NIGERIA

MAKING
“REACHING EVERY WARD”
OPERATIONAL

A step towards revitalizing Primary Health Care in Nigeria

2009
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ACRONYMS AND ABBREVIATIONS

COMPASS  Community Participation for Action in the Social Sector (USAID)
DFID  United Kingdom’s Department for International Development
DPHC  Director of Primary Health Care
DPT  Diphtheria-pertussis-tetanus vaccine
DQS  Data Quality Self-Assessment
EU PRIME  European Union Partnership to Reinforce Immunization Efficiency
HF  Health facility
IMMbasics  IMMUNIZATIONbasics (USAID)
IPDs  Immunization Plus Days
JRIST  Joint RI Strengthening Team
LGA  Local Government Area
LZC  LGA Zonal Coordinator (an IMMbasics staff position)
MOLG  Ministry of Local Government
NICS  National Immunization Coverage Survey
NPHCDA  National Primary Health Care Development Agency
PHC  Primary health care
PRRINN  Partnership for Reviving Routine Immunization in Northern Nigeria (DFID)
RED  Reaching Every District
REW  Reaching Every Ward
RI  Routine immunization
SMOH  State Ministry of Health
SPHCDA  State Primary Health Care Development Agency
UNICEF  United Nations Children’s Fund
USAID  United States Agency for International Development
VDC  Village development committee
WDC  Ward development committee
WHO  World Health Organization
FOREWORD

In 2004, Nigeria adopted the WHO RED approach and renamed it REW in order to improve routine immunization coverage in the country. This approach outlines five operational components that are specifically aimed at improving coverage in every ward: improving access to immunization services; supportive supervision; community links with service delivery; monitoring and use of data for action; better planning and management of human and financial resources.

Since then, REW implementation in the country has been faced with a number of problems that include weak PHC system, poor funding especially at LGA levels, haphazard and uncoordinated implementation often stopping at the LGA level etc.

In 2006, USAID floated the IMMUNIZATIONbasics project to assist in strengthening the routine immunization systems in Bauchi and Sokoto States. As part of its efforts in doing so, IMMUNIZATIONbasics project rolled out in a very practical manner the REW approach. This booklet summarises the experience of IMMUNIZATIONbasics staff, as well as that of the Bauchi State Primary Health Care Development Agency and the Sokoto State Ministry of Health working with service providers in the Local Government Areas implementing the REW components.

I find this document very useful not only in improving routine immunization services but of practical guidance in strengthening the PHC system in the country. I therefore do not hesitate to recommend the booklet to service providers in the country (as well as in neighboring countries), just as we continue with our efforts of strengthening the routine immunization system and reducing the incidence, associated morbidity and mortality from vaccine-preventable diseases.

Dr Muhammad Ali Pate
Executive Director/CEO
NPHCDA
June 2009
INTRODUCTION

The World Health Organization (WHO) and partners designed the Reaching Every District (RED) approach in 2002 as an innovative method to increase and sustain high levels of routine immunization (RI), particularly in the Africa region. This approach has a number of unique characteristics, including:

- targeting unimmunized children;
- prioritizing limited resources by basing planning on weaker performing areas;
- decentralizing with focus on the district or Local Government Area (LGA) level downward; and
- aiming at flexibility and adaptation to include integration and strengthening of other primary health care interventions.

The RED approach, which supports the Global Immunisation Vision and Strategy 2006-2015, was developed by WHO and UNICEF for setting a vision for equal access to immunization services. Specifically, RED calls for: “At least 90% national vaccination coverage and at least 80% vaccination coverage in every district by 2010 or sooner.”

Nigeria adopted the RED approach in December 2004 to its country context for “Reaching Every Ward” (REW). In Nigeria, a ward represents the lowest administrative and political level. In 2006, Nigeria developed and disseminated nationwide its REW guide and tools. Comprehensive training was then provided to all States and LGAs in 2007.

In October 2006, IMMUNIZATIONbasics Nigeria, a USAID-funded project, embarked on a two-and-a-half year effort in two States to put REW into action, and thereby strengthen routine immunization services. In April 2009, a project review team concluded that IMMUNIZATIONbasics (IMMbasics) had developed a practical and affordable way to make REW operational in the context of the weak Primary Health Care (PHC) system in Nigeria. This document, MAKING REW OPERATIONAL, describes how it was done and what the project and partners learned.

MAKING REW OPERATIONAL supplements the National Primary Health Care Development Agency's (NPHCDA) REW Field Guide (pictured on left) by describing the lessons learned on making the five components of REW operational. It highlights the process and experiences involved in implementing REW's components Statewide in Bauchi and Sokoto States. It also incorporates the ideas from partners involved in promoting the REW approach, including: NPHCDA, WHO, UNICEF, USAID's COMPASS project, DFID's PRRINN project, EU PRIME and others. MAKING REW OPERATIONAL is designed primarily for health management teams at State and LGA levels, and also for stakeholders and partners involved in strengthening routine immunization and primary health care.

Before describing the process for making REW operational, we will first review the five basic components of REW.
REW, the Five Components

The REW Field Guide defines “Reaching Every Ward approach as:

“a strategy aimed at provision of regular, effective, quality and sustainable routine immunization activities in every ward, so as to improve immunization coverage. It focuses at improving the organization of immunization services so as to guarantee equitable immunization for every child. Based on most common barriers to achieving immunization goals, the REW approach has the following five operational components needed for planning to Reach Every Ward:”

THE FIVE REW COMPONENTS

1. **PLANNING AND MANAGEMENT OF RESOURCES** — better management of human and financial resources.
2. **IMPROVING ACCESS TO IMMUNIZATION SERVICES** — establishing or re-establishing both fixed immunization sites as well as outreach or mobile immunization sites.
3. **SUPPORTIVE SUPERVISION** — regular visits with on-the-job training by supervisors; feedback and follow-up with health staff; promotion of use of data.
4. **MONITORING FOR ACTION** — using tools and providing feedback for continuous self-assessment and improvement, including review meetings to promote use of data, charting of doses, participatory mapping of the population in each health facility catchment area.
5. **LINKING SERVICES WITH COMMUNITIES** — community participation in health services; planning and jointly identifying a role for the community; involving village development committees (VDCs), ward development committees, (WDCs) traditional birth attendants, etc.

*We have listed the “community linkages” component last to emphasize that reliable supplies and well trained health workers are needed in a health facility before focus is placed on increasing demand."

WHO/Africa Regional Office’s revised RED Guide (pictured on right) emphasizes that: “Attention to each of the five RED components is important to improve immunisation coverage.”

In addition, WHO’s RED Guide reminds the reader that “[m]any of the components contain intentionally overlapping content.” This overlap between components helps to reinforce the lessons learned in each component, which in turn reinforces the entire RED, or REW approach.

**Picture:**WHO Africa’s regional revised RED Guide for country adaptation. See footnote for website details.

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1. PLANNING AND MANAGEMENT OF RESOURCES

**Required tools for good planning.**

- A health facility catchment area map showing every settlement, target populations, outreach sites, roads, major physical and social structures, etc.
- Session plan for the health facility catchment area showing when sessions will be held.
- A workplan showing activities, persons responsible and timetable, including supervisory visits.
- A monitoring chart, regular local data analysis and system for tracking defaulters.
- A supply/re-supply plan.

2. IMPROVING ACCESS

**Establish or re-establish fixed immunization site.**

- Determine number of health facilities providing RI services regularly (at least 4 times in the previous 12 months).
- In each ward at least one health facility must conduct RI services at least once every week as a fixed delivery site.

**Establish or re-establish outreach/mobile immunization sites.**

- Each fixed immunization delivery site must plan with the community and conduct outreaches as required.

**Use own data to show where the unimmunized infants are and plan accordingly.**

- List activities needed to reach all the infants, prioritizing un-immunized and incompletely immunized infants.
- Use existing resources better: regular fixed outreach sessions, community involvement.
- Budget additional resources to reach more infants as required through Local Immunization Days or Child Health Weeks.
- Prioritize unimmunized and incompletely immunized.

3. SUPPORTIVE SUPERVISION

**Characteristics**

- Combines on-the-job training, problem solving and monitoring.
- Is an effective motivation tool.
- Provides continuous capacity building for delivery of quality services.
- Consists of more than just a check-list.

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3 Source: NPHDCA presentation made at the 2009 annual planning retreat, Gusau
4. MONITORING FOR ACTION

- Ensure availability of monitoring tools, vaccination cards, tally sheets, vaccine ledgers, monthly summaries, etc.
- Monitor timeliness and completeness of reporting by LGA/Ward.
- Regularly analyze and review collected data.
- Analyze data to identify problems: access and utilization.
- Conduct regular performance reviews:
  - Health Facility Level: monthly
  - LGA Level: monthly
  - State level: monthly meetings with EPI Managers and other Stakeholders
  - Zonal level: quarterly
  - National level: annually
- Tailor activities to solve problems based on data findings.
- What resources are needed? Explore existing resources versus additional resources.
- Continually update your workplan and add revised activities as the year progresses.
- Prioritize the activities on your workplan.

5. LINKING SERVICES WITH COMMUNITY

To best promote regular involvement with communities.

- Establish or re-activate LGA PHC Development Committees, Ward Health Committees and Village Health Committees.
- All level of committees should hold monthly meetings to provide appropriate feedback.
- Involve local communities in planning, especially including their input so that services are offered on convenient days.
- Train local people, such as vaccination session volunteers.
- Use Community Based Organizations for social mapping and resource mobilization, community mobilization, defaulter tracking, newborn tracking for timely vaccination and implementation of REW.
- Give regular feedback to communities.
Nationwide Assessment of REW - 2008

In 2008, Nigeria conducted a nation-wide assessment of REW. Teams visited two to three LGAs per State and two health facilities per LGA, one rural, one urban. The assessment team reported the following key findings.

1. PLANNING AND MANAGEMENT OF RESOURCES
   - Training: although variation existed between States and LGAs, most health workers who provide RI services received REW orientation through cascaded training.
   - Micro-planning: only 40% of health facilities had RI session plans and only 55% of LGAs had RI plans.

2. IMPROVING ACCESS TO IMMUNIZATION SERVICES
   - While only 40% of health facilities had RI session plans, those with plans conducted above 80% of their planned fixed sessions.
   - Over a third of the health facilities could not conduct up to 80% of planned outreach sessions.

3. SUPPORTIVE SUPERVISION
   - Only 46% of assessed LGAs had a supervisory plan.
   - About 30% of the health facilities visited had not been supervised in the last three months.
   - Over 52% of health facilities sampled in North Central Zone and North West Zone had not been supervised in over three months.

4. MONITORING FOR ACTION
   - 46% of health facilities had coverage monitoring charts that were on display.
   - Only 37% of the LGAs have regular monthly review meetings.
   - Analysis of data is not taking place at LGA or health facility levels.

5. LINKING SERVICES WITH COMMUNITIES
   - Only a few States, mostly in the South East Zone, South West Zone and North East Zone, had functional LGA and health facility community health committees which meet regularly.

