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IMMUNIZATIONbasics NIGERIA
End of Project Review Report

24 March – 7 April 2009

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ACRONYMS AND ABBREVIATIONS

BaSPHCDA	Bauchi State Primary Health Care Development Agency
CBO	Community-Based Organization
CCO	Cold Chain Officer
COMPASS	Community Participation for Action in the Social Sector (a USAID project)
DPHC	Director Primary Health Care
DPT	Diphtheria-pertussis-tetanus vaccine
DSNO	Disease Surveillance and Notification Officer
EU PRIME	European Union Partnership to Reinforce Immunization Efficiency
HE	Health Educator
HF	Health Facility
HW	Health Worker
IMMbasics	IMMUNIZATIONbasics (a USAID project)
IPD	Immunization Plus Days
LGA	Local Government Area
LIO	Local Immunization Officer
LZC	LGA Zonal Coordinator (an IMMbasics staff position)
M&E	Monitoring and Evaluation
MOLG	Ministry for Local Government
MOWA	Ministry for Women's Affairs
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PRRINN	Partnership for Reviving Routine Immunization in Northern Nigeria (a DFID project)
RED	Reaching Every District
REW	Reaching Every Ward
RI	Routine Immunization
SIO	State Immunization Officer
SMOH	State Ministry of Health
SMOLG	State Ministry for Local Government
SPHCDA	State Primary Health Care Development Agency
SS	Supportive Supervision (a component of the REW approach)
TBA	Traditional Birth Attendant
TISS	Task Identification and Standard Setting
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
VPD	Vaccine Preventable Diseases
WDC	Ward Development Committee
WHO	World Health Organization

EXECUTIVE SUMMARY

In October 2006 IMMUNIZATIONbasics Nigeria (IMMbasics) began a project to strengthen Routine Immunization (RI) in Bauchi and Sokoto States. Near the end of the project, between 24 March and 7 April 2009, a team representing: the National Primary Health Care Development Agency (NPHCDA), Ministry of Local Government (MOLG), Ministry of Women's Affairs (MOWA), Sokoto State Ministry of Health (SMOH)/Bauchi State Primary Health Care Development Agency (BaSPHCDA), IMMbasics and consultants, carried out a review of the project. This review focused primarily on documenting the achievements and the remaining gaps for strengthening Routine Immunization in Bauchi and Sokoto States. The review consisted of a desk review of project monitoring data, key informant interviews, and onsite observations where possible at national, state, Local Government Area (LGA) and health facility levels. Interviews followed the five components of the Reaching Every Ward (REW) approach: (1) Planning and Management of Resources, (2) Increasing Access to Services, (3) Monitoring for Action, (4) Supportive Supervision, and (5) Community Linkages; as well as Capacity Building. The review team visited 18 randomly selected LGAs and 39 health facilities in the two states.

At the national level there was high praise for IMMbasics' contribution to strengthening RI, as well as their coordination with partners. IMMbasics has established an influential presence at the decision-making level. However, the immunization partners all agreed that the project's timeline was too short to firmly establish all of the REW components required to strengthen RI.

State health officials in both Bauchi and Sokoto praised IMMbasics' participatory and gradual step–by-step approach for planning and capacity building. They value their newly developed cadre of RI Master Trainers and Peer Motivators, who can now carry forward with capacity building. Both states have established committees for RI and are increasing financial support. However, financial support remains insufficient at state level to adequately meet the needs for supervising RI services. At the state level there is growing interest in integrating RI support supervision with other primary health care (PHC) activities, but also concern over the gap which will be left with the departure of IMMbasics.

In terms of **Planning and Management of Resources,** 17 of the 18 LGAs visited had up-to-date RI plans, which include: maps, vaccine distribution plans, and support supervision schedules. Nearly all health facilities had up-to-date catchment area maps and RI session schedules posted. Although there has been some improvement with LGA financial support for RI, funding remains mostly inadequate and irregular.

Access to Immunization Services is showing a steady increase in both states. Both LGAs and health facilities are directing more effort on improving immunization coverage in the hard-to-reach areas. But, lack of skilled health workers remains a major obstacle for Reaching Every Ward. Up-to-date immunization coverage and drop out **monitoring** charts were found in 36 of the 39 health facilities visited. But more work remains to ensure that all health workers fully understand and utilize this monitoring data.

Health workers highly appreciate the **Supportive Supervision** visits from the LGA teams, which they feel also contributes

to sharpening their skills. Some LGAs have now reached a sufficient level for conducting support supervision visits without the assistance of IMMbasics staff. However, most LGAs still do not provide sufficient funding for maintaining routine supervision over health facilities.

For **Community Linkages**, there is increasing activity on promoting community participation in various LGAs and health facilities. But the project primarily focused on systems strengthening and building capacity to manage and provide quality RI services, and therefore, the two-and-one-half years lifespan of the project was not sufficient for systematically developing the community linkages component of REW.

The review team concluded that the project has built **Capacity** at State, LGA and health facility levels for managing and monitoring RI. In addition, there is now a cadre of RI Master Trainers at the state level for continuing the capacity building effort. However, a well-defined government plan, structure, and budget still do not exist in either state for training new staff and for refresher training after the end of IMMbasics.

The Review team recommends that the MOLG and LGA health teams should increase their advocacy with LGA chairman for adequate and regular funding for RI services. In terms of monitoring, the team urges the government and immunization partners to adopt the practice of separating the reporting and analysis of Immunization Plus Days (IPD) and RI data to ensure more accurate monitoring of the RI system. They also encourage even greater use of the monitoring data by routinely producing graphs at LGA level ranking health facility performance. To further enhance the sustainability of support supervision, the review team recommends that the LGAs take a leading role in providing the supervision and monitoring tools. In addition, they urge state and LGA government officials to provide adequate funding for support supervision. Now that quality RI services are being established, the Team recommends increasing efforts on promoting community linkages and participation. Finally, the Team emphasizes the need for the State to put in place and fund a long term structure for maintaining capacity building of heath staff, utilizing to full potential their cadre of Master Trainers.

