is there an evident of minute of meeting of the VHDC/WHDC of the catchments area?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	advise to start very soon	
20 Is there an outreach plan with all feature pasted on the wall?	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
TOTAL	9	11	ROUND 1	
%	45%	55%		

ANNEX C: Case Study on Planning and Management of Resources


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A LITTLE PLANNING & MANAGEMENT GO A LONG WAY

Planning and managing resources is an important part of Nigeria's Reaching Every Ward, or REW, approach. REW is Nigeria's main strategy to revitalize routine immunization.

REW emphasises microplanning at the health facility, ward, LGA levels and planning at the state level. First it identifies any problems and then uses a problem-solving approach in planning. Achievements and barriers are considered realistically, and human, material and financial resources are taken into account in the process.

Realistic targets with timelines are set, taking into consideration past performance and national goals and objectives. Plans are regularly reviewed and revised as needed throughout the year.



When discussing work plan activities, be sure to cost each activity line in detail
Photo: IMMbasics Nigeria

“GOOD PLANNING AND MANAGEMENT have been an important part of the Bauchi State Primary Health Care Development Agency's successful start-up,” said Dr. Musa M. Dambam, Executive Chairman of the agency and Senior Special Adviser on Primary Health Care to the Bauchi State Governor.

The Bauchi State Primary Health Care Development Agency, or BASPHCDA, was created in 2007 with a mandate to improve primary health care services and reduce infant, child, and maternal mortality. Making sure that Bauchi's children have access to and receive their routine immunizations is a key component of the agency's mandate.

Recognizing this, Dr. Dambam took special care to ensure that Bauchi's routine immunization program would be well planned and managed and in line with Nigeria's Reaching Every Ward (REW) approach. He recognized that his newly appointed officers would need to understand how good planning and management positively affect primary health care and learn how to pass this knowledge on to other health workers.

Dr. Dambam arranged for the BASPHCDA officers to be trained in how to develop effective work plans and how to apply participatory methodologies to work planning. While assisting the officers in developing the agency's routine immunization work plan, the trainers paid particular attention to building the officers' capacity so that they themselves would be able to guide future work plan development in other areas of the agency's primary health care mandate.

The officers' training also included a component to nurture skills in communication to better mentor their staff. “The time and money spent on training was well worth it,” said Dr. Dambam, “We were preparing our staff to be able to implement our work plan in the best possible way.”

Also playing a part in the agency's success was the fact that enough funding was allocated to each line item in the immunization work plan. “I cannot stress enough how important it is to cost the work plan,” says Bakoji Ahmed, one of three zonal coordinators whose job it is to supervise primary health care activities in the southern zone in Bauchi. *(Continued on page two)*



Regular meetings are essential to discuss recent trends in immunization data and to modify the work plan and budget accordingly.
Photo: Hassan Adu Musa, IMMbasics.

(Continued from page one)

There are many LGAs struggling to make sure their Chairman sets aside enough funds per month to cover all planned routine immunization activities. Dr. Dambam and his team are working with the Ministry of Local Government and the LGA Chairmen to address this costing gap.

"Once the work plan was completed, we made sure to discuss its progress during monthly meetings. The plan needs to stay relevant and we need to be flexible about revising and updating it as the local context changes. Regular meetings helped us do this," says Dr. Dambam.

The BASPHCDA schedules and facilitates monthly meetings, which sends a clear message about how seriously they are focusing on managing and following up on their planned activities.

"As a zonal coordinator, I routinely visit LGAs and facilities and see first-hand what the challenges are," says Bakoji. "We do our best to follow up on these challenges at state level without delay. It really is amazing how much good planning and management can improve a routine immunization system."

FOR MORE INFORMATION
please contact
the Bauchi SPHCDA or the Sokoto SMOH.