In addition to the REW assessment in 2008, the last National Immunization Coverage Survey (NICS) in 2006 revealed that many States continue to struggle to reach all of their target populations of children under one year of age and women of child bearing age. As shown in Figure 1, only 11 States had DPT3 coverage of 50% or more based on the 2006 NICS survey. Only Lagos approached the national coverage target of 80%. Bauchi and Sokoto States, the focus States for the IMMbasics project, were particularly low in DPT3 coverage with Bauchi achieving only about 25% and Sokoto less than 10%.
This 2008 REW assessment and the 2006 NICS highlight that considerably more effort is needed for making REW operational. Less than half of the LGAs and health facilities visited practiced the required components of REW. Nationally, immunization coverage for RI remains very low. The REW assessment shows that more than a cascade training effort is needed to make REW operational at an effective level.

**The IMMUNIZATIONbasics Project**

For quality services to be used, people must have confidence that: they will receive the vaccinations for which they came; they will be treated respectfully; and they will know when to come back. This means that the health system at national, State and LGA levels must be well managed and organized, with clearly outlined responsibilities and regular support supervision providing encouragement and guidance. This concept stands as one of the fundamental principles for the IMMbasics project.

IMMbasics Nigeria, a two-and-a-half year USAID-funded project, provided technical assistance to the Government of Nigeria for strengthening the routine immunization system in Bauchi and Sokoto States. The project worked closely with government agencies at national, State and local levels, and alongside international partners to develop the human and institutional capacity needed to strengthen delivery of quality RI services. IMMbasics worked in all of the 43 Local Government Areas (LGA) in Bauchi and Sokoto States.

The project’s objectives centered on four key areas:

1. increasing service delivery points that provide RI;
2. promoting systematic distribution of vaccine and vaccination supplies to service delivery points;
3. increasing and sustaining optimal attendance during immunization sessions; and
4. improving data quality and use at LGA and health facility levels.

The goal of the 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 weak PHC system in Nigeria. The project strongly endorsed and utilized participatory approaches at all levels. It did not provide funds to carry out new or supplemental activities; rather it provided technical assistance to support the government for improving and operationalizing what was already in place in terms of: strategies, health facilities, and government staff.

**Project Approach**

Because the health facility and the LGA are the most critical for providing access to quality RI services, IMMbasics concentrated efforts on these two levels. However, the project also actively worked at State level for building capacity and promoting advocacy, and at the national level for coordination and advocacy with partners and stakeholders. The project’s first priority centered on strengthening human resource and systems capacity. After the health system was prepared for providing quality immunization services, the project then initiated greater effort on promoting community involvement to increase both access to and utilization of these quality services.

IMMbasics together with a State/LGA team followed a phased approach for strengthening RI. This process occurred in groups of three LGAs at a time, one LGA from each Senatorial Zone. One group of
three LGAs was started approximately every quarter. The following maps depict phasing of LGAs in Bauchi and Sokoto.

Maps of Bauchi (left) and Sokoto (right), with color-coded phasing of LGAs by project implementation.

This phased approach allowed more attention to be directed on each individual LGA and its health facilities during the crucial start-up period. Concentrating on a few LGAs at a time also promoted emphasis on participation and ownership, which are critical for strengthening RI in a sustainable manner.

IMMbasics worked not only to strengthen RI in Bauchi and Sokoto, but also to provide an affordable and practical way forward for the Federal Government of Nigeria’s effort to improve RI and PHC nationally. There was no existing step-by-step reference on “how to” implement REW in a practical way, only a Field Guide on what is generally required. Thus the work of the project was also developmental and innovative, which required committing time and staff for developing and field testing new approaches and tools. As the approach and tools became refined, the project made more and more progress on strengthening the systems and the capacity of health workers. The project directed more effort on strengthening community linkages only after improved planning, management, and monitoring and supervision systems became operational.
**Project technical staff**

In Abuja the project’s technical staff included a Country Representative, a Deputy Country Representative, and a National Program Officer. In addition to project planning and coordination, they provided support at the policy level and technical to the Federal Government of Nigeria. At the State level the State Coordinator was responsible for relationship building with the State government and partners, coordination and implementation of the project, and capacity building of project staff.

Two Monitoring/Data support Officers provided institutional and human resource capacity building on data management for the State and LGA PHC team. They were also responsible for overseeing data quality and for ensuring data quality spot checks took place at regular intervals.

The project deployed three LGA Zonal Coordinators (LZC) per State, with one in each of the three senatorial zones. The LZCs were responsible for continous mentoring and coaching of the LGA PHC team and for assisting with the daily implementation of the project’s RI strengthening activities. The LZCs provided hands-on technical assistance from the LGA level down, and were the project’s most important link in ensuring that LGAs and health facilities received appropriate mentoring and support throughout the RI strengthening process.

The LZCs provided LGAs with in-depth support for at least the first three months of entry-related work, but the project also hired consultants to assist the LZCs because the limited number of LZCs could not cover all of the territory in these States. As the LZCs moved on to new phases of LGAs, these consultants helped LGA health teams maintain and facilitate continued RI strengthening activities. The consultants were trained on-the-job by the State Coordinator and LZCs. Each State had an average of 6-8 consultants at a given time. Had the project had the funds and a more thorough understanding of the large and difficult terrain, it would have ideally hired as many as double the number of LZCs.

As part of building the State’s capacity to maintain a continuous in-service training system, the project worked with both Bauchi and Sokoto to develop a cadre of Master Trainers. A minimum of 24 health staff were selected by each State to become Master Trainers. The project with the State conducted a comprehensive workshop where the Master Trainers received extensive training on RI, including on-site health facility based practical training. These Master Trainers then formed six training teams with at least three per team. These teams then provided training to health workers, with criteria to maintain a facilitator-participant ratio of 1:5, so that all health workers received focused attention and mentoring.

All of the activities for strengthening RI in the State were carried out by a Joint RI Strengthening Team (JRIST). This team was composed of: either the State Ministry of Health (SMOH) in Sokoto State or the State Primary Health Care Development Agency (SPHCD) in Bauchi State, as well as the Ministry of Local Government (MOLG), LGAs and the IMMbasics project.

**Project Baseline Assessment**

Prior to start up, project staff, a State team (SMOH/SPHCD, MOLG Director for PHC, LGA PHC teams) and external consultants conducted a baseline assessment in each State in 2006. The assessment included all LGAs in both States, and also a desk review of reports from 879 functional health facilities in Bauchi, and 548 health facilities in Sokoto.4

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4 SMOH administrative data, 2006.
Key findings from these rapid assessments showed that by disaggregating routine immunization data\(^5\) from supplemental immunization activities and Immunization Plus Days (IPDs) data during the period of January-December 2006, the approximate number of infants immunized with DPT3 through the RI system was 57,063 and 42,510 in Bauchi and Sokoto States respectively. However, using data for the 12 months preceding introduction of immunization plus days (IPDs), March 2005 - April 2006, gave Bauchi 40,447 DPT3 immunizations and Sokoto 35,648 from RI alone. By this method a clearer baseline on immunizations provided by RI was established, without reflecting those provided by time limited mass campaigns, IPDs. Both States had a shortage and also mal-distribution of qualified personnel. In Bauchi, 44% of health facility staff were qualified health professionals and in Sokoto only 40%. A majority of health workers in the health facilities were found to be non-professional staff, such as cleaners, security guards, and messengers. Only a handful of facilities provided regular RI services at least four times per year in 2006. The greater number of facilities provided RI services less than four months a year on an intermittent basis. In Bauchi, only 28% (247) of health facilities provided immunization services during four or more months in 2006. In Sokoto, 43% (241) of health facilities, provided RI services for 4 months or more out of the year.

According to this assessment, LGAs did not regularly schedule distribution of vaccine and vaccination supplies, or provide details of planned immunization sessions. Regular monitoring and use of data to guide planning was mostly absent. Findings from this assessment highlighted the critical need to focus on strengthening the routine immunization system in order to increase access to and utilization of immunization services in both States.

For a detailed report on the project’s baseline assessment, please see the *Statewide Assessment on Routine Immunization System in Bauchi and Sokoto States, Nigeria: BASELINE REPORT – 2007.*\(^6\)

**MAKING REW OPERATIONAL, Seven Steps**

Given the many challenges not only for strengthening RI, but also the entire primary health care system, how can States and LGAs begin to focus their RI strengthening efforts? This section describes how Bauchi and Sokoto States worked toward revitalizing their RI services, and built on their achievements.

Starting in 2007, Bauchi and Sokoto States together with IMMbasics, initiated a step by step processes for putting REW into action with the ultimate goal of a stronger PHC system for reducing the number of children dying from vaccine preventable and other preventable diseases. Although more work remains to complete the REW process, both States are making considerable progress toward making their REW operational. In the IMMbasics end of project review in April 2009, the review team found most health facilities and LGAs actively engaged in planning and monitoring their RI services. Documented performance scores showed definite improvements in the quality of RI services. The following describes how they are doing it; the step by step approach which is putting REW into action.

\(^5\) Same as above.

SEVEN STEPS for Making REW Operational:

1. **State Planning and Management of Resources**
2. **LGA Planning and Management of Resources**
   - a) Sensitization; b) Mini Review; c) Work Planning
3. **Strengthen Systems – Supervision and Monitoring**
4. **Build Capacity**
5. **Increase Access to Services**
6. **Link Services with Communities**
7. **Maintenance and Expansion**

As with the five REW components, it is important to realize that these seven steps for making REW operational are not exclusive of one another. Each depends on the other, and certain steps can be ongoing with other steps.

**Getting Started in Bauchi and Sokoto**

To put the REW “operational components” in place, both Bauchi and Sokoto States followed a systematic effort at State and LGA levels using the steps outlined in the *Reaching Every Ward Field Guide* and the *Basic Guide for Routine Immunization Service Providers* as guidance. Because baseline findings confirmed that both States had weak RI systems, efforts first focused on strengthening LGA management and coordination. Later efforts moved to the health facility level to strengthen capacity to provide better quality and to expand access. To facilitate the improvement of LGA management and health facility service delivery, a Joint RI Strengthening Team (JRIST) formed, consisting of: the Sokoto SMOH or, the Ministry of Local Government (MOLG), LGAs and IMMbasics. The JRIST first worked to build competence at the State level. Next, they worked with LGA PHC personnel, and then the health facility staff. After a minimum standard of service regularity and quality were in place, the JRIST then focused more on encouraging community support and use of services.

**Step 1: State Planning and Management of Resources**

The first step in making REW operational involves a Statewide assessment. State assessments were conducted in Bauchi and Sokoto in early 2007. The State assessment reviews existing documents, such as LGA monthly RI summaries, health worker staff lists and qualifications, and data on both immunization coverage and access to immunization services. This participatory exercise helps the States realize the status of their RI services in terms of number and locations (by ward) of the health facilities actually providing RI. The States also work on revising their work plan for strengthening RI in coordination with partners such as: WHO, UNICEF, IMMUNIZATIONbasics, and COMPASS. Where a five-year plan already exists, they fine tune and update their plans. The State then works on improving their planning through regular meetings and by making planning a continuous, integral part of program management, as opposed to a once a year, short-lived exercise.