The IMMbasics project has developed an effective and affordable process for strengthening RI. This approach can also be applied for strengthening other PHC interventions. However, the two-and-one half years lifespan of the project was not sufficient for all of the five REW components to achieve full maturity. More work remains for full maturation of the RI strengthening process in these two states and to expand the effort to other States. But from early indications, the process is clearly achieving its intended objectives. The Team encourages the Federal Government of Nigeria, USAID and other partners to continue to support the effort on strengthening RI in Sokoto and Bauchi States, as well as to promote national use of the tools, methods and approach developed by IMMUNIZATIONbasics Nigeria for strengthening RI.

INTRODUCTION

IMMUNIZATIONbasics/Nigeria (IMMbasics) began a project in October 2006 to strengthen Routine Immunization (RI) in northern Nigeria. The project worked with international partners and relevant government agencies at both the national level and in two northern states, Bauchi and Sokoto. The project aimed at strengthening both human resource and system capacities for improved delivery of RI services following Nigeria's REW (Reaching Every Ward) guidelines, which was adapted from WHO's RED (Reaching Every District) approach for improving RI. The project had a short lifespan, only two-and-one-half years.

Background on IMMUNIZATIONbasics/Nigeria

IMMbasics worked in collaboration with the State Ministries of Health and Local Government to strengthen LGA management skills and health workers' capacity to deliver quality RI services. Considering the limited resources and the very weak PHC system, the project aimed at sharing best practices and low-cost sustainable solutions. The project focused on capacity building and system strengthening. The primary objectives of the project included:

1. promoting regular distribution of vaccines and vaccination supplies to service delivery points;
2. increasing and sustaining optimal attendance during routine immunization sessions;
3. improving data quality and use at LGA and health facility (HF) levels; and
4. increasing service delivery points providing routine immunization.

To strengthen RI, a State and IMMbasics team followed the NPHCDA's Reaching Every Ward (REW) methodology, which was adapted from WHO's Reaching Every District (RED) approach. The project aimed at covering all LGAs in the two states using a phased approach, by initiating activities in approximately 3 to 4 new LGAs per State on a quarterly basis. At the time of this review, April 2009, all of the wards in all LGAs in both states were fully involved in the project's RI strengthening process, with the final phase of newly-entered LGAs beginning in June 2008 in Bauchi and in September 2008 in Sokoto. The project was staffed in each state with one State Coordinator, one Finance/Administrative Assistant and three LGA Zonal Coordinators (LZC); one LZC was assigned per each of the State's three political senatorial zones.

Reaching Every Ward - REW

IMMUNIZATIONbasics worked with the State Ministry of Health (SMOH) in Sokoto and the State Primary Health Care Development Agency (SPHCDA) in Bauchi by technically supporting implementation of the REW components. These components also served as the structure for this project review, and include:

1) *planning and management of resources*
2) *improving access to immunization services*
3) *monitoring for action*
4) *supportive supervision*
5) *linking services with community*

Because baseline findings confirmed that both states had very weak RI systems, the project concentrated efforts first on strengthening LGA RI management. The project then moved to the

health facility level to strengthen capacity and to increase access to RI services. After establishing a minimum standard of quality service in all of the LGAs in these two states, IMMbasics planned to focus attention on the demand side—the community linkages component of REW. The details of the project's approach for strengthening RI can be found in the Project Review Report released in September 2008 ("IMMUNIZATIONbasics Nigeria Project Review, 27 August – 9 September 2008"). In addition, the project has prepared a document*, Making REW Operational: a step toward revitalizing PHC in Nigeria,* which describes the entire approach[1].

END OF PROJECT REVIEW OVERVIEW

Purpose

The IMMbasics End Of Project Review was carried out between 24 March and 7 April. The purpose of this End of Project Review was twofold: (1) to review the overall level of implementation of the project's process for strengthening both health workers' capacity and the RI system, and (2) to document key lessons learned for dissemination to RI partners for continuing and expanding the effort to strengthen RI in Nigeria. The objectives included the following.

Objectives

1. To help IMMUNIZATIONbasics (IMMbasics)/Nigeria review life of project achievements in routine immunization systems strengthening and 'operationalizing' the Reaching Every Ward (REW) approach in Bauchi and Sokoto States.

2. To review the project's approaches and interventions in their implementation context. Areas for review include: supportive supervision; community linkages; monitoring and use of data; and planning and management of resources.

3. To learn from the project implementation so that lessons can be drawn that can be the basis for instituting improvements to project planning, design and management for sharing with partners and for future projects.

4. To measure project achievements and outcomes, both positive and negative, in relation to baseline indicator measurements.

Methodology

The IMMbasics End of Project Review was carried out by a team consisting of members from: NPHCDA, SMOH/BaSPHCDA, MOLG, MOWA, four external consultants, and IMMbasics staff from both Nigeria and the USA headquarters office. Three of the consultants also participated in the Project Review conducted in September 2008 six months prior to this End of Project Review. The team was divided into six groups and visited 9 LGAs (3 LGAs per senatorial zone) for a total of 18 LGAs in the two states. The LGAs were randomly selected. Two to three health facilities were visited in each LGA, for a total of 39 health facilities.