IMPROVE PLANNING AND MANAGEMENT IN YOUR AREA

How can you or your supervisor improve management and planning at your level to strengthen routine immunization service delivery? While this story highlights how a State Primary Health Care Development Agency planned and organized its services, the steps described can be used throughout the system—whether you are at the state, LGA, ward or health facility level:

- **Develop a new work plan or microplan every year.** The REW approach considers planning (national and state levels) and microplanning (LGA, ward and health facility levels) as the cornerstone to a good routine immunization program. A high-quality plan takes into consideration the local situation and tailors and budgets the plan to fit each specific location. For more details on developing costed work plans, along with microplanning forms, see the *Reaching Every Ward Field Guide*.
- **Prepare to implement the work plan.** Once the work plan is developed, managers need to make sure there are enough resources allocated to implement each line item listed in the plan. For example, if the plan includes supportive supervision, have funds been allocated for transportation and fuel for all supervisors to make regular visits?
- **Implement the work plan.** Be flexible and make changes as needed to the work plan. If it is truly a "living document," the plan may be revised several times throughout the year so that it continues to reflect the real situation in your state/LGA/ward/health facility. Revising plans with the health team involved and displaying the plans for everyone to see is an important part of management and can help a team stay motivated as it assesses progress to date.
- **Continuously monitor the implementation of the work plan.** Using supportive supervision visits as opportunities for active monitoring, look at routine immunization data and analyze performance (include self assessment data at your level) compared to the previous year and the preceding months. Use this data to identify weaker LGAs and health facilities and decide what support is needed to help them improve their performance. Besides using coverage data to review routine immunization progress at an LGA/facility, also look at checklist scores to review progress in other areas such as management and supportive supervision.

ANNEX D: Case Study on Supportive Supervision

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SUPPORT SUPERVISION IS BECOMING A REALITY



Bengaje Health Facility, Yabo LGA, Sokoto State

In the face of many challenges, a health worker in Bengaje village has been able to increase the number of families in his community that are up-to-date with their immunizations.

"For me, helping to serve my community by reducing our health problems is the most important thing," says Aliyu Sarkin Aski, 35. "There aren't enough health workers as it is – only two of us in Bengaje – and so it is important for us to improve our skills and continually provide better service."

Support supervision has made all the difference for Aliyu and for the people of Bengaje. "Before we started using support supervision, routine immunization services were conducted with negligence and no standards," said Aliyu. "We didn't have a good understanding of how to manage vaccines or the cold chain or even how to track people's immunization records."

Support supervision is widely recognized as essential for improving the quality of an immunization program, both in terms of management and services provided, and hence is one of the five key components of the Reaching Every Ward (REW) approach. It is a process in which experienced staff, designated and trained as supervisors, assess other staff's job performance, give constructive feedback, and work cooperatively to improve weaker performance areas.

Photo by Dr. Zainab Mohammad, IMMbasics: Proper vaccination techniques can be maintained through regular support supervision visits.

If you are a PHC staff at the State or LGA level and you want to start support supervision (a component of Reaching Every Ward) to strengthen your routine immunization system, talk to your State/LGA health team. Bauchi and Sokoto started support supervision in 2007 and used a step-by-step method that began with jointly developing LGA and health facility level standardized checklists which everyone agreed on. What came next and how do you proceed? Contact the Bauchi SPHCDA or Sokoto SMOH to find out more!

"I had heard about support supervision before," said Aliyu, "but I thought it was a fault-finding activity. Now I realize that it is about helping me build my skills and I even look forward to the next rounds [visits] and hope my LGA will continue the process. Having a more experienced supervisor support my work has given me the opportunity to be creative in initiating good health strategies in my community. Now parents and caregivers are asking for routine immunization services and my good relationships with them allows me to track defaulters. I have gained back my respect."

(Continued on page two)



Support supervision rounds can both improve data quality and increase employee job satisfaction. Photo: Dr. Zainab Mohammed, IMMbasics.

(Continued from page one) A team from the Sokoto SMOH came to Yabo to conduct a review of all routine immunization activities in the LGA. The review revealed that support supervision was not being conducted there at all. Upon learning this, the state team and Yabo's Primary Health Care Director decided to prioritize support supervision right away.

The LGA identified an appropriate supervisor for each of the health facilities in Yabo. The supervisors were trained in support supervision before they began working with individual health workers. In Bengaje, Aliyu's supervisor conducted supervision using a checklist of appropriate practices that the LGA and health facilities created together as result of the immunization review. The checklist ensures that the health facility and supervisor are paying attention to issues that are specific to Yabo's immunization services. The checklist serves both as a **self assessment** tool for the health facility and a **supervision** tool for the LGA.