The State assessment team compiles all relevant national, State and LGA documents and recruits consultants to collect a specific set of health systems information. This information, coupled with the data already available through both States and WHO, forms the basis of the State RI work plan and also serves as baseline data for the State for assessing their progress later on.
Pre-assessment stage: The pre-assessment stage focuses on the development and field testing of the assessment instruments in collaboration with the SMOH/SPHCDA and MOLG. Two data collection instruments were developed in Bauchi:

**St 1:** Statewide Baseline Assessment: Public Health Facilities & Staff (Annex A);

**St 2:** Statewide Baseline Assessment: Coverage Data Entry (Annex A).

If data are not available at the LGA level, the team makes a strong attempt to collect the missing data from State and/or WHO archives, and they mark these data as coming from the State-level archives.

Assessment stage: Data tools St-1 and St-2 are dispersed to the LGAs’ department of Primary Health Care (PHC) for review in preparation for the arrival of the State assessment team. The assessment team then makes advocacy visits to the LGA chairman and other relevant officers. These visits focus on formal introduction of the RI strengthening process and its objectives, and solicit support in gathering the baseline data. This data gathering process also involves diligently separating the IPD campaign data at each RI system level.

Post-assessment stage: The post-assessment stage includes data entry, collation and analysis by the assessment team using Microsoft Excel, and if available SPSS 11.

**Step 2: LGA Planning and Management of Resources**

The next steps focus on the service delivery level: the LGA and health facilities. This involves a series of activities organized by the JRIST.

- **Sensitization** meeting held with three to five LGAs together to introduce PHC teams to the coming effort.
- **Mini-Review** to establish baseline information in each LGA and to expose everyone in a participatory manner to the complete situation of the RI system in their LGA.
- **RI Planning in each LGA** to identify objectives, targets, next steps, schedule, and responsibilities for strengthening RI, immediate actions to take, planning making use of local information from the LGA review and other LGA sources

The following briefly describes each activity.

1. **Sensitization**

   The sensitization meeting provides a forum to introduce the RI strengthening process and identify roles and responsibilities of all partners. Open discussions are held to ensure a shared understanding of the process, as well as jointly develop plans for the rollout. This preparatory step is key as it is informative and participatory, employing a peer-to-peer approach. The meeting is hosted by one of the LGAs which places the LGA PHC team in the driving seat of the process. This is usually a two day meeting, providing ample time for discussion.

   The objectives of the sensitization activity are to:
   - clarify the role and responsibility of LGAs in providing RI services;
   - introduce the steps to begin the process for strengthening the RI system;
   - orient LGA officials to the State’s and IMMbasics’ role in strengthening RI; and
   - plan and schedule the RI Mini-Review in each LGA.
2. Mini-Review

Once the initial “Sensitization Meeting” is held to introduce each new group of LGAs to the State’s RI strengthening initiative, the Joint RI Strengthening team moves into each LGA to work with LGA staff to conduct a “Mini-Review” of the LGA’s RI system. The Mini-Review focuses on two operational areas:

- LGA management of the RI system, and
- Health facilities that are not providing RI services, but have the potential to begin RI services.

The objectives of the RI Mini-Review are to:

- instill the idea that every detail of RI service management will be revealed;
- establish a systems-management baseline;
- create awareness of the need to change the way RI services are currently managed; and
- identify those health facilities which do not provide RI services, but have the capability and should be providing RI services.

The RI Mini-Review usually takes place in the LGA the week following the introductory Sensitization Meeting, and takes from six to ten working days to complete, depending on the number of health facilities and the terrain. The Mini-Review is conducted by a team composed of at least two LGA staff, including RI staff and other LGA management staff, such as Maternal and Child Health staff or Health Educators; one staff from the State level; and one IMMbasics staff, the LZC. The preparatory and implementation steps of the Mini-Review involve:

- introductory visits to key LGA political, traditional and administrative officials;
- an RI management review using a set of seven instruments described below and found in Annex B;
- a listing of all settlements with populations by Ward;
- identifying health facilities which have the capability of providing RI services;
- visits to the health facilities selected as potential sites for expansion of RI services using a set of four instruments (See Annex C):
  - Health Facility Assessment: Staff (HF-1)
  - Health Facility Assessment: Services (HF-2)
  - Health Facility Assessment: Environment (HF-3)
  - Health Facility Assessment: Cold Chain & Vaccine (HF-4)
- Collation and analysis of data using Excel.

The RI Mini-Review covers of the following areas:

1. LGA vaccine usage and coverage, using data from 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 instruments for the LGA Mini-Review at LGA level, which are seven worksheets in one Excel workbook (Annex B), include the following:

**LGA-1: LGA Vaccine Usage & Coverage Worksheet**

*Purpose:* obtains HF-by-HF data of DPT vaccine and numbers immunized for previous two years.

*Output:* frequency of service, RI coverage, drop-out and vaccine usage data by HF.

**LGA 2: LGA or LGA Zonal Cold Store**

*Purpose:* obtains information on the structure, reliability, and condition of the vaccine distribution system.

*Output:* status report on the vaccine distribution system, capacity, reliability and quality of record keeping.

**LGA 3: LGA Equipment & Supplies**

*Purpose:* obtains information on the availability and storage condition of immunization supplies.

*Output:* inventory and condition of available and/or reserve supply items for routine use and for expanding RI services to additional health facilities.

**LGA 4: LGA Data Management**

*Purpose:* identifies how the LGA RI team collects, reports, analyzes, and uses RI data.

*Output:* status report on the LGA RI unit’s organization, management and use of data, including population statistics.

**LGA 5: LGA Support Supervision**

*Purpose:* identifies how the LGA RI team organizes and documents their supervision of activities.

*Output:* description of the current RI supervision system.

**LGA 6: LGA Waste Disposal**

*Purpose:* know how the LGA is organizing the disposal of used vaccination materials.

*Output:* description of the waste disposal system and its adherence to minimum standards.

**LGA 7: LGA Health Staff Worksheet**

*Purpose:* defines staff distribution by ward and by facility for planning the strengthening of service provision and increasing access.

*Output:* staff listed by name, sex and qualification by health facility.

### 3. Work Planning

The third entry activity is ‘short-term’ planning. This planning activity is referred to as “short-term” because LGA staff are not yet sufficiently prepared to plan for the long term. Short-term planning involves:

- using the results and information gathered in the RI **Mini-Review** for developing the workplan and decision making;
- focusing on LGA RI management; and
- scheduling the initial implementation steps for strengthening RI.
MAKING RI OPERATIONAL

This third entry activity uses the results and information gathered during the RI Mini-Review for developing the RI work plan, including activities and schedules for strengthening RI. At the end of this ‘short term’ planning process, the health team briefs the LGA Chairman and council members on their Mini-Review results, and the initial steps, work plan and budget developed for strengthening RI. During this time the LGA PHC team updates: their LGA maps indicating facilities providing RI and their list and session schedules of health facilities providing RI. They also develop and prepare budgets for their support supervision and vaccine distribution plans.

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

Step 3: Strengthen Systems: Supervision and Monitoring

Supervisors should always apply data from every level of monitoring and reporting as a part of their responsibility for:
- mentoring and joint problem solving.

Once the three initial activities (sensitization, Mini-Review, planning) in Step 2 are completed, the LGA staff prepare to strengthen their supportive supervision. This first involves: task identification and standard setting. The LGA identifies the key RI tasks and then they set the standards for them. This is accomplished through a series of exercises lasting an average of two days each during which LGA PHC staff and the JRIST facilitate the following process.

1. Study, identify, and prioritize the basic RI management tasks using the Basic Guide for Routine Immunization Service Providers as key reference material, which includes the following:
   - vaccine management,
   - regular vaccine distribution,
   - supply management and distribution,
   - data organization, analysis, use, and feedback, and
   - supportive supervision.

2. Jointly set standards for the tasks and prepare a supervisory checklist with guidance, and also a self-assessment checklist (Annex D). The Supervision Checklist with guidance is used by the supervisor from the next level to score the tasks listed. It provides a quantitative score which reflects the number of tasks done correctly. The Self-assessment Checklist essentially is the same as the Supervision Checklist, but is self administered by the health worker. The Self-assessment Checklist also provides a score on correctly performed tasks. Self-assessment is encouraged at least monthly to promote self learning and improved performance. Self-assessments serve as a bridge for maintaining standards of practice in places where supervision may not be well established or regular.


4. Initiate supportive supervision and monitoring for action in the health facilities.

After these tasks are completed, the State supervisors and the IMMbasics LZC assist LGA staff with correcting the problems identified from the Supervisory Checklist with guidance. The LZC mentors the LGA staff and supervisors for a period of several months until the LGA will be able to effectively supervise and mentor the health facilities without project support.
The next step involves joint supportive supervision visits by the LGA PHC health team and the LGA peer motivators. Peer Motivators are fellow health workers who have demonstrated high level of competency in RI tasks, and have leadership and facilitative skills. Each Support Supervision visit includes:

- a completed supervisory checklist with guidance, a copy of which should be left with the health facility after the visit;
- a score on the performance of the facility; and
- on-the-job correction and mentoring on the problems identified.

Thus the supervisory team documents the status of the health facility’s performance using the Supervision Checklist with guidance for referral and comparison during future visits.

The graphs below on supportive supervision scores demonstrate how health worker knowledge increased over time with regular support supervision. The graphs show the aggregated service delivery performance in a total of 258 health facilities in Bauchi and Sokoto that completed at least 3 rounds of supportive supervision as of April 2009. Graphs showing comparison of individual health facility performance as well as summary graphs such as those below provide visual evidence to managers on performance improvement, and serve as encouragement for continued improvement.

Figure 2: Comparison of Supervision Scores by Round in Silame LGA, Sokoto, 2009.

Figure 3: Supportive Supervision Check List Scores (color coded by category) in HFs in Bauchi (171) and Sokoto (87) that completed at least 3 rounds of RI supervision from Nov, 2007 to April, 2009.
The immunization coverage and drop-out monitoring chart provides a valuable tool for supervisors for readily assessing the health facilities immunization coverage and drop-out rate status, as well the health workers’ 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 can also be used as advocacy with the LGA Chairman and his executive to regularly support routine immunization.

One of the most unique features of this approach for making REW operational is that:

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

Rolling out a comprehensive capacity building package with this sequence adds to the impact from the workshop training by providing follow up, on-the-job reinforcement from supervisors after the class room training. Near the end of the IMMbasics Project, the Project Review Team and many health workers interviewed commended this longer term and more thorough approach for improving the skills of health workers.

See Annex H for a case study on SUPPORTIVE SUPERVISION: “Support Supervision is Becoming a Reality”

And See Annex I for a case study on MONITORING FOR ACTION: “Good Data Save Lives”
Making REW operational centers on the concept that:

**Capacity Building and training are a continuous process, requiring on-the-job reinforcement and active participation.**

Recognizing and practically adopting adult learning methodologies was central to the training sessions. Some of the key elements applied included: eliciting the participant’s knowledge of the subject matter very early in the training, assigning roles and responsibilities, 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 where the facilitators presented the message using various methods in a friendly manner. This definitely induced their motivation to learn and participate.