Team members conducted key informant interviews and took notes on unstructured observations at the LGA and in health facilities. In the health facilities the officers in charge and the RI service providers were interviewed. In the LGAs the RI team members such as the LGA Immunization Officer (LIO) and Cold Chain Officer (CCO) were interviewed, and other senior LGA health staff when available. At State level, one group of team members interviewed representatives of the SPHCDA, the SMOH, the Director of PHC, the State Immunization Officers (SIOs), State CCOs, the MOLG

[1] See http://www.immunizationbasics.jsi.com/Docs/Making_REW_Operational.pdf

Director for PHC, and Monitoring & Evaluation (M&E) and Data Management officers. At the national level the team interviewed key persons from the RI partners at the national level, including: USAID, the NPHCDA, WHO, UNICEF, the USAID-funded COMPASS project (Community Participation for Action in the Social Sector), the DFID-funded PRRINN project (Partnership to Revitalize Routine Immunization in Northern Nigeria), and the EU PRIME project (European Union Partnership to Reinforce Immunization Efficiency). Project monitoring data were used for supplementing the qualitative information collected during the reviews. The list of review team members is found in Annex A.

To provide uniformity and completeness of information, team members were provided an interviewing guide (Annex D) and then considerably refined interview guides for national, state, LGA, health facility and community levels (Annexes E, F, G, H and I, respectively). The list of the persons interviewed is found in Annex J and LGAs and HFs visited in Annex C.

At the end of each day of field work, each team group prepared a daily summary of their findings and observations. Team members were then assigned a REW component to summarize the group findings according to the strengths and areas needing strengthening, as well as proposed recommendations. After preparation of the state review summary, the review team and the state IMMbasics staff discussed the findings. Findings and recommendations were then presented to State health officials in the respective states. In addition, the review team later reviewed and combined the state findings and recommendations for presentation to the CORE group in Abuja.

SUMMARY OF KEY FINDINGS

The findings and observations reported by the individual team members were consistent among the team. The following summarizes their key findings at National, State, LGA and health facility levels. As the project's primary focus was on LGAs and health facilities, the findings for these levels are presented according to the 5 components of REW: *(1) planning and management of resources; (2) improving access to immunization service delivery; (3) monitoring for action; (4) supportive supervision; and (5) linking services with community.* Unless otherwise noted, the findings mentioned below apply to both Bauchi and Sokoto States.

National Level Key Findings, NPHCDA and Partners

Positive findings

- The project follows reality, making efficient use of the existing resources.
- The project has done a good job raising specific data quality issues concerning RI monitoring and reporting. Also, the Project's database has been helpful for Partners.
- IMMbasics has found ways to share their best practices based on field work at the national level, such as how to make support supervision more systematic and better documented.
- The project tries to do everything according to state's policies and capacity, and in a participatory manner. IMMbasics collaborates well with partners.

Areas needing strengthening

- States seem less involved when donors and partners come in and do things without proper consideration of ownership.
- Partner coordination at state level does not always trickle down to LGA level coordination; sometimes there are competing activities in the same LGA.

- Project implementation timeline was too short; many of the LGAs need more focused mentoring to firmly establish things like supportive supervision, use of peer motivators as trainers and mentors.

"You cannot deliver immunization in isolation. It must be done within the context of all PHC needs." NPHCDA – Zonal Staff

State Level Key Findings

Positive findings

- Health Officials in both states praised IMMbasics participatory, gradual, and step-by-step, approach for planning and capacity building. They also appreciate the new cadre of RI Master Trainers which can now carry forward with capacity building.
- Support from the state for RI is improving. Bauchi now has a budget line item for RI support supervision and has provided 84 motorcycles with N20,000 per month per motorcycle for maintenance and operation. In Sokoto the Governor has informed all LGAs to provide N100,000 per month for RI support, although the mechanism for doing this is still being determined. The MOLG in Sokoto has provided computers to the LGAs, which can be used to further improve monitoring of RI.
- Partnerships for RI have been strengthened in both states. Bauchi has established a stake holders–partner coordination unit with an appointed coordinator. This unit meets monthly. In Sokoto a Health Sector Partners forum was established in February 2009.
- Involvement by the MOLG is increasing. The MOLG has participated in the RI planning and capacity building exercises.
- In both states the MOLG, LGA chairmen, and other key groups, traditional and religious, are becoming more aware and involved in RI, in part due to IMMbasics advocacy at state and LGA levels. This effect is even more pronounced in Bauchi.

Areas needing strengthening

- The end of IMMbasics will leave a big gap for RI. Other donors are more diverse and therefore will devote less attention to RI.
- The MOLG should be even more involved and should be the entry point for community linkage strengthening.
- Mechanisms and funding for hiring new staff are still a problem. In addition, it is difficult to keep younger staff, who tend to leave after being trained.
- Funding for RI, although improved, remains inadequate and uncertain.
- Support supervision for RI has improved, but a more MCH integrated approach and check list are needed.
- More work is needed to improve the community's trust of the health services.

LGA and Health Facility Level Key Findings

The following summarizes the review team’s key findings at both LGA and health facility levels. These findings are presented according to the five components of REW: (1) Planning and Management of Resources, (2) Increasing Access, (3) Monitoring for Action, (4) Supportive Supervision, (5) Community Linkages, and an added area on Capacity Building.

Planning and Management of Resources

Positive findings

- LGA RI plans, which include: maps, vaccine distribution plans, and supportive supervision schedules were up-to-date and displayed in 17 of the 18 LGAs visited.
- Nearly all HFs have up-to-date maps and RI session schedules posted, and they are using their maps for identifying hard –to-reach communities.
- Involving all PHC staff in the planning process from the beginning generated more active participation and interest during training.

- LGAs are allocating between N5,000 to N130,000/month for RI, although most LGAs are allocating only from N30,000 to N50,000 per month. The task force on immunization in Sokoto State determined that at least N100,000 per month is necessary for maintaining RI in an LGA.

Areas needing strengthening

- Inadequate funding, an insufficient number of skilled staff, and staff turn over are major constraints to the implementation of RI plans.
- Irregular release of RI funds by the LGA causes delays in implementation of the plans, and also impacts negatively on health worker morale.