"My supervisor has become really interested in support supervision and has become good at it. What's best is that in addition to assessing my performance, my supervisor gives me on-the-job training to improve my technical skills." The supervisor has continued to regularly support Aliyu's work by coming out to Bengaje to provide follow-up support on areas that need improvement and working with the health facility in creating a plan for improving areas that are still weak.

Starting Support Supervision in Your Area

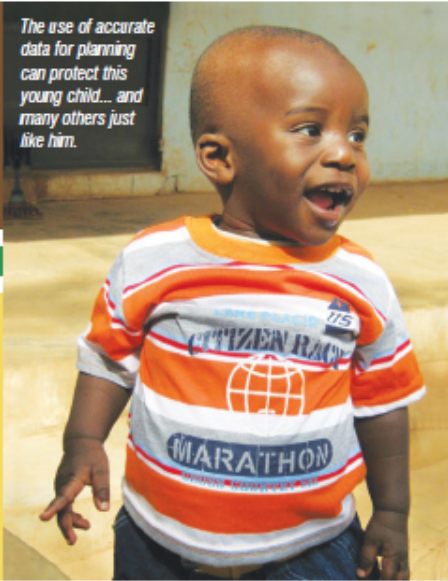
- **Do you have the technical know-how to start conducting support supervision?** The Reaching Every Ward field guide and the Mid-Level-Managers supervision module introduce health staff at all levels to conducting supervision that is supportive instead of faultfinding.
- **Include support supervision as an activity in your microplans,** complete with the financial, material, and human resources you'll need to conduct regular visits to LGAs and health facilities. Plans should prioritize supervision sites and the minimum number of visits recommended at each level.
- **Do you have enough resources?** The Ministries of Local Government in Bauchi and Sokoto states encouraged LGA Chairmen to set aside monthly routine immunization funds. These resources, although sometimes irregular and inadequate, cover activities in each LGA's routine immunization microplan, including support supervision. For more details, contact the Executive Chairman of the Bauchi SPHCDA or the Director of PHC in Sokoto.
- **Do you have enough staff to conduct support supervision?** Many other countries use a team approach, in which each supervisor is responsible for a number of health facilities. In Bauchi and Sokoto states, each supervisor on the LGA team provides support for one cluster of health facilities so that all health facilities receive the mentoring and follow-up they need to improve services.
- **How is your health facility performing?** Do you collect and analyze monthly data to improve how immunization services are organized and delivered? A big part of support supervision is self assessment. You can track your own performance and review your own data. What are your DPT1-3 drop-out rates now as compared to this time last year? If you have negative drop-out rates, what does that mean? What can you do to make some practical changes in how services are delivered? Some health facilities with enough qualified health staff have changed their antenatal days to be on the same day as their immunization days. This has greatly increased attendance and reduced missed opportunities during immunization sessions!

ANNEX E: Case Study on Monitoring for Action

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GOOD DATA SAVE LIVES

The use of accurate data for planning can protect this young child... and many others just like him.



If you work in primary health care at the state or LGA level and you want to start monitoring for action (a component of Reaching Every Ward) to strengthen your routine immunization system, talk to your state or LGA health team. Contact the **Bauchi SPHCDA** or **Sokoto SMOH** to find out more!

Hard data can lead to concrete actions. When the Gwadabawa LGA Chairman in Sokoto State was presented with the low immunization coverage in his local government area (LGA)—only 6% DPT3 coverage as of June 2008—he was extremely uncomfortable.

"I immediately called a meeting with all of my service providers and my primary health care director to discuss the situation. I learned that routine immunization services were not extended to all the communities in the LGA and we began to take steps to change this."

In the past, data monitoring didn't exist in Gwadabawa LGA. The LGA Immunization Officer (LIO) often compiled routine immunization data at the LGA level without verifying the numbers at the health facility level. The LGA was providing the requested data to the state level, but this data was often incorrect and furthermore, it was never used in making planning decisions.

Today, data monitoring is a regular activity in Gwadabawa and occurs during several processes explained in the box shown here.