The formal RI training begins after Steps 1 – 3. Before the training workshops begin, the JRIST identifies and trains a group of RI Master Trainers selected from senior staff from the State and LGAs. These Master Trainers, which were described earlier, assist with cluster training, and also provide the future cadre of trainers for long term capacity building in the State.

**Cluster training** involves training a small group of participants, no more than 20 participants, with 3 facilitators over a 5 day period. The NPHCDA *Basic Guide for Immunization Service Providers* serves as the reference. Depending on the number of participants, there may be several clusters in one LGA.

The five day cluster training covers the following topics:

1. NPI Target Diseases and Vaccines (Tuberculosis, Diphtheria, Pertussis, Tetanus, Poliomyelitis, Measles, Neonatal Tetanus, Yellow Fever);
2. Organizing a vaccination session;
3. Injection Safety;
4. Data Management and Tools, including vaccination coverage and drop-out monitoring chart;
5. Involving the community; and
6. the Cold Chain.

Throughout training participants are encouraged to interact. They take part in role plays, share experiences, and participate in practical sessions, such as using dolls or oranges to practice giving injections. During training, the local language is used freely by both facilitators and participants. This was found to be very effective in ensuring clear understanding of the topics. Other techniques applied to encourage participation included: role play and drama, simulation games, demonstration/return demonstrations, practicing injection techniques on dolls or fruit, and field visits.

*See Annex J for a case study on CAPACITY BUILDING: “Reaching Every Health Worker: Capacity Building and Training”*
Step 5: Increase Access to Services

Once the preliminary implementation steps 1 - 4 are in process, the LGA 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 system are established.
- Staff are trained.
- LGA map showing health facilities providing RI is drawn/updated.
- Health facility catchment areas are clearly mapped.
- Data management tools and basic vaccination equipment are available.
- LGA approval and financial support are sought.

Health Facility Catchment Area Mapping

Among steps 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 tool defines the communities being “served by” the health facility, thus helps the health facility plan and monitor immunization services for the community.

The map below shows a fictitious LGA map with various health facility catchment areas. Information on this map includes health facilities with their catchment areas clearly drawn in red lines, as well as target populations, and service delivery strategies (fixed or outreach; F or O).

An LGA Map showing Aggregated Health facility Catchment Area Maps
The highlighted red catchment area boundaries are critical as they show the health worker the communities for which they are responsible for delivering services to. Defining these boundaries together with a community is an extremely rewarding exercise, not only for health managers and workers but also for the populations being served. This joint exercise allows health personnel and community members to interact and to perform the most basic, yet critical of step for building a strong primary health care system. 7 A sample health facility catchment area map prepared with community input in Misau LGA in Bauchi State is shown on the right.

**Increasing access to RI services** is an ongoing process which cannot be accomplished by a one time effort. The requirements described above cannot be achieved Statewide rapidly. Figure 4 below shows the steady increase in access to RI services in Bauchi and Sokoto States over a three year period—but also highlights that there is a long way to go.

*Figure 4. Health facilities providing RI at least 4 times per year, January 2006 – December 2008.*

Note: Bauchi is in the process of rationalizing HFs, so denominator has changed since baseline and is being monitored by the project.

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

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Step 6: Link Services with Communities

Increasing access and utilization of health services should occur after systems strengthening and capacity building.

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

- exchange feedback and review progress;
- listen to the concerns and suggestions of each;
- plan ways to overcome local obstacles to health service utilization (drop-outs and unimmunized children); and
- seek mutual support.

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

Efforts for strengthening Community Linkages involve inviting the traditional leaders for various interactions with the LGA and health workers. In addition, training for service providers should include guidance on how to plan with the community and link up with community structures, such as village development committees (VDCs) and ward development committees (WDCs). Another way to involve communities is inviting them to be involved in updating birth registers. This can even be done at the Ward head’s house as part of a child’s naming ceremony. An accurate birth register is fundamental to addressing the issues of the unimmunized and drop-outs. Once the 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 of involving the community include: planning of outreachs and public announcements that the outreach team has arrived in the village; collecting vaccines and transporting the health worker to visit the community for scheduled outreach; and building burn and bury sites for safe injection waste disposal. Also, the MOLG, the government’s mechanism for working with community structures, should participate in planning exercises and the Mini-Reviews.

Given the relatively short life of this project of only two-and-one-half years, IMMbasics did not have sufficient time to adequately establish community linkages on a Statewide basis. Efforts focused largely on field testing in 6 of the 43 LGAs of a participatory health facility catchment area planning exercise as an entry point for strengthening community linkages.

In 2007 Bauchi State field tested a participatory health facility catchment area planning exercise in six LGAs. The Emirate system was fully involved in this exercise. This participatory process involved a series of interactive advocacy meetings at the State, LGA, district, and ward/village levels. Also, State Ministry of Health officials, Emirs, district and ward heads, LGA PHC officials, and health workers participated. Participants prepared catchment area maps by ward during community meetings.
In addition to mapping, these meetings served as a platform for communicating key immunization messages and for engaging the community in a dialogue about RI and other PHC issues.

See Annex L for a case study on LINKING SERVICES WITH COMMUNITIES: “Getting and Keeping Communities Involved in Health”

**STEP 7: Maintenance and Expansion**

**Sustaining quality RI services**

These first six steps for making REW operational actually represent only the first step. These six steps are always necessary for: updating plans, keeping health workers trained, revising tools according to developing needs, and expansion to include other PHC interventions. Any effort to strengthen RI will not last unless:

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

Assessments in Bauchi and Sokoto reveal that government funding remains inadequate for supporting RI. One of the fundamental reasons for this lies in the lack of awareness by the LGA administration on the exact funding requirements for RI. However, these 7 steps for making REW operational not only provide accurate information for budgeting, but also can lead to more cost-effective health services through planning better resource allocation, and by improving supervision and monitoring for timely detection of problems. A thorough planning process also leads to cost savings, such as a decrease in vaccine wastage.

Health workers cannot acquire and maintain a level of skill necessary to provide quality PHC services from a single, start-up workshop. Everyone needs continuous on-the-job reinforcement through support supervision and periodic refresher training from established in-service training. Also, there is a continuous flow of new health workers who must receive fundamental training. However, States have yet to establish their own structure and strategies for maintaining the skills of their health workers. Strengthening RI and revitalizing PHC requires a government driven structure which provides low-cost training for health workers, periodically and continuously.

Every system, methodology, and tool needs periodic revision to keep up-to-date with evolving needs. In addition, tasks ultimately lose value and become boring when performed over and over for months and for years. The REW approach should be expanded to benefit other PHC interventions. Like capacity building, keeping monitoring and supervision systems effective requires a long term State structure and support for reviewing and updating methods and tools.
Revitalizing Primary Health Care

The REW approach is not exclusive to immunization. All public health programs need effective planning, monitoring and supervision, increased access to services, community linkages and well trained health workers. The REW approach developed in Bauchi and Sokoto States can and should be applied within a broader and integrated context of Maternal and Child Health, such as the Integrated Maternal, Newborn and Child Health strategy. These seven steps can easily be adopted and applied for benefiting other PHC interventions and overall health services.

LESSONS LEARNED

Fundamental Principles

Rebuilding the RI system involves an ongoing effort, with strong partner collaboration and continuous capacity building. There are no short cuts. Reviving an RI system throughout a State requires two to three years of concentrated effort for the initial strengthening. However maintaining it is a continuous process which lasts forever. Factors affecting the strengthening of RI include: numerous delays due to mass immunization campaigns, logistics obstacles, strikes and political unrest, and insufficient human resources in the health sector.

All levels of the health care system must be strengthened: ward/health facility, LGA, and State. In addition to building capacity, continuous advocacy is required to ensure that the RI system is adequately funded at all levels. In addition to the SMOH or SPHCDA, the MOLG is essential for ensuring the availability of resources within the LGAs. The MOLG must be continuously engaged in the RI strengthening process.

The most critical factor in strengthening an RI system involves ensuring that quality RI services will be available and also well managed. To achieve this, it is necessary to first establish a structure and capacity for supportive supervision, even before health workers are retrained on the immunization essentials. Having a supportive supervision system in place before training provides timely mentoring and skills reinforcement after the formal classroom training.

Ownership and Participation

Participatory planning and tools development promotes ownership and commitment. It generates follow up on the objectives of plans and the results of supportive supervision visits. For example, collecting baseline information together with the LGA and health facility staff helps the health workers better understand the weak status of RI in their LGA. This leads them to prepare realistic and action oriented plans.

Health staff setting their own standards by which to be supervised results in a better understanding of the tasks which they need to perform. And, it prepares them to better meet required standards. On-the-job training and mentoring combined with supportive supervision provides a powerful re-enforcement for capacity building.
Planning and Management of Resources

It is not enough to simply introduce REW. The government and partners must also ensure that RI receives sufficient and timely financial support, particularly at the LGA and health facility levels. Some States such as Jigawa, Bauchi and Nassarawa States are focusing on advocacy with their LGA Chairmen who have budgeted monthly funds specifically for RI activities.

The concepts of REW need to be understood at all levels, right down to the ward councillors. One of the key questions with REW and any PHC intervention is how to entrench a planning culture? One way involves using a recognition approach. Recognition among peers can be used as motivation and encouragement for others to adopt good planning and management practices. LGA management teams also must realize that:

LGA management plays a critical role in both the political and the technical aspects of RI and PHC. Their actions or inactions affect other levels.

Usually, LGA PHC teams are not involved in the LGA’s budgeting process. Therefore, it is not surprising that inadequate funding, untimely release of funds, and inadequate transport for RI, outreach and other PHC activities continue to be major obstacles.

It is necessary to continuously revisit the REW concept with decision makers and program implementers, particularly because of the high staff turnover. This includes NPHCDA putting more weight on REW at higher levels and also orienting new leadership.

Increasing Access to Immunization Services

Before expanding services, it is important to first make sure that fixed services in a health facility are fully functional and friendly. It is also critical that the health workers are well trained, which includes good interpersonal communication skills, and have a clean working environment.

Obstacles preventing access to RI include: lack of trained health staff, dilapidated buildings and health worker absenteeism. The LGA must regularly maintain and renovate its existing health facilities. Low cost expenditures can result in increased access to RI services from the existing health facilities.

Increasing access requires a well defined catchment area by the health facility. This allows for easier implementation and more accurate monitoring, and also for better linkage with the community.

Supportive Supervision

If there is a realistic supervision plan with clearly defined roles, the supportive supervision system works effectively. However, to keep this component of REW functioning effectively requires adequate and timely government funding for support supervision at all levels.