“Before promoting any intervention, RI etc. the human resource problem in the health sector must be solved. How can you have a sustainable and effective health service when facilities lack equipment and staff, and the staff are not paid or supported?” An international partner

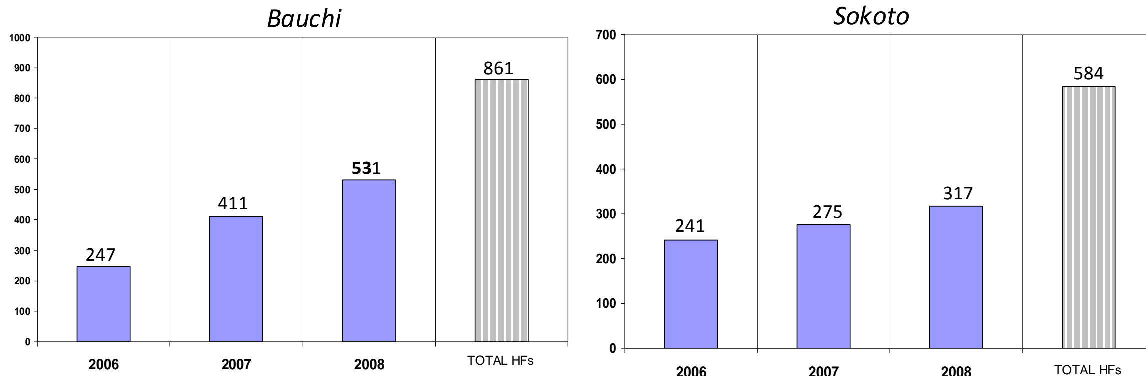
Increasing Access

Positive findings

- All of the 18 LGAs visited continue to increase the number of HFs providing RI. Reported data from each state supports the review team’s findings. (Note: The definition of RI used by the Review team and by IMMbasics was “providing immunization at the facility 4 or more times per year.”)
- The frequency of RI services ranges from 1 to 8 times per month in the health facilities visited.
- LGAs have established satellite cold stores in Bauchi to improve vaccine accessibility.
- LGA teams and health workers (HWs) have identified hard to reach areas, and are directing more attention to these areas with outreach and mobilization. Some HFs have adjusted their

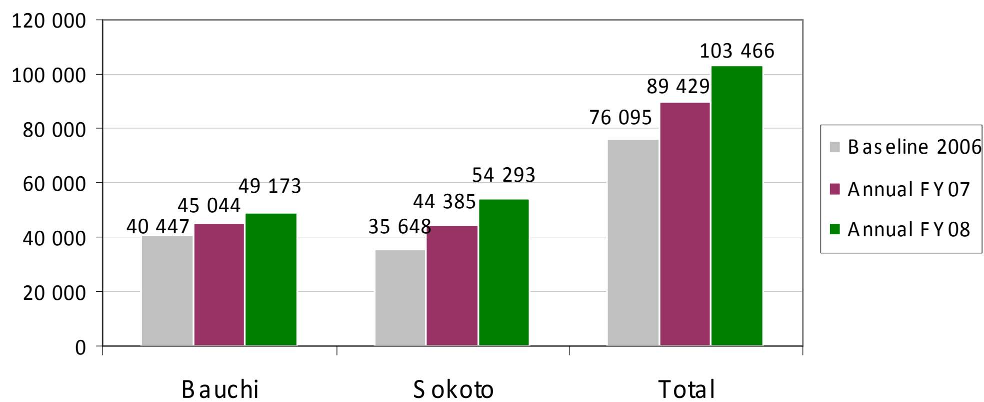
RI session schedules to fit the convenience of their communities. The RI session schedule in one health facility was displayed in 4 different local languages, which reflects an effort to meet the needs of the diverse groups in the catchment area.

Figure 1: Number of 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

Figure 2: Number of children under 1 year immunized with DPT3, reported by fiscal year, not including Immunization Plus Days (IPDs). Because of a focus on improving data quality, the project has not expected to see significant immediate improvement in coverage data.



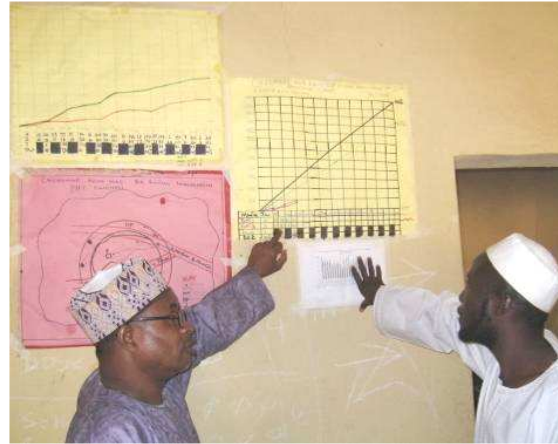
Areas needing strengthening

- Inadequate number of skilled HWs and funding for RI services continue to pose a serious obstacle for increasing access and for realizing the goal of: **R**eaching **E**very **W**ard.
- Logistics and funding gaps continue to be major constraints for supporting most existing planned outreach services.

Monitoring for action

Positive findings

- Monitoring charts were up-to-date and displayed in all of the 18 LGAs and in 36/39 HFs visited. Most of the LGAs and HFs display their catchment area maps.
- Based on their discussions with HWs and their observations, the review team believes that the process, tools, and methodology for improving the monitoring of immunization services in the two states are well established and can be adapted for uptake nationwide.
- The LGA and HF ranking charts for coverage and drop out rate, and the support supervision scores are very useful feedback for health staff, as well as local officials.