(Continued on page two)

Opportunities for Data Monitoring in Gwadabawa LGA, Sokoto State

- **Supportive supervision** – During this process, the LGA team visits health facilities, monitors the data entry procedures of the service provider, and assesses the data tools. After the session, the LGA team supports the service provider to correct errors regarding data entry process and content.
- **Data quality check** – Although this is carried out during supportive supervision using a specially designed tool, the LGA team also carries out spot checks in between sessions using the same tool. The facilities are selected at random and the frequency occurs at least once a month.
- **Monthly review meeting with service providers** – This meeting allows for monthly RI report submission and review of supportive supervision findings. Service providers and the LGA team discuss issues related to RI data findings and decide on necessary action.
- **LIO report tracking** – The LIO now uses a chart to monitor and track health facility reporting dates. The chart helps the LIO to track overdue reports and is used to follow up and retrieve such reports from the health facilities. The late reports are then compiled and sent to the state.



Health workers and LGA staff working together to truly understand data leads to effective planning decisions. Photos: Halima Abubakar, IMMbasics.

Hurdles Overcome (Continued from page one)

- Poor commitment of LGA staff.
- LGA council does not provide enough funds to effectively improve data monitoring in the LGA.

Keys to Success

- Frequent visits by LGA staff to monitor data at health facilities sparked health workers' interest and built their data monitoring skills.
- With increased commitment on the part of LGA staff, the LGA teams advocated to the LGA council several times to seek financial support for the primary health care department to conduct data monitoring without relying on international support.
- The advocacy paid off when the LGA re-established its former practice of giving additional funds to district coordinators for conducting data quality assessments in addition to routine supportive supervision.
- The LGA DPHC made it mandatory that all service providers must meet on the last Wednesday of every month to submit and discuss RI data-related issues.

Advice on How to Start Data Monitoring

"We would absolutely encourage other LGAs to monitor their data and use it for decision making. We ourselves have seen the gains of doing so and it really makes the work easier and more interesting. Any LGA that would like to follow our example should start by understanding the data itself. Get the state MOH or other partners to build their skills and support them on how to keep accurate data and how to analyze data to make potentially life saving decisions. After this, they can be on their own like we are now."

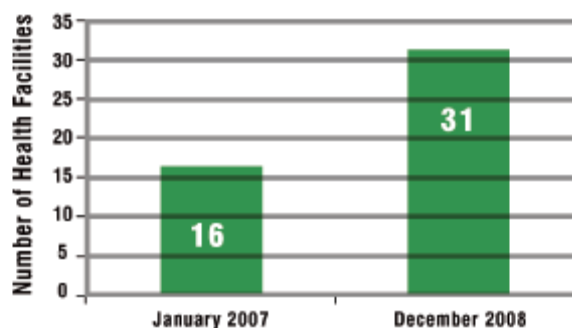
—CHAIRMAN, GWADABAWA LGA, SOKOTO STATE

Data Leading to Action!!

The use of data has helped Gwadabawa LGA advocate effectively to policy makers through the use of supporting documents. The following examples show how data monitoring led to concrete actions:

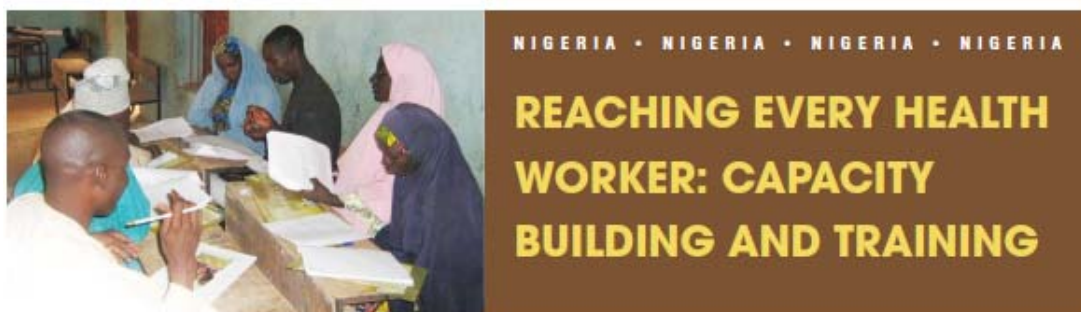
- The analysis of data showed that there were several underserved areas that had the potential to increase immunization coverage and reduce drop out. Data showed that if more service delivery points were opened or re-established, coverage would improve. The LGA acted on this data and increased the number of service delivery points from 16 to 31.
- Once policy makers understood the importance of good data, the amount of monthly data monitoring funds released to district coordinators increased.
- Data advocacy made the primary health care department decide to meet with service providers on a monthly basis to verify their reports and also give them feedback on RI activities. Such meetings will continue to improve the quality of data in the LGA.