Not everything can be taught during formal classroom training, or workshops. Adults learn best on-the-job and when faced with concrete problems which they need to overcome. Supportive supervision and training go hand in hand, providing the much needed reinforcement training through coaching.
There are other ways to motivate besides money. Recognition by acknowledging LGAs and health workers performing well also promotes better supervision and better performance.

Effective supervision depends on accountability. If a person is designated as a supervisor, there must be written evidence that he or she has conducted the supervision visit. Routine use of an analytical supervision check list with guidance, documenting the visit and measuring the performance, provides this accountability. The NPHCDA Deputy Director, Dr. Nuhu, States:

“Supervisors also learn from the process of supervision.
You return a better informed person.”

Monitoring for Action
Using real data during training and mentoring, which has meaning to the health worker and planners, encourages them to actively use their data. Health workers need and want training on how to analyze and use their own data, not just on filling in forms and reporting. Capacity must be built around: what to monitor; how to use data tools correctly; the importance of timely data; and how to interpret and use data for action.

Simple charts and hand drawn graphics can be used. Compiling and using data does not depend entirely on having a computer. When staff understand the value of their own data, data quality improves. Compromising on the quality of data can lead to erroneous decisions that result in disease outbreaks and child deaths, especially where coverage rates are overinflated.

Using data effectively includes discussing and reviewing it with staff, and even local leaders, at least monthly at all levels. Monitoring and analyzing data regularly help health staff track progress or stagnation, and provide opportunity for timely problem solving.

Monitoring and use of data by health staff go hand in hand for improving data quality. Training and ongoing efforts to improve data quality, such as supportive supervision and data quality spot checks are essential for a reliable and an effective reporting system. Experience from this project proves that attention to the service delivery level is critical for data quality assurance. Data quality spot checks (see Annex E) provide an opportunity for on-the-job training reinforcement and for correcting data recording and management errors. This process also complements the Data Quality Self Assessments (DQS) which is being promoted at least quarterly in the country.

Building Capacity
While projects train many health staff, they fail to strengthen long term structures for training new staff or for refresher training. A government driven structure for capacity building and for maintaining standards is especially critical given the high staff turnover in Nigeria. Participatory and
practical training should be built into a long term process and government driven system for continuous capacity building.

**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. When the health facility works hand in hand with their ward, the needs of all members in the community can be better met. Unfortunately, such collaboration can be difficult when the community and the health worker may be accustomed to receiving extra allowances from donor projects or through well funded, but temporary mass campaign events. However, in Bauchi and Sokoto States, RI services and community linkages are being strengthened without providing monetary incentives.

**CONCLUSION**

In the context of a weak Primary Health Care System, the whole package of REW’s five components provides a mechanism that can overcome barriers to better quality service delivery. Many of the components contain intentionally overlapping content. This overlap between components helps to reinforce the lessons learned in each component, which strengthens the entire PHC system.

Operationalizing REW is clearly a step-by-step process, implemented LGA by LGA, ward by ward and health facility by health facility. A systematic approach which does not skip any steps ensures a strengthened RI system. This strategy, using RI as an entry point, demonstrates a way forward for strengthening the entire PHC system in Nigeria. Applying a mentoring and coaching approach, tested tools and participatory methods ensures quality RI services for every child. This approach has a number of unique characteristics, including:

- targeting the unimmunized children;
- prioritizing very limited resources by focusing planning on the weaker performing areas;
- focusing on the LGA and downward, a truly decentralized approach; and
- flexibility for strengthening other primary health care interventions.

REW can be implemented using low technology methods. Neither costly equipment requiring maintenance systems, nor capacity beyond that of the average health facility personnel are essential. REW is particularly well suited for countries with limited resources.

Renewed efforts must focus on consistently implementing the REW strategy to address the widespread constraints of inadequate human resources and weak institutional capacity. The lessons learned and methods highlighted in this document present a practical, effective and affordable approach for implementing REW within inadequately functioning Primary Health Care systems.
ANNEX A: Statewide Baseline Assessment - Forms and Guidelines
St-1 Statewide Baseline Assessment, Public Health Facilities & Staff

This tool required the use of multiple sources of information at the LGA Headquarters to compile the data. We:

- Obtained a current and official list of the number, names and total population of every Ward in the LGA, whether or not it has a health facility;
- Collected a list of the names of all government health facilities in each Ward and the type of HF (e.g., Dispensary, Maternity, MCH, PHC etc.);
- Identified which of these Health Facilities are currently “functional” (providing health services of any kind);
- Identified which Health Facilities are “said to be” providing RI services (see documentary information from the LGA Immunization Officer (LIO) and Cold Chain Officer);
- From the personnel/human resource section, obtained the required staffing information (numbers, gender, qualification) of health system staff at each health facility listed AND at the LGA office.

Data tool template:

<table>
<thead>
<tr>
<th>LGA</th>
<th>Name of EVERY Ward (alphabetically) in the LGA</th>
<th>Total Population (2006)</th>
<th>Name of EVERY Health Facility (alphabetically) in each Ward</th>
<th>Type of Facility (e.g., Disp)</th>
<th>Functional (Yes/No)</th>
<th>Provided RI Services in 2006 (Yes/No)</th>
<th>Total Number of Staff</th>
<th>Number by Gender</th>
<th>Number by Designation</th>
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ANNEX A (cont): St-2 Statewide Baseline Assessment, Coverage Data Entry

This required reviewing monthly immunization reports at LGA level (starting from October 2005) to record the number of immunizations given (DPT 1 and DPT 3) to children under one year of age each month disaggregated by RI, Child Health Weeks and IPDs. Description:

- Available information was found in the LIO’s office but was not easy to collate (required search and organization of old files);
- The information was disaggregated (RI, Child Health Weeks, IPDs) by close reading and comparison of monthly reports. Where reports showed a major surge in a month’s comparative results, a calendar and local knowledge were used to identify the months in which the returns could be ascribed to Child Health Weeks and IPDs as opposed to RI results (NOTE: the issue of Child Health Weeks and special campaigns other than IPDs was particularly appropriate in Bauchi UNICEF-supported LGAs of Giade, Darazo and Dass LGAs but also applied to other LGAs where special “catch-up” campaigns have been held);
- The number of immunizations given (DPT1 and DPT3 under 1 year) were entered under the appropriate sections of St-2.

Data tool templates for St-2a and St-2b on following pages.
# ANNEX A-1: Data Tool Template (Coverage Data for All Services)

## ANNEX A (cont); St-2a Statewide Baseline Assessment

Statewide Baseline Assessment: Coverage Data Entry (St-2a)

| Name of LGA: __________________________ | Name of Reviewer: _______________________ | Date: ___________
|----------------------------------------|-------------------------------------------|------------------|

<table>
<thead>
<tr>
<th>ROUTINE IMMUNIZATION SERVICES ONLY</th>
<th>CHILD HEALTH WEEKS &amp; PULSES ONLY</th>
<th>IPD RESULTS ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Months/Year</td>
<td>Annual LGA Population &lt; 1</td>
<td>Number of Facilities Reporting this Month</td>
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**Statewide Baseline Assessment: Coverage Data Entry (St-2a)**

**Name of LGA: __________________________**

**Name of Reviewer: _______________________**

**Date: ___________**

**Routine Immunization Services Only**

**Child Health Weeks & Pulses Only**

**IPD Results Only**
ANNEX A-2: Data Tool Template (RI Service Data Only)

ANNEX A (cont); St-2b Statewide Baseline Assessment

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<th>Name of LGA:</th>
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**Routine Immunization Services Only**

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**State Assessment: DPT Coverage -- 3 Tables (St-2b)**

- **Routine Immunization Services Only**
- **Cumulative: Start October 2005**
- **Cumulative: Start January 2006**
- **Cumulative: Start October 2007**

**DPT-1 Given to Children < 1 Year of Age**

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**DPT-3 Given to Children < 1 Year of Age**

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**Dropout**

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### ANNEX A-3: Data Tool Template (Child Health Weeks & RI Pulses Data Only)

### ANNEX A (cont): Continuation (p2) of St-2b Statewide Baseline Assessment (Child Health Weeks & RI Pulse Data Only)

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<th>DPT-3 Given to Children &lt; 1 Year of Age</th>
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Guideline for the Mini-Review of the Routine Immunization System in an LGA

Introduction:

As the resources available do not allow start-up in all 43 LGAs of the State simultaneously, the State/IB team will initiate the effort in a phased manner. Current plans call for initiating the strengthening process in groups of three LGAs at a time (one LGA from each Senatorial District) to start one group of three LGAs approximately every quarter.

As the initiative to strengthen the RI system begins in a group of three LGAs (on a phased basis), the State/IB team organizes a sequence of “entry” activities. They are:

- a “Sensitization Meeting” held for the 3 LGAs together (for the State/IB team to introduce LGA partners to the coming effort)
- a “Mini-Review” of the status of RI in each LGA (selected components)
- a “RI Planning Workshop” in each LGA (to identify objectives, targets, steps, schedule and responsibilities for the strengthening effort)

The purpose of this document is to describe, in brief, the “Mini-Review” activity.

Objectives and Scope of the RI Mini-Review:

The objectives of the RI Mini-Review are to:
1. Instill the idea that the initiative to strengthen RI will reveal every detail of the status of RI service management in the LGA
2. Establish a systems-management baseline
3. Create a recognition of the need to change the way RI services are currently managed
4. Identify health facilities (HF) that do not provide RI services but which could (and should) provide such services.

The RI review will focus on only two operational issues:
- LGA management of the RI system
- HFs that should provide (but currently do not provide) RI services

Baseline information for the other operational issues will be obtained through the soon-to-be established:
- support supervision system; and
- local-area monitoring system
ANNEX B (Cont): Organization of the RI Review:

The RI review is to take place in each LGA immediately after the initiative to strengthen RI reaches that LGA (in the week following the introductory “Sensitization Meeting”). As soon as the Review is concluded, the collected information will be used by the LGA and partners during the LGA RI planning exercise.

The review is expected to take approximately seven (5-8) working days (depending on number of health facilities and terrain). It will be conducted by a team composed of at least four LGA staff, one IB staff (LGA Zonal Coordinator) and one staff from State level. The team will break into two sub-teams when reviewing service organization at HF level.