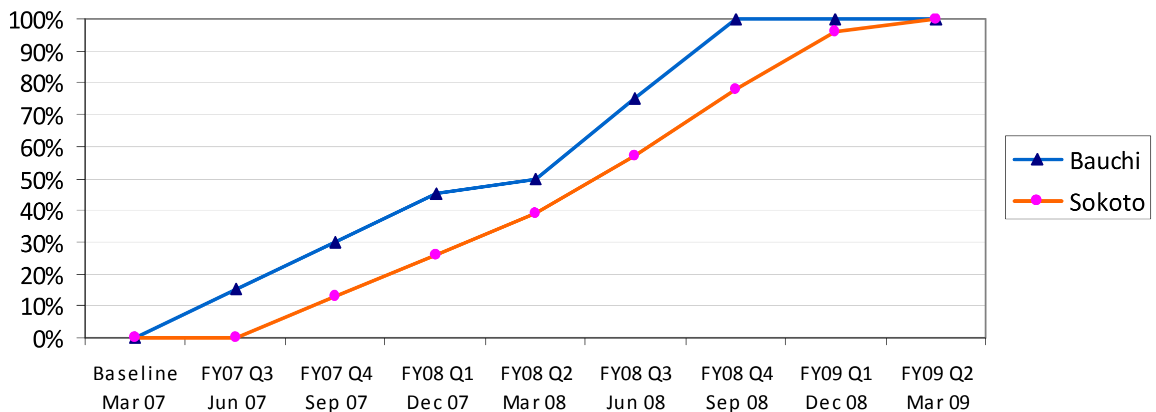


Reviewing HF data on an updated monitoring chart; note best practice of keeping prior year chart for comparison (top left of picture).

- HFs and LGAs attribute improvements in quality and use of data to supportive supervision, the data quality assessment process, and the monthly meetings where their data are discussed.

"The project did a good job in both states of focusing on good data, and helped the states take an important step in making the data more honest; this is just the beginning of quality data, but it is a good beginning." NPHCDA – Zonal Staff

Figure 3: Percent of LGAs with up-to-date monitoring charts displayed, by fiscal year quarter. (Cumulative DPT monitoring and dropout charts.)



Areas needing strengthening

- Understanding of the coverage chart varies greatly among health workers. More follow up is required to ensure that everyone understand and use the chart as a working advocacy tool, particularly at the HF level.
- Although there are indications of a decline in drop outs in many HFs, drop out rates are still high, well above 10%. Left Outs are also too high as well.

- Although great strides have been made on improving monitoring, data quality, and the use of data; the structure in the BaSPHCDA and the SMOH for maintaining effective monitoring remains fragile.
- Some LGAs have computers, but their use varies greatly and is dependent on LIO/CCO computer skills.

Supportive Supervision

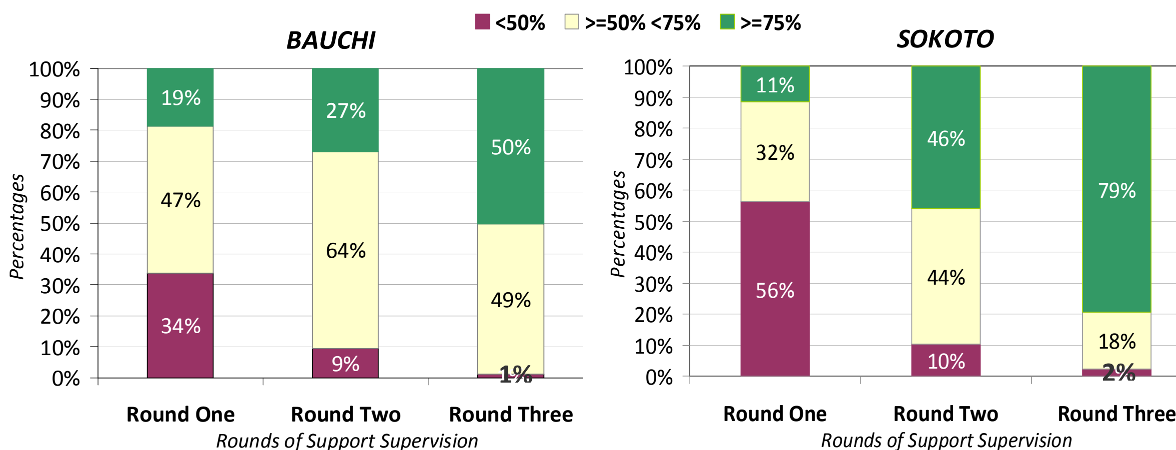
Positive findings

- Supportive supervision is much appreciated by HWs in the LGAs and HFs, and has contributed to improving the quality of service delivery.
- Support supervision skills, documentation, use and application of relevant data tools by the LGA teams have improved.
- LGA Support Supervision responsibilities are being shared by the entire LGA PHC team.
- LGA and service providers mentioned improved teamwork and coordination, and better working relations with other units of the PHC Department as benefits of conducting supportive supervision (SS) as a team.
- Non-RI focal persons on SS teams, such as health educators, maternal and child health staff, and M&E officers, also reported benefits of participating in SS. Benefits mentioned included improved communication skills and better documentation of RI and other PHC activities.

Areas needing strengthening

- Management of transport resources and funding for SS were identified as the major bottlenecks for effective supervision of RI.
- Documentation at LGA and HF levels on all SS visits in the form of copies of the check list is inadequate. Overall, the team did not observe check lists on file according to the number of SS visits mentioned during interviews, especially in Bauchi.
- Sustaining the SS process in the states beyond the life of the project is a source of concern, especially from the LGA to HFs.
- Self Assessment by using the check list at both LGA and HF levels is not being done regularly in HFs.