Health Facilities Providing RI Services (Gwadabawa LGA, Sokoto State)



The analysis of accurate data influenced Gwadabawa LGA officials to increase the number of health facilities providing RI services as a means to improve coverage.

ANNEX F: Case Study on Capacity Building



Nigeria is revitalizing routine immunization with the Reaching Every Ward, or REW, approach. The REW Field Guide highlights that in order for the immunization system to become fully functional, staff at all levels need to be trained and retrained on a regular basis. With health worker shortages, difficulties in filling rural posts with qualified staff, and frequent transfers, both capacity building and training must be addressed within every facet of primary health care in Nigeria.

When Bauchi and Sokoto States began the process of strengthening routine immunization in early 2007, health workers taking part in the initial planning meetings were puzzled. “Why is training for health workers one of the final steps of the process?” they asked. The proposed step-by-step approach to strengthening routine immunization included several steps before any formal training started—quite the opposite to what health workers normally see, where training is a first step.

What health staff began to realize when the training finally took place, was that even though training was the fifth out of six steps, that participating in all of the preceding steps better prepared them for the content of the formal training—and made it much more meaningful.

The shaded box on this page outlines the routine immunization strengthening steps followed in Bauchi and Sokoto states. There are several key capacity building steps that were implemented before training health workers. After introducing the **routine immunization strengthening process** to the LGAs (step 1), each state health team conducted a **baseline study** (step 2), which provided detailed data on the routine immunization system. The findings? Very few functional health facilities were providing routine immunization services on a regular basis. Also, staff identified a wide range of management and service delivery gaps that existed in their LGAs.

The teams then began with a focus on strengthening LGA routine immunization management through improved **workplanning** (step 3). Afterwards, a participatory method was used to **identify routine immunization tasks, set standards for those tasks**

and then to **develop checklists for supervisors** to monitor progress, and for health workers to self-assess how they are progressing (step 4). This hands-on approach made a difference.

Never before had health workers been involved in identifying and setting standards by themselves. Now, health workers had self-designed checklists, and a new style of supervision as well. *(Continued on page two)*

Routine Immunization Strengthening Steps in Bauchi and Sokoto States

- **Introduction of the routine immunization strengthening process** to the LGAs
- **A joint in-depth review** of the status of the routine immunization system in the LGA (baseline study)
- **LGA work planning, including budget development**, for routine immunization system strengthening
- **Identifying key routine immunization tasks, setting standards** around those tasks, and then **developing supportive supervision checklists** (LGA level focusing on management and health facility level focusing on providing health services for the community)
- **Designing a training program and training health workers in routine immunization** using NPHCDA's *Basic Guide for Routine Immunization Service Providers* and *Reaching Every Ward Field Guide*
- Working with health facilities, traditional leaders and communities to **jointly develop or update health facility catchment area maps** and promote closer linkages with communities

Photo by IMMbasics Nigeria: Strengthening the routine immunization system requires a proven step-by-step approach.



KEY LESSONS IN CAPACITY BUILDING AND TRAINING

Training can be more effective when it takes place after an initial capacity building preparatory process. Photo: Halima Abubakar, IMMbasics.

(Continued from page one) Before the routine immunization strengthening plan, supervision was often critical and negative in nature, if it occurred at all. With supportive supervision, managers began to provide helpful and constructive advice on a regular basis to the extent that many service providers actually look forward to such visits.

After participating in the first round of supportive supervision, the staff began to notice in what particular areas their own health facility was not doing well—and how important it was for them personally to gain the skills and capacity to make improvements. This made them more eager to receive training (step 5) that was actually useful for their particular work situation.