The preparatory and implementation steps of the review include:
- Briefing/discussion with key LGA staff during the “Sensitization Meeting” and scheduling of the review;
- Arrival in the LGA and courtesy visits to key officials
- Management review at the LGA RI office, Cold Store and RI Store
- Concurrent efforts to obtain listing of all settlements (with population) by Ward from the LG Population Commission
- Identification (using data obtained through the LGA management review) of HFs that could potentially provide RI services
- Review visits to LGA zonal cold stores (if any)
- Review visits to HFs selected as potential candidates for expansion of RI services
- Collation and analysis of data

Data Collection Instruments:

LGA Level Instruments(see following pages)
ANNEX B (Cont):

**LGA-1: 2006/07 LGA Vaccine Usage & Coverage Worksheet**

**Purpose:** obtain HF-by-HF data of DPT vaccine and numbers immunized for 2006 and 2007  
**Output:** frequency of service, coverage, drop-out rate and vaccine-usage data by HF  
**Method:**  
1. “DPT Vaccine Vials” section of the form (left-hand columns):  
   1a) Visit the vaccine cold store.  
   1b) Obtain the vaccine stock book.  
   1c) Turn to the section in the stock book for DPT.  
   1d) Find where January 2006 vaccine distribution is recorded [or the earliest month in 2006 vaccine distribution is recorded].  
   1e) Using one form per Health Facility, record ALL DPT vaccine distribution to each Health Facility.  
   1f) Record each time vaccine was distributed in a month in a different column (example, if vaccine was distributed 4 times in January, record the number of vials for each distribution in the first four columns; if vaccine was distributed to the HF only two times in that month, record the number of vaccine vials distributed each time in the first two columns).  
2. “DPT Immunizations Given” section of the form (right-hand columns)  
   2a) Go to the LIO Office.  
   2b) Obtain copies of the Health Facility reports and/or copies of LGA reports to the State for 2006 and 2007.  
   2c) Find the report for each Health Facility by month.  
   2d) Record all DPT immunizations given (by age group) by month on the assessment form for the specific Health Facility.

**LGA 2: LGA or LGA Zonal Cold Store**

**Purpose:** obtain information on the structure (availability and condition) of the vaccine distribution system  
**Output:** status report on the vaccine distribution system (capacity, condition, and current documentation of the distribution system) in the LGA  
**Method:**  
NOTE: this form is to be used only in the actual cold store for equipment presently in use or present in the cold store room; it is not for use in the “dry store” (supply storeroom).  
1. Tick the appropriate box at the top of the form (LGA Cold Store or LGA Sub-Cold Stores)  
2. Fill each row as requested to include the comments section
ANNEX B (Cont):

**LGA 3: LGA Level Review: Equipment & Supplies**

**Purpose:** obtain information on the availability and storage condition of immunization supplies  
**Output:** inventory and condition of available and/or reserve supply items (for routine use and in preparation for expanding RI services to additional HFIs)  
**Method:**  
NOTE: this form is to be used only in the “dry store” (storeroom) for unused equipment and supply and/or materials not presently in use.  
1. Tick the appropriate box at the top of the form (LGA RI Store or RI Sub-Stores)  
2. Fill each row as requested to include the comments section

**LGA 4: LGA Level Review: Data Management**

**Purpose:** identify how the LGA RI team is managing (collecting, reporting, analyzing and using) routine immunization data  
**Output:** status report on the LGA RI unit’s organization, management and use of data (to include population data)  
**Method:**  
1. The reviewer and LGA staffs read each question in turn and physically observe what is present or how the matter is being conducted.  
2. If the answer to the question is a “no,” the reviewer should write an explanatory note (use the back of the form as necessary)

**LGA 5: LGA Level Review: Support Supervision**

**Purpose:** identify how the LGA RI team is organizing supervision of activities (planning, content and reporting)  
**Output:** description of the current RI supervision system  
**Method:**  
1. The reviewer and LGA staffs read each question in turn and physically observe what is present or how the matter is being conducted.  
2. If the answer to the question is a “no,” the reviewer should write an explanatory note (use the back of the form as necessary)  
3. If the LGA uses an RI checklist, attach a copy
ANNEX B (Cont):

**LGA 6: LGA Level Review: Waste Disposal**

**Purpose:** know how the LGA is organizing the disposal of used vaccination materials

**Output:** description of the waste disposal system and its adherence to minimum standards

**Method:**
1. The reviewer and LGA staffs read each question in turn and physically observe what is present or how the matter is being conducted.
2. If the answer to the question is a “no,” the reviewer should write an explanatory note (use the back of the form as necessary)
3. The reviewer and staff will physically visit any disposal site identified

**LGA 7: LGA Level Review: Health Staff Worksheet**

**Purpose:** understand staff distribution by ward and facility for planning strengthening of service provision

**Output:** staff listed by name, sex and qualification by health facility

**Method:**
1. The reviewer and LGA staffs will obtain the names, sex and qualification of each health staff and record them legibly by health facility, by ward.
2. Wards and health facilities are to be arranged alphabetically and staff attributed to each facility AND the LGA health office.
ANNEX B-1: LGA Vaccine Usage and Coverage

LGA Vaccine usage and Coverage (LGA-1)

Name of LGA: ____________________________________

1a) Visit the vaccine cold store. 1b) Obtain the vaccine stock book. 1c) Turn to the section in the stock book for DPT. 1d) Find where January 2006 vaccine distribution is recorded [or the earliest month in 2006 vaccine distribution is recorded]. 1e) Using one form per Health Facility, record ALL DPT vaccine distribution to each Health Facility. 1f) Record each time vaccine was distributed in a month in a different column (example, if vaccine was distributed 4 times in January, record the number of vials for each distribution in the first four columns).

2a) Go to the UO Office. 2b) Obtain copies of the Health Facility reports and/or copies of LGA reports to the State in 2006 and 2007. 2c) Find the report for each Health Facility by month. 2d) Record all DPT immunizations given (by age group) by month on the assessment form for the specific Health Facility.

Ward: ____________________________   Health Facility: ___________________________   Type: ___________________________

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</tr>
<tr>
<td>March 07</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ANNEX B-2: LGA or LGA Zonal Cold Store

**LGA Level Review: LGA or LGA Zonal Cold Store (LGA-2)**

Check Appropriate Box:  
- [ ] LGA Cold Store  
- [ ] Zone Cold Store

**NOTE:** This form is for use in the cold chain only. It is not for use in the store/supply room.

<table>
<thead>
<tr>
<th>LGA: ______________________</th>
<th>Ward: ______________________</th>
<th>Location: ______________________</th>
</tr>
</thead>
</table>

#### Item | Available | TOTAL Number of Units | Condition | # Functioning | # Not Functioning | Additional Description & Comment |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Freezer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Refrigerator, solar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Refrigerator, electricity, gas or kerosene</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Cold Box</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Vaccine carrier, geostyle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Generator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Connected to the national grid?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Vaccine Distribution and Handling:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a Vaccine Stock Ledger available and in use for all the RI vaccines?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are the columns in the Vaccine Stock Ledger for the previous month filled correctly and is it up-to-date?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is the number of vials/doses recorded in the balance column the same number of vials/doses on hand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is the temperature in the refrigerator between +2 and +8 degrees C.?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is the vaccine in the refrigerator stored neatly according to shelf arrangement in the Basic Guide?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Are all the vaccines in the refrigerator NOT expired and all VVMs in Stage 1 or Stage 2?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Is there a functioning thermometer in the refrigerator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Are there sufficient frozen icepacks in the refrigerator or freezer for the next day's vaccine distribution?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Is there an up-to-date temperature monitoring chart on the vaccine refrigerator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Is there a vaccine distribution plan/schedule in the LGA/Zone? NOTE: to answer YES the distribution plan must show all Health Facilities providing RI, the day of vaccine distribution, estimated number of vials to be distributed and the responsible person for the distribution.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

**Comments on vaccine distribution and handling:**

---

*MAKING REW OPERATIONAL*  
*Page 39*
## ANNEX B-3: LGA Dry Store Equipment & Supplies

### LGA Level Review: Dry Store Equipment & Supplies (LGA-3)

LGA: __________________  Ward: __________________ Location: _________________

NOTE: this form is for use only at the LGA Dry Store Room (DO NOT list equipment currently in use in the Cold Store).

<table>
<thead>
<tr>
<th>Equipment or Supply</th>
<th>Yes/No</th>
<th>#</th>
<th>Description and Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Freezer. Chest type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Refrigerator, solar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Refrigerator, electric</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Refrigerator, gas/kerosene</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Cold Box</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Vaccine Carrier, Geostyle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Icepacks (0.3 &amp; 0.4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Icepacks (0.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Reconstitution syringes/needles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Syringe/needle (for DPT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Syringe/needle (for BCG)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Safety Boxes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. RI Posters (english)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. RI posters (hausa)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. RI registers (health facility)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. RI tally sheets (pad)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Road to Health Cards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. HF Reporting forms (pad)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. LGA Reporting forms (Monthly Summary Book)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Motorcycles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Bicycle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Generator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

Further Comments:
## LGA Level Review: Data Management (LGA-4)

<table>
<thead>
<tr>
<th>LGA: ________________________________</th>
<th>Issue</th>
<th>YES</th>
<th>NO</th>
<th>Description/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the LGA have a &quot;report-receipt&quot; monitoring chart prepared and in use for 2007 that uses the date-of-receipt system?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Is there a systematic method for filing copies of monthly reports coming from health facilities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Is there a system established for filing copies of LGA monthly reports sent to the State?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Are there copies of health facility reports available for every HF recorded on the LGA report to the State for last month?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Is the data in the HF reports the same as the data in the LGA report to the State for last month? NOTE: check three health facility reports for the previous month (one antigen) comparing the data.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Does the LGA calculate vaccine usage by Health Facility on a monthly basis?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Does the LGA have a map showing all Health Facilities by Ward that shows which HFs provide RI services?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Is there a list of settlements by catchment area of each HF showing the population that is to be covered?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Does the LGA have an annual (by month) coverage/drop-out monitoring chart for DPT prepared and on the wall for 2007?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Is any tabular or graphic analysis (feed-back) given to HFs and/or officials at LGA level on a monthly or quarterly basis?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

**Further Comments:**

---

**MAKING REW OPERATIONAL**

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### ANNEX B-5: LGA Support Supervision

#### LGA Level Review: Support Supervision (LGA-5)

<table>
<thead>
<tr>
<th>Issue</th>
<th>YES</th>
<th>NO</th>
<th>Description/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a RI supervision plan for 2007 showing schedule of supervision and responsible official?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does the LGA have a RI checklist that is used during supervision?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are there any RI supervision reports/checklists on file showing results of supervision during the last 6 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

**Further Comments:**
## ANNEX B-6: LGA Waste Disposal

**LGA Level Review: Waste Disposal (LGA-6)**

<table>
<thead>
<tr>
<th>LGA: ___________________</th>
<th>Issue</th>
<th>YES</th>
<th>NO</th>
<th>Description/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the LGA have a written plan or system for receiving or picking up used syringes/needles from HFs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Does the LGA have a plan or system for receiving or picking up used vaccine vials from HFs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Has the LGA collected any used RI syringes/needles and/or used vaccine vials in the last three months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Does the LGA have a place for incineration of RI syringes, needles and used vials?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Is the LGA place for incineration of RI syringes, needles and vaccine vials in use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Is the LGA place for incineration of syringes, needles and vaccine vials up to standard (walled/fenced, material in the pit at least one meter below ground level)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Is the material in the pit completely burned or buried with no unburned syringes/needles seen in the pit or surrounding the pit?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

**Further Comments:**
ANNEX B-7: LGA Health Staff Worksheet

LGA Level Review: Health Staff Worksheet (LGA-7)