*Figure 4: 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.*



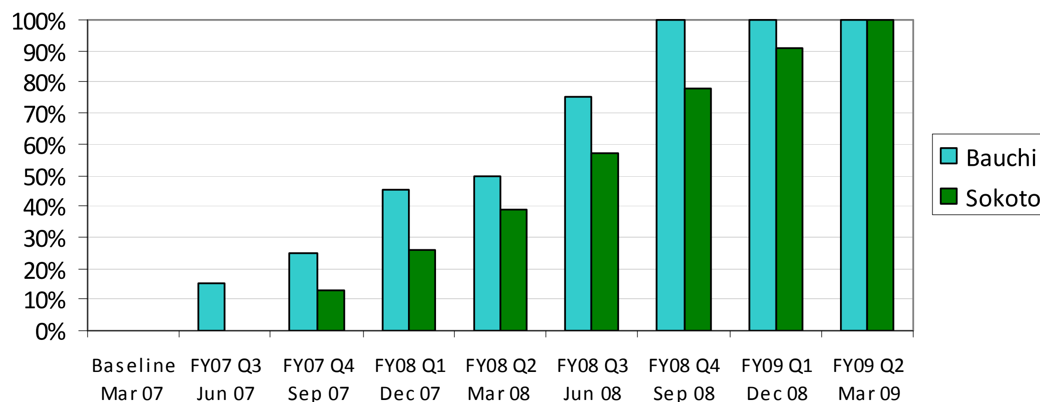
Community Linkages

It is important to note that the project first focused on building the capacity of LGAs and HFs to manage and deliver quality RI services. The next step was to promote community involvement in RI to optimize the use of quality RI services. However, the Project did not have enough time or resources within its two-and-one-half years lifespan to sufficiently promote the Community Linkages component of REW.

Positive findings

- Activities strengthening community linkages have noticeably increased, through increased collaboration with the LGAs and partners.
- District heads in many LGAs have met with their village heads urging them to mobilize their communities for RI and IPDs.
- Some traditional and religious leaders, communities (through Ward Development Committees and Village Development Committees, or WDCs and VDCs) and Traditional Birth Attendants (TBAs) are involved in mobilization for RI, and to a lesser degree in catchment area mapping, outreach scheduling, digging burn and bury sites.
- In some wards, TBAs have been trained to refer newborns to HFs for RI.
- In some LGAs there is a good relationship with Community-Based Organizations (CBOs): WDCs, VDCs, Community Coalitions, Quality Improvement Teams, Miyetti Allah, and LGA social mobilization committees.

Figure 5: Percent of LGAs that disseminate RI data to LGA Chairmen, by fiscal year quarters from June 2007 – March 2009.



The data in *Figure 5* point to functionality of LGA health teams in advocating for RI, and describe sharing of updated information from monitoring charts with the LGA leadership.

Areas needing strengthening

- High numbers of “Left outs” and drop outs point to gaps in a majority of LGAs and HFs in working with their communities to plan and conduct specific actions for improving access, utilization, and quality of RI services
- Where regular meetings with communities do occur at either LGA or HF levels, it is rare to find records of these meetings.
- A majority of WDCs and VDCs in the 18 LGAs visited are not functioning. Meetings, if they occur, are irregular.

- Many health workers do not routinely involve communities in RI activities or give feedback to them on the immunization status of the community.

Capacity Building

Positive findings

- The project has built the capacity at state, LGA and HF levels in: Planning and Management of Resources, Supportive Supervision, the Management and Use of Data for Action and quality service delivery.
- A pool of Master Trainers at State level and Peer Motivators at the LGA level have been established for training others in all areas of RI. They also provide a foundation for future training in other areas of PHC.
- The practical, flexible, and participatory approach used by IMMbasics in training is highly appreciated by heath workers and promotes better qualitative training.
- Exchange visits promoted by the project served as motivation and provided an avenue to learn from best practices in RI Service provision.

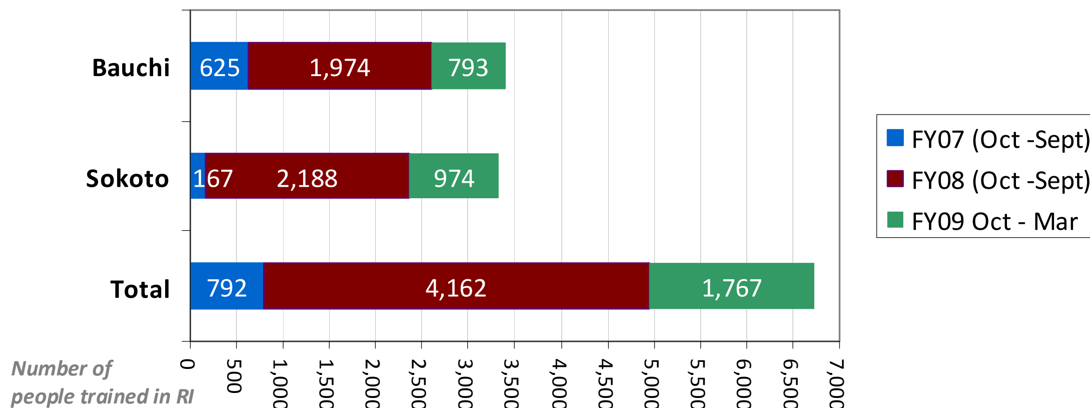
"IMMbasics is not about distributing money, their work is to dust the brain and thereby improve the knowledge and skills of health workers. By this they have also influenced other partners to begin to focus on RI." Observation from an LIO

Areas needing strengthening

- Newly transferred and newly employed health workers need to be trained. All health workers need refresher training to update their knowledge and skills.
- A government driven structure is not sufficiently in place in either state to continue the necessary training and retraining in RI.
- Ward Development Committee (WDC) and Village Development Committee (VDC) members need training on finance and resource management, and on their roles and the importance of RI and child tracking.

The project facilitates SMOH/BaSPHCDA and LGA staff with implementing a series of six training packages—through Master Trainers and Peer Motivators. Follow-up after training through the supportive supervision process is an exercise in continuous quality improvement, and is at the core of what the project promotes.