“We were all hoping to get training early, because that’s how it’s always done. But as we went through the formal training, we realized not only that we were already familiar with the topics, but more importantly, we all realized how much they impacted our job and so we all participated much more actively. It was this active participation that made the training all the more meaningful,” said a health worker.

Indeed, building capacity before training was the key to success.

FOR MORE INFORMATION
please contact
the Bauchi SPHCDA or the Sokoto SMOH.

Important capacity building and training principles to follow:

- **Use adult learning methods.** A participatory and team-centered approach worked best in Bauchi and Sokoto states. This ensured both ownership of the process and commitment to follow-up on objectives. We used the following participatory approaches in Bauchi and Sokoto:
- **LGA and health facility staff collected baseline information together.** This helped them better understand the weak status of routine immunization in their LGA and prepare plans focusing on realistic steps to rebuild their system.
- **Health staff determined their own standards** by which to be supervised, resulting in a better understanding of the tasks they needed to perform to provide quality services.
- **On-the-job training during supportive supervision** ensured that newly acquired skills were immediately reinforced through both practice and positive encouragement.
- **Build a group of state level “master trainers.”** Master trainers are a group of persons who are instructed to conduct formal training for new health workers and to set up a quarterly state-to-LGA supportive supervision system (focusing on management). They also know how to implement an LGA-to-health facility supportive supervision system to provide regular on-the-job visits to all health workers (focusing on mentoring).
- **Implement ongoing training.** Once is not enough. An ongoing mix of formal training, on-the-job training and refresher courses are needed to ensure that all current health workers are trained and have the most recent knowledge.

ANNEX G: Case Study on Increasing Access

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REACHING PEOPLE AND INCREASING THEIR ACCESS TO SERVICES

Increasing access to services is an important part of Nigeria's Reaching Every Ward, or REW, approach. REW is Nigeria's main strategy to revitalize routine immunization.

Read below to find out how you can improve access to immunization services in your area, and how to encourage people to use them.



Every child that enters a health facility for any reason and at any time is an opportunity for vaccination.
Photo: Halima Abubakar, IMMbasics

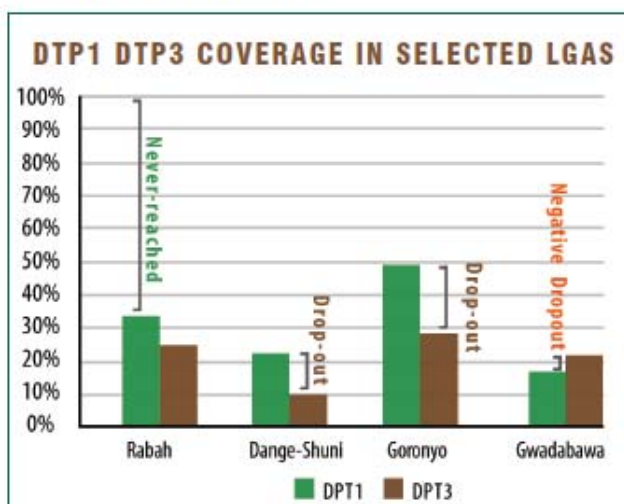
When Sokoto State began its effort to improve routine immunization, one idea became apparent from early on. "We really need to focus on how to reach every eligible person," the health workers said. "We aren't reaching all the women and children we can possibly reach (the never-reached), we aren't treating people in a way that makes them want to come back to complete their vaccinations (drop-outs) and we are letting others walk out the door without receiving immunizations (the missed opportunities)!"

Each of the three scenarios, the never-reached, the drop-outs and the missed opportunities, indicate issues that must be addressed to ensure high immunization coverage.

The Never-Reached (Left-Out)

In Dange-Shuni Local Government Area (LGA) in Sokoto State, there were 7,781 children under one year of age in the 2006 census. Of those children, only 776 received the DPT1 vaccine (Sokoto SMOH data for November 2006). A DPT1 rate of 10% means that the other 90% of children were never-reached by the routine immunization system.