<table>
<thead>
<tr>
<th>LGA:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Write the Ward Name* then list all Health Facilities under that Ward (alphabetically) leaving sufficient rows to write the staff names</th>
<th>Type of Facility (e.g., Disp)</th>
<th>RI Service in 2006 (Yes or No)</th>
<th>Name of Health Staff</th>
<th>Male or Female</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Surname</td>
<td>First and Middle Names</td>
<td>Junior CHEW</td>
</tr>
</tbody>
</table>

* NOTE: ensure all wards and Health Facilities are recorded whether they are providing RI or not.
### ANNEX C: Health Facility Assessment - Forms

#### ANNEX C-1: HF Staff

<table>
<thead>
<tr>
<th>LGA:</th>
<th>Ward:</th>
<th>Health Facility:</th>
<th>Type of Facility:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Health Staff</th>
<th>Gender</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
<td>First and Middle Names</td>
<td>Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Responsibility</th>
<th>Last RI Training (month &amp; year)</th>
<th>Live on Site (3)</th>
</tr>
</thead>
</table>

NOTES:
1. Main Responsibility = current major responsibility at Health Facility (e.g., antenatal care, consultation, giving injections, in-charge)
2. Last RI Training = training related to routine immunization SYSTEM (not IPD) . . . If no such training, "write "None" in the RI Training column
3. Live on Site= whether staff live in the settlement in which the Health Facility is located (Yes or No)
ANNEX C-2: HF Services

<table>
<thead>
<tr>
<th>Health Services</th>
<th>Service Presently Provided (Yes/No)</th>
<th>Service Register Available (Yes/No)</th>
<th>Register in Use (Yes/No)</th>
<th>Date of last entry in the register</th>
<th>Number of Clients Registered in the previous month</th>
<th>Number of Clients Registered in the previous three (3) months</th>
<th>Names of settlements from which clients come in the last three months (if more space is needed enter names in the back of sheet)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under-5 Clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Consultations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB and Leprosy Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE 1: Fill column (2) first before asking questions regarding each service being provided.

NOTE 2: If no register is available for a particular service, write "no" in column 3 and ask no further questions for that service.
### ANNEX C-3: HF Environment

#### Health Facility Assessment: Environment (HF-3)

<table>
<thead>
<tr>
<th>SN</th>
<th>Issue</th>
<th>Status</th>
<th>Remarks: for each question, describe the situation as found</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there a room or space (at least 4x4m) available in which routine immunization services can be provided?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is the roof that covers the immunization room or space intact (without holes)?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Does the room or space have sufficient natural light by which to easily read markings on a syringe?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Does the room or space have cross or through ventilation (does it feel airy; not stuffy)?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is there at least one table that can be used exclusively to set up immunization materials for a session?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Are there at least two chairs (one for the staff and one for the client) that is available for RI?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Are there sitting arrangements for at least 20 clients to wait for immunization?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Is the waiting area under a roof or in an area shaded from the sun?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Does the health facility have clean water source within 100m?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is there at least one functioning toilet available for client use (not locked) that is maintained?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Is there a pit already available for burning and burying medical waste?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Is the top of the material in the pit at least 1 meter below ground level?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Is the area around the facility (compound) free of medical waste and trash?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Is the health facility inside its own walled or fenced compound?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Is the fence or wall well maintained (unbroken so that animals etc. do not wander through)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Are there any groups/CBOs/VDCs that are currently assisting the Health Facility?</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

LGA:  
Ward:  
Health Facility:  
Type:  

---

MAKING REW OPERATIONAL
## ANNEX C-4: HF Cold Chain & Vaccines

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Model</th>
<th>Number of Units</th>
<th>Condition</th>
<th>Additional Description &amp; Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Freezer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Refrigerator, solar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Refrigerator, gas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Refrigerator, kerosene</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Refrigerator, electricity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Cold Box</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Vaccine carrier, geostyle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8) Generator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) Connected to the national grid?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Vaccine Distribution:**

- **Time of travel between LGA and Health Facility:**
- **Condition of road and seasonality:**
- **Closest location to which vaccine is currently distributed (travel time):**
- **Additional comments about Vaccine distribution:**
## ALKALERI LGA: LGA LEVEL ROUTINE IMMUNIZATION MANAGEMENT CHECKLIST

<table>
<thead>
<tr>
<th>S/N</th>
<th>MANAGEMENT ISSUES</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS (PLEASE USE THE BACK PAGE FOR ADDITIONAL COMMENTS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Is there a vaccine temperature chart placed on each Refrigerator and being monitored twice daily?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Are there functional thermometers in each of the refrigerator with vaccine?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Do all vaccine have readable labels?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Is there a correct and up-to date vaccine ledger?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Is there a functional stand by generator?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Are all vaccine for RI available in the cold store?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Are there corresponding diluents equal to reconstitution vaccine?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Are there frozen ice packs needed for vaccines/distributions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Is the vaccine balance in the ledger corresponding to the physical stock?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Is the dry store available and spacious?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Is there a separate ledger for dry materials with correct and up to date entries?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Are items in the dry store arranged by types of kinds?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Are there equal numbers of syringe/s equivalent to injectable vaccine/s?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Are there at least two safety boxes for each HF providing RI?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Is there a burnt and burry site for used immunization materials and being put to use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Are there HF monthly summary RI reports for all HF providing RI?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Did the reports from the HF tally with monthly reports sent to the State for the last three months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Is there DPT coverage/drop-out monitoring chart with correct/up to date entries and pasted on the wall in the cold store.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Is there poster size LGA map showing all HFs snd HFs providing RI/ major features?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Is there a supportive supervision work-plan pasted on the wall at cold store?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Is there an updated vaccine use rate monitoring chart pasted on the wall at the cold store?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Is there an updated report receipt monitoring chart pasted on the wall at the cold store.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Is there a vaccine distribution plan (indicating HFs, target pop, vaccine, gioskyle, icepacks requirement, delivery days, and responsible officer) pasted on the wall at cold store?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Is there an LGA immunization session schedule pasted on the wall at cold store ?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Is there an updated DPT coverage/drop-out monitoring chart pasted on the wall of the LGA chairman office?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>Total “Yes”</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% “Yes”</td>
<td></td>
</tr>
</tbody>
</table>

Name of reviewer: _________________________   Date of Review: _________________________
Signature: _________________________
## ANNEX D-2: Sample HF Level Supportive Supervision Checklist

**ALKALERI LGA: HEALTH FACILITY LEVEL RI SERVICE DELIVERY CHECKLIST**

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

<table>
<thead>
<tr>
<th></th>
<th>Total “Yes”</th>
<th></th>
<th>% “Yes”</th>
</tr>
</thead>
</table>

Name of reviewer: ___________________________   Date of Review: ____________________
Signature: _________________________
### ANNEX D-3: Sample HF Supportive Supervision Checklist (Completed)

<table>
<thead>
<tr>
<th>ISSUES</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS (use extra sheet if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a HF catchments area map with all the required features</td>
<td>L</td>
<td></td>
<td>Boundary map not indicated supported and corrected</td>
</tr>
<tr>
<td>posted on the wall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Did the HF have an RI poster pasted on the wall for clients to see?</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Did the HF have an RI immunization session schedule posted on the</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>wall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Are the vaccines in the Geostyle having readable label, not</td>
<td>L</td>
<td></td>
<td>No supervision on the clinic day</td>
</tr>
<tr>
<td>expired, with batch number and VVM in stage 1?</td>
<td></td>
<td></td>
<td>Police to start refilling RIs if conducted</td>
</tr>
<tr>
<td>5 Is the HF having an extra Geostyle with frozen ice packs for</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>replenishment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Did the HF have at least a place for 20 clients to sit and</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>waiting for immunization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Are the opened vaccine vials in used placed in the Geostyle foam</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pad slit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Did the Service Provider wash his/her hands before and after</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>giving immunization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Did the Service Provider administer the vaccine correctly</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>according to dose, route, site and age?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Did the Service Provider use a sterile syringe and needle</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for each antigen, each dose, and each client?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Did the Service Provider discard the used syringe and needle in</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the safety box without recapping?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Is there an up to date immunization monitoring chart pasted on</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the wall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Are the data tools (Register, tally sheet, child immunization</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>card and facility summary book) available?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Did the Service Provider enter correctly the information into</td>
<td>L</td>
<td></td>
<td>Supported &amp; corrected</td>
</tr>
<tr>
<td>the register DOR?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Did the number of children immunized in the tally sheet</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>correspond with that in the register and HF summary?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Is there available an up to date vaccine/supply book in the HF?</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Is there available record for self-assessment and</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>supportive supervision conducted in the HF?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Did the HF have a functional burn and bury pit and a person</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>assign to manage it?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Is there an evidence of minute of meeting of the</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VHDC/WHDC of the catchments area?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Is there an outreach plan with all feature posted on the wall?</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>45%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>ROUND 1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### DATA QUALITY SPOT CHECK TOOL AT THE HEALTH FACILITY LEVEL

<table>
<thead>
<tr>
<th>Name of Health Facility:</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tally Sheet</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Is there a Tally Sheet available?</td>
</tr>
<tr>
<td>2</td>
<td>Does the Tally sheet have Dates written for each session’s data?</td>
</tr>
<tr>
<td>3</td>
<td>Is there a line drawn at the end of each session on the tally sheet?</td>
</tr>
<tr>
<td>4</td>
<td>Does Column Summation at the bottom of the Tally Sheet done correctly?</td>
</tr>
<tr>
<td><strong>Immunization Register</strong></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is there a Child Immunization Register available?</td>
</tr>
<tr>
<td>6</td>
<td>Does Child Information in the Child Immunization Register filled appropriately?</td>
</tr>
<tr>
<td>7</td>
<td>Does the Child Immunization Register have Date of vaccination written in the column provided for all antigen.</td>
</tr>
<tr>
<td><strong>Health Facility Monthly Summary</strong></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Is there a Health Facility Monthly Report Summary available?</td>
</tr>
<tr>
<td>9</td>
<td>Does the Health Facility Monthly report Summary have Session Date written for each session data?</td>
</tr>
<tr>
<td>10</td>
<td>Does Column Summation at the bottom of the Health Facility Monthly report done correctly?</td>
</tr>
<tr>
<td><strong>Consistency Check</strong></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Does the number of children immunized for a specific antigen (eg DPT) in a specific session of the Tally Sheet correspond to the number of children immunized under same antigen in the Child Immunization Register?</td>
</tr>
<tr>
<td>12</td>
<td>Does the number of children immunized for a specific antigen (eg DPT) in a specific session in the Tally Sheet correspond to number of children immunized in the Health Facility Monthly Report summary under same session and antigen?</td>
</tr>
</tbody>
</table>

Name of Reviewer: ___________________________ Signature: ___________________________
ANNEX E-2: Spot Check Tool Guidance at the HF Level

**DATA QUALITY INTERVENTION AT THE HEALTH FACILITY**
*(INSTRUCTION FOR USE)*

**NOTE:** If tool is being use for data quality intervention, six month previous data and current month should be looked at.
If Random spot check is being conducted, one month previous data and current month should be looked at.
In both situation, for already submitted data, the attached format should be used to note findings or corrections and attached to the affected monitoring tool.