Figure 6: Number of people trained in routine immunization, by fiscal year, Oct -Sept, 2007 -2009.



RECOMMENDATIONS BY THE REVIEW TEAM

Planning, Management, and Advocacy

- MOLG and LGA health teams need to advocate more to LGA Chairmen for sufficient and regular funding for RI to achieve the goal of Reaching Every Ward. "Model LGAs," where adequate funding is being given, should be used as peer examples. An example of a model LGA should include: receiving at least N100,000/month RI financial support from the LGA, good team work, and significant expansion of access to RI services.
- The Local Government Service Commission needs to recruit and ensure equitable distribution of HWs.
- LGA teams should work with HFs to rationalize and prioritize realistic plans for outreach, based on agreed levels of funding.
- BaSPHCDA, the SMOH, LGAs, and HFs need to institute specific planned actions to address the high number of drop outs and left outs from the RI system.

Monitoring

- SMOH/BaSPHCDA should continue to internally track RI data and IPD data separately, to better identify gaps in the RI system and target efforts towards for strengthening.
- SMOH/BaSPHCDA should take the lead in routinely producing charts showing the ranking of LGAs according to coverage, drop out, and quality of immunization services, and thereby further promote use of data for action.

Supportive Supervision

- LGAs should take a leading role in ensuring the availability and continued use of routine supervision tools and monitoring charts ranking the HFs according to coverage, drop out, and quality of immunization service (SS scores).
- States and LGAs should provide sufficient funds and transport for regular supervisory visits to LGAs and HFs.

Community Linkages

- LGAs and Health Facilities need to do more to establish community and HF linkages and community involvement. Planning with the communities should be strengthened, especially with WDCs, VDCs & TBAs on defaulter tracking, mobilization, and referral of newborns for RI.
- More Health Facilities should plan "user friendly" immunization sessions: planning the days and hours for routine immunization with input from members of the communities in their catchment area.

Capacity Building

- SMOH/BaSPHCDA in collaboration with MOLG should put in place a long term training strategy and structure to provide periodic refresher training for staff and training for new staff on all areas of RI.
- The States and LGAs should utilize the existing pool of State level Master Trainers and LGA level Peer Motivators for future training.
- LGAs should provide basic training for members of WDCs and VDCs on the importance of RI and child tracking.

Partner Relations

- SMOH/SPHCDA and MOLG along with LGAs and partners should focus on keeping RI strengthening high on their agenda.
- The SMOH/SPHCDA with the MOLG should continue to lead the very important process of coordinating development partners, with regular meetings being the backbone to effective coordination.
- Partners should make it a priority to coordinate their plans and activities with the SMOH/SPHCDA and MOLG.

LESSONS LEARNED BY THE PROJECT

Based upon their observations and interviews with government leaders and health officials; health staff at State, LGA and health facility levels, and immunization partners, the Review team highlights the following as the key lessons learned from the IMMbasics project.

- Making REW operational in the context of a weak RI system requires a tremendous and consistent effort. The first step is ensuring that quality and well managed immunization services are in place. Once a well managed service is in place, then community linkages should be promoted to make optimal use of the service.
- The life of this project, two-and-one-half years, was not enough time to fully establish and nurture all 5 components of REW, especially considering the context of the weak PHC system.

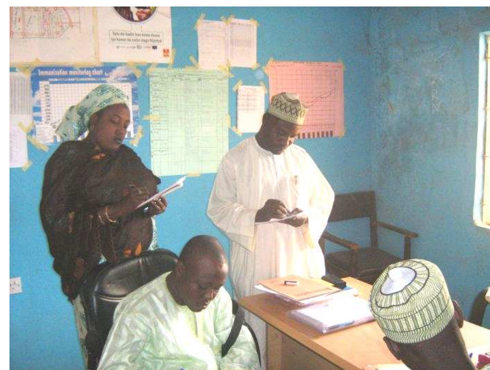
"Behavior change cannot be done in a day.
More work and time are needed to fill the gaps."
An international partner

- Providing training after a structure for supportive supervision is in place, promotes more effective training because the health worker receives timely follow up and mentoring from supervisors on applying the new skills learned during training.
- Continuous use of opportunities to reinforce learning as part of a comprehensive capacity building process is more effective than one-off training.
- The step by step process taken in the two states to make REW operational applies to all PHC services, and therefore can be applied to improve PHC over all.
- The team believes that the participatory approach with health staff at all levels has been a key part in building ownership, and thereby promotes sustainability of quality routine immunization. Examples of best practices followed by the participatory approach include:
  - Collecting LGA baseline information together with the HWs helped them to better understand the weak status of RI in their LGA, and also to prepare work plans based on realistic steps to rebuild their system.
  - Having health staff determine their own standards by which to be supervised (check list development)—in line with national standards—has resulted in their better understanding of the standards which they must maintain in order to have quality immunization services.

The IMMbasics Nigeria staff provide the most complete insight into the experiences gained from the step-by-step approach to revive routine immunization in Nigeria. The following are the key lessons mentioned by the IMMbasics Project staff.