It became apparent that in Sokoto State, large numbers of children were never-reached (or left-out) because many of the health facilities were not offering routine immunizations. This realization spearheaded efforts by state and LGA officials to expand the number of immunization sites in the state.



The Drop-Outs

A low drop-out rate shows that a mother or caretaker is a repeat customer. Vaccination services are available and are of good quality so that community members want to return to the health center. It is likely that health center visitors are respected, treated fairly, and that the health center offers the vaccination services at a convenient time of day and week for her. Health workers in Sokoto State are now being encouraged to pay attention to the quality of services that they provide to communities and to make sure that supportive supervision visits and self-assessment checklists are keeping them on track. This is helping to reduce the number of drop outs in Sokoto State.

(Continued on page two)



Where can I find out how to increase access to routine immunization services in my area?

**Contact the: SMOH in Sokoto
BASPHCDA in Bauchi**

This health worker is examining how to reach all of the community members that her health facility needs to serve. Photo: IMMbasics Nigeria.

Negative Drop-Out (Continued from page one)

The figure on the previous page shows poor data quality as exemplified by Gwadabawa LGA, where in 2006, DPT3 was higher than DPT1 coverage. This “negative drop-out” shows the impossible event of more children receiving their third dose of DPT than their first dose. This was not unusual among LGAs and was a red flag indicating poor data quality.

Monthly meetings held with the LGA Immunization Officers (LIOs) contributed to the reduction in negative drop out rates in the state. In these meetings, feedback on the previous month’s activities is provided and topics such as data collection, data analysis, and challenges with data management are discussed. These routine meetings are critical for improving and maintaining data quality to avoid negative drop-outs.

The Missed Opportunities

“He’s had a fever for the past several days and started having diarrhea yesterday,” a mother complained, cradling her six-month-old son. For many health workers, this could mean giving a prescription for paracetamol and oral rehydration salts,

and then quickly moving on to the next patient. But wait! This visit could be an opportunity to ensure that the child’s vaccinations are up-to-date as well.

To avoid missed vaccination opportunities, health workers in Sokoto are encouraging parents to always bring the child’s health card, irrespective of the reasons for visiting the health center. Health workers are instructed to check the vaccination cards of every child that enters the health facility for any reason, and to vaccinate eligible children at any time. Otherwise, they could let missed children walk out the door, unprotected against preventable illnesses. By teaching health workers to follow these simple steps, Sokoto state is reducing the number of missed opportunities.

By taking systematic steps to reach the un-reached, decrease the number of dropouts, prevent “negative” dropouts and avoid missed opportunities, health workers and managers in Sokoto State are making progress in reaching the target population and increasing access to routine immunization services.

ACCESS TO IMMUNIZATION SERVICES CHECKLIST

- Do you know how many children under one year of age are in your area? (Or, do you know your target population?) Ask the same question regarding women eligible for tetanus toxoid.
 - Are health workers checking the immunization status of all children entering a health facility and taking the opportunity to vaccinate them? (Avoiding missed opportunities).
 - Is your drop-out rate low? (Are good services provided that keep mothers and children coming back for more?)
- If the answer is “no” to any of these questions, work with your colleagues to find solutions to change “no” to “yes!”**

ANNEX H: Case Study on Community Linkages

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GETTING AND KEEPING COMMUNITIES INVOLVED IN HEALTH

Linking services with the community is an important part of Nigeria's Reaching Every Ward, or REW, approach. REW is Nigeria's main strategy to revitalize routine immunization.

Although establishing a positive and friendly relationship with the community is key to improving health service delivery, it is not enough. These links must be maintained in a regular and organized way!



To be a successful merchant, one must have a friendly relationship with clients and understand their needs. This recipe is no different for health facilities and their communities. Both health workers and managers must have a dynamic relationship with the populations they serve in order to provide services that are both appropriate and in-demand.