<table>
<thead>
<tr>
<th>S/N</th>
<th>Who is to Check</th>
<th>What to Check (Quality Indicator)</th>
<th>How to Check</th>
<th>What to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Reviewer</td>
<td>Is there a TALLY SHEET available?</td>
<td>If Tally Sheet is not sighted answer &quot;NO&quot;</td>
<td>Comment and assist the officer to obtain one from the LIO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does the Tally sheet have DATES written for each session’s data?</td>
<td>Check if session date was written with the corresponding session. If written answer “YES” if not written answer “NO”</td>
<td>Comment and assist the officer in identifying date from the health facility summary / Immunization Register and train the officer how to write date on the tally sheet.</td>
</tr>
<tr>
<td></td>
<td>Reviewer and Health Facility Personnel</td>
<td>Is there a LINE drawn at the end of each session on the tally sheet?</td>
<td>Check whether line was drawn at the end of each session. If line was drawn answer “YES” if not drawn answer “NO”</td>
<td>Comment and assist the officer in drawing lines under each session.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does COLUMN SUMMATION at the bottom of the Tally Sheet done correctly?</td>
<td>Check two or three column summations at the bottom of the tally sheet for at least two antigens, particularly DPT. If summations are done correctly answer “YES” if not answer “NO”</td>
<td>Comment and assist the officer to sum up correctly.</td>
</tr>
<tr>
<td>3.</td>
<td>Reviewer</td>
<td>Is there a CHILD IMMUNIZATION REGISTER available?</td>
<td>If Child Immunization Register is not sighted answer “NO”</td>
<td>Comment and assist the officer to obtain one from the LIO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does CHILD INFORMATION in the Health Facility Immunization Register filed appropriately?</td>
<td>Check whether child information was filled appropriately? e.g. Card Number, Name, Sex, Address and Date of Birth if entered correctly (NOT AGE) in the column “DOB” answer “YES” if not answer “NO”</td>
<td>Train the Officer to ask mothers the age of their children and probe (relating to any major event, eg festivities) to determine the actual date, month and year also on correct filling of the child information (Card no. Name, Address, Sex).</td>
</tr>
<tr>
<td></td>
<td>Reviewer and Health Facility Personnel</td>
<td>Does the Immunization Register have DATE OF VACCINATION written in the column provided for all antigens?</td>
<td>If date of vaccination/doses is written then answer “YES” or if “TICK” is used then answer “NO”</td>
<td>Train the officer on how to write date of vaccination in the appropriate column.</td>
</tr>
<tr>
<td></td>
<td>Reviewer</td>
<td>Health Facility Monthly Report Summary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------</td>
<td>----------------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Reviewer</td>
<td>Is there a HEALTH FACILITY MONTHLY REPORT SUMMARY available?</td>
<td>If Health Facility Monthly Summary not sighted answer &quot;NO&quot; and comment.</td>
<td>Comment and assist the officer to obtain one from the LIO</td>
</tr>
<tr>
<td></td>
<td>Reviewer and Health Facility Personnel</td>
<td>Does the Health Facility Monthly report Summary have SESSION DATE written for each session data?</td>
<td>Check if session date was written with the corresponding session. If written answer &quot;YES&quot; if not written answer &quot;NO&quot;</td>
<td>Comment and assist the officer in identifying date from the Tally Sheet and train the officer how to write date on the Health Facility Summary.</td>
</tr>
<tr>
<td></td>
<td>Reviewer and Health Facility Personnel</td>
<td>Does COLUMN SUMMATION at the bottom of the Health Facility Monthly report done correctly?</td>
<td>Check one or two column summation at the bottom of the Health Facility Monthly report summary for a particular antigen e.g. DPT-3. If summations are done correctly answer &quot;YES&quot; if not answer &quot;NO&quot;</td>
<td>Comment appropriately and assist the officer to sum up correctly.</td>
</tr>
<tr>
<td></td>
<td>Reviewer and Health Facility Personnel</td>
<td>Does the number of children immunized for a specific antigen (e.g. DPT) in a specific session of the TALLY SHEET correspond to the number of children immunized under same antigen in the CHILD IMMUNIZATION REGISTER?</td>
<td>Check if total vaccination for a specific antigen (DPT) in a specific session of the tally sheet correspond to number of children immunized for the same antigen in the Child Immunization Register and answer &quot;YES&quot; if it does not correspond answer &quot;NO&quot;</td>
<td>Comment and train the officer on how to correctly enter vaccinations given into the Tally Sheet and Child Immunization Register.</td>
</tr>
<tr>
<td>7</td>
<td>Reviewer and Health Facility Personnel</td>
<td>Does the number of children immunized for a specific antigen (e.g. DPT) in a specific session in the TALLY SHEET correspond to number of children immunized in the HEALTH FACILITY MONTHLY REPORT SUMMARY under same session and antigen?</td>
<td>Check at least two session entries (row) in the health facility monthly summary and compare with the corresponding summation in the tally sheet. If records match answer &quot;YES&quot; if not answer &quot;NO&quot;.</td>
<td>Comment and train the officer on how to correctly enter vaccinations given into the tally sheet and transfer into the monthly summary at the end of the day’s session.</td>
</tr>
</tbody>
</table>
## ANNEX E-3: Spot Check Tool at the LGA Level

### DATA QUALITY SPOT CHECK TOOL AT THE LGA LEVEL

<table>
<thead>
<tr>
<th>S/N</th>
<th>QUALITY INDICATOR</th>
<th>YES</th>
<th>NO</th>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there a Filing System for all Health Facility Monthly Reports?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Does the number of children immunized in the Health Facility Monthly Summary for a specific antigen in a specific health facility correspond to number of children immunized for the same antigen and same Health facility in the LGA Monthly Report Summary?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Is there an LGA Monthly Report Summary available?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Does the LGA Monthly Report have Name of Wards, Health Facility and Reporting Month written correctly?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Does the Wards Sub-Totals in the LGA Monthly Report done correctly?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Does the Grand Total of children immunized for a specific antigen correspond to the sum of individual Sub-Totals of same antigen in the LGA Report Summary?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of Reviewer: ___________________________  Signature: ___________________________
### ANNEX E-4: Spot Check Tool Guidance at the LGA Level

#### INTERNAL DATA QUALITY INTERVENTION AT THE LGA
**(INSTRUCTION FOR USE)**

**NOTE:** If tool is being used for data quality intervention, six months previous data and current month should be looked at.

If random spot check is being conducted, one month previous data and current month should be looked at.

In both situations, for already submitted data, the attached format should be used to note findings or corrections and attached to the affected monitoring tool.

<table>
<thead>
<tr>
<th>S/N</th>
<th>Who is to Check</th>
<th>What to Check (Quality Indicator)</th>
<th>How to Check</th>
<th>What to do</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Filing System:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Reviewer</td>
<td>Is there a FILING SYSTEM for all health facility monthly reports?</td>
<td>Check if the LGA has a filing system for health facility monthly summary by month and by wards, answer “YES” if not answer “NO”</td>
<td>Comment and train the LIO on how to file health facility records appropriately.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Health facility Monthly summary and LGA Monthly Summary:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Reviewer</td>
<td>Does the number of children immunized in the HEALTH FACILITY MONTHLY SUMMARY for a specific health facility correspond to number of children immunized for the same antigen in same health facility in the LGA MONTHLY SUMMARY</td>
<td>Check for at least 5 health facilities the total number of children immunized under a specific antigen (DPT) for a specific health facility if it correspond to the same health facility’s data in the LGA summary, if it correspond answer “YES” if not answer “NO”.</td>
<td>Comment and train the LIO on how to transcribe correctly.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>LGA Monthly Summary:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Reviewer</td>
<td>Is there an LGA MONTHLY REPORT SUMMARY available?</td>
<td>If LGA Monthly Summary is not sighted answer “NO”</td>
<td>Comment and inform the PHC Director.</td>
</tr>
<tr>
<td>2.</td>
<td>Reviewer and LIO/CCO</td>
<td>Does the LGA Monthly report have name of WARDS, HEALTH FACILITY and REPORTING MONTH written correctly?</td>
<td>Check if the reporting month and correct name of wards and health facilities are written answer “YES” and if not answer “NO”</td>
<td>Comment and train the officer to correctly indicate the month and name of wards and health facilities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does wards SUBTOTALS in the LGA Monthly Report done correctly?</td>
<td>Check if wards sub-totals are correct by summing up entries for health facilities in those wards and crosscheck with the written subtotals, if they correspond answer “YES” if not answer “NO”</td>
<td>Comment and train the officer to correct the summations and documents appropriately.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does the GRAND TOTAL of children immunized for a specific antigen correspond to the sum of individual SUB TOTALS of same antigen in the LGA Report Summary?</td>
<td>Check if the LGA grand total is correct by summing up the individual sub-totals and compare with the written grand total, if it correspond answer “YES” if not answer “NO”</td>
<td>Comment and train the officer to correct the summations and documents appropriately.</td>
</tr>
</tbody>
</table>
ANNEX F: RED Quick Reference

<table>
<thead>
<tr>
<th>1. Planning and Management of Resources</th>
<th>2. Reaching the Target Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Human, material and financial)</td>
<td>&quot;Reaching the target populations&quot; 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.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Linking Services with Communities</th>
<th>4. Supportive Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Regular on-site teaching, feedback, and follow-up with health staff)</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Monitoring for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Self-monitoring, feedback and tools)</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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ANNEX G: Case Study on Planning and Management of Resources

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 emphasizes micropotential 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.

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 Aliyu Musa, RMNbasics.

(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 BA2PhCDA 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 Bako. "We do our best to follow up on those 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.
ANNEX H: Case Study on Supportive Supervision

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.

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)

Photo by Dr. Zainab Mohammed, IMMbasics: Proper vaccination techniques can be maintained through regular support supervision visits.
Support supervision rounds can both improve data quality and increase employee job satisfaction. Photo: Dr. Zainab Mohammed, IMM basics.

(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 fact-finding.

- **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 Chairman 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 SPHCCA 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 I: Case Study on Monitoring for Action

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!

and 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.

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 roots. 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.

(Continued on page two)
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)

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2007</td>
<td>16</td>
</tr>
<tr>
<td>December 2007</td>
<td>31</td>
</tr>
</tbody>
</table>

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.

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

**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
ANNEX J: 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)
- LGAs 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 (LCA 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.
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 tools, 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.

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 K: Case Study on Increasing Access

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 SMC/ 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)
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!”

This health worker is examining how to reach all of the community members that her health facility needs to serve. Photo: IMRIbasics Nigeria.
ANNEX L: Case Study on Community Linkages

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 the exercise was finished. What can be done to maintain community linkages? (Continued on page two)

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

MAP OF BAI LGA SHOWING HEALTH FACILITIES, MPS PROFICIENCY R1

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 figures or census under one year
- Health facilities providing routine immunization services, including outreach sites
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

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

Local committees can play a strong role in routine immunization, if they meet regularly.

Photo: Ahmed Naja, MinBasics.

(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 health person, traditional leader, religious leader, 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!)