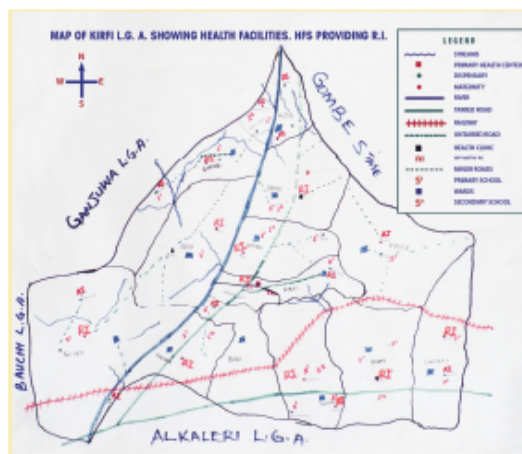
How can we form this type of dynamic relationship? One way to encourage a closer relationship between the community and a health facility or LGA is by using participatory activities. Designing or updating a health facility catchment area (part of the REW microplanning process) can be an effective participatory activity if the community is involved. Bauchi State in Nigeria experimented with using a hands-on participatory approach when revising its health facility catchment area maps.

This participatory mapping process involves health workers, health managers, traditional leaders, local officials, and community members coming together to collectively decide which health facility is the most convenient for each settlement. Instead of the catchment area map being delineated by out-of-town officials, the people actually involved in the local area work together to decide the map boundaries and create the final product.

According to one health worker in Bauchi, "before implementing the mapping process in my area, many people weren't seeking medical assistance because they had no connection with

a specific health facility. They either didn't know which one to go to or they didn't trust the health workers." The participatory mapping process lets the community decide where they want to go for their health concerns and makes them more comfortable with their local health staff as well.

Although the health facility catchment area mapping process used in Bauchi was crucial to initially involving the community, it was not enough to continue keeping the community actively participating after that exercise was finished. What can be done to *maintain* community linkages? *(Continued on page two)*



This sample LGA level catchment area map in Bauchi State was developed by community members. It includes the following information:

- Hard-to-reach settlements
- Population targets of children under one year
- Health facilities providing routine immunization services, including outreach sites

Photo by Dr. Amos Bassi, IMMbasics: Allowing communities to participate in drawing the health facility catchment area map builds a relationship between the health facility and the communities it serves.

The health facility catchment area mapping process used in Bauchi State is only one way to establish good community linkages. For more specific information on how Bauchi and Sokoto states are reaching out to communities and maintaining their participation in order to improve routine immunization services, contact:

BASPHCDA In Bauchi State • SMOH In Sokoto State



*Local committees can play a strong role in routine immunization, if they meet regularly.
Photo: Ahmed Naiya, IMMbasics.*

(Continued from page one)

Both Bauchi and Sokoto states can attest that strong **village development committees (VDC)** and **ward development committees (WDC)** are necessary to keep the community involved. These structures are also encouraged by the Nigeria National Primary Health Care Development Agency's "Ward Minimum Health Care Package." A ward development committee may include members such as a Chairman, ward focal person, traditional leader, religious reader, and non-governmental organization (NGO) representative. This diverse grouping of individuals ensures that all local viewpoints are included in committee functions.

In a broad sense, a ward development committee coordinates all primary health care activities within the ward. At a minimum, the WDC meets on a monthly basis. During these meetings, the committee may review routine immunization performance and discuss steps to move forward. The WDC should also hold quarterly outreach meetings on routine immunization, or another topic of interest, with the local communities. (It is best if the committee allows the community to select the topic!)

A village development committee (VDC) is similar to the WDC, but at the village level. Members may include a traditional leader, head representative of a health facility, religious leader, NGO representative, and school headmaster. Like the ward committee, the village committee should meet on a monthly basis both to review the current status of primary health care within the village and think of ways to both reduce disease and increase quality of life for their fellow friends and neighbors.

A committee is only as strong as the regularity of its meetings. It doesn't help the community if the WDC or VDC

exists on paper but never actually meets! Find out today what committees exist in your area and what you can do to support or revitalize them. The only way a development committee comes alive is by health workers and communities actively participating in them, including meeting **regularly** and not only because of an upcoming campaign. Creating membership criteria, selecting meeting dates, having a clear agenda and terms of reference, informing participants, being flexible about schedule conflicts, and actually holding the WDC and VDC meetings are critical steps to **maintaining** community links.

Quick Guide to Community Linkages

- **Establish community linkages** through a participatory health facility catchment area mapping process
- **Maintain community linkages** through regular meetings of ward development committees and village development committees