Lessons Learned by the IMMbasics Project Staff

- It is best to pay more attention to those LGAs and Health Facilities which lack commitment. Commitment depends mostly on the individual, and not necessarily on the distance or remoteness of the LGA or the health facility.
- During the Task Identification and Standard Setting (TISS) facilitation workshop, when supportive supervisions check lists are jointly developed and agreed upon (both for LGA level and for HF level), it is more effective when all participants participate in all of the training modules instead of dividing the modules into various group work sessions. This allows participants to interact more and promotes better participation. In this way it is also easier to select the best participants who will serve as PEER MOTIVATORS for future training and for promoting best practices.
- Training was more efficient and more effective because of the following:
  - Putting the participants in the driver's seat by their active participation, instead of being passive passengers watching lectures, greatly improves the output from the training.
  - A critical review of the training and supervision tools with the LGA team before the actual training begins, makes training easier and more participatory.
  - For data management training, it is best to concentrate on data which are more relevant to the person being trained. For example, Health Facility staff should focus on their own HF level data, rather than trying to introduce them to data from the LGA level.
  - Tools and training materials require continuous revision to become the most effective.
- At the inception of the project, there were disagreements by the State and LGAs about the immunization statistics presented. Some feared that the project's focus on data would lead to a bad impression. But the project continued to explain and simplify the data and to prepare stake holders on understanding the data presented. These changes resulted in great improvement in the quality of training and the supportive supervision. These improvements were seen more in the later phase LGAs, as experienced was gained.
- Exchange visits between better performing and later phase LGAs within a State, and also between Sokoto and Bauchi States greatly helped to establish commitment early on. Exchange visits were later expanded to include visits among zonal states. For example, many NW Zonal states visited Sokoto (Jigawa, Kano, Kaduna, Katsina, and Kebbi) and Sokoto also visited Zamfara.



Exchange visit to Sokoto by NW zonal states: taking notes while being briefed by health officials in Sokoto North LGA.

- Going through the MOLG significantly helped with engaging the LGAs. The MOLG has direct oversight of the LGAs in the State. This makes them very strategic, as the project discovered, in communicating with the LGA leadership, engaging the LGAs and promoting adequate funding for RI and PHC activities.
- The Wild Polio Virus problem can serve as a good example of what happens when you let down your guard and do not maintain a strong RI system. We can promote RI by using the WPV issue as an example. RI should also utilize the polio eradication initiative for promoting RI.

CONCLUSIONS

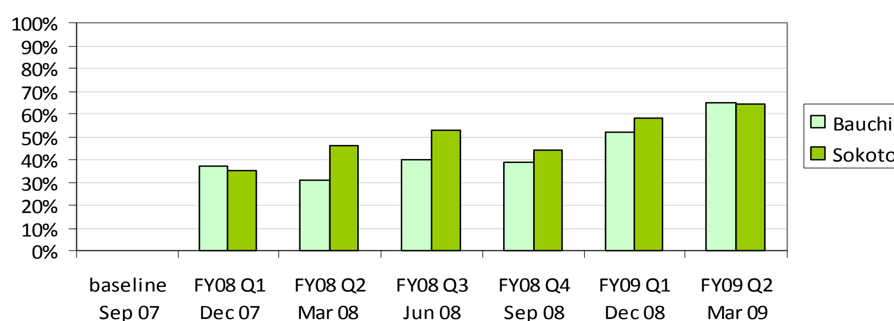
To fully realize the achievements of the IMMbasics Nigeria project, it is necessary to review the historical context from which this project evolved. In their trip reports on preliminary project design visits just three years ago, IMMbasics Technical Director Robert Steinglass and international consultant Mark Weeks emphasized four significant barriers against reviving routine immunization in Nigeria:

- ownership and Identity;
- vaccine security;
- a development environment based on monetary incentives ; and
- lack of influence owing to: a small project budget (when compared against other well-funded initiatives and donor projects) and prevailing misconceptions that rapid quantitative results are the only measure of success.

Three years ago there was no common understanding for the term "Routine Immunization." National ownership of RI was lacking as nearly all attention focused on delivering immunizations by mass campaigns. During pre-project visits IMMbasics had to introduce every meeting with a standard definition of RI. Immunizations given during mass campaigns were being recorded and reported as "RI." Today in Bauchi and Sokoto States there is no longer a need to clarify the difference between IPDs and immunizations given according to a routinely scheduled immunization or outreach session from a health facility. State health officials in these two states now realize the importance of separating the reporting of mass campaign immunization (IPDs) from immunizations provided routinely through an established health facility. Interviews at national level suggest changing attitudes at higher levels also; for example, more interest in the concept that analysis of IPDs campaign data should be distinguished from routine immunizations.

One of the urgent needs for reviving RI in Nigeria reported at the time of the project design visits was the overwhelming consensus among health officials and immunization partners that vaccines were not available in the health facilities. Assessments of the immunization program in 2005 and 2006 led to a concerted effort to improve vaccine security in Nigeria. By the time of this end of project review in April 2009, the review team detected no evidence of major vaccine stock outs. Nearly everyone in Bauchi and Sokoto States mentioned receiving sufficient supplies of the EPI vaccines. Such a dramatic improvement in vaccine security underscores the value of partners working together in a coordinated effort, focusing on all levels to correct a problem. While UNICEF, WHO, and other RI partners provided cold chain equipment and technical support, IMMbasics worked at the operational level to improve stock management and monitoring of vaccine supply. *Figure 7* below not only illustrates the steady improvement in timely distribution of vaccines in Sokoto and Bauchi, but also shows the value of monitoring vaccine distribution. Prior to this project, there were huge challenges in effectively determining the extent of the vaccine security problem, and also in monitoring the situation.

Figure 7: Vaccine Distribution: Percent of HFs receiving vaccines, by quarter.



The indicator in *Figure 7* tracks availability and distribution of vaccines at service delivery points and refers to at least one antigen (DPT) being sent.

At the beginning of this project many were skeptical that health workers and committee leaders, who are accustomed to receiving extra allowances for participating in mass immunization campaigns, would have interest in an effort to improve RI which did not include such monetary incentives. Disproving this myth is perhaps one of the greatest achievements of the IMMbasics Nigeria project. The review team generally found enthusiasm for routine immunization and appreciation for the skills upgrade and new methods acquired through the project. While there are some still expecting a reward for participating in RI, this review found that, by and large, community participation is increasing, and without monetary incentives.

Finally, before the project began in October 2006, there was considerable concern that a project with a relatively small budget for Nigeria development projects would have little influence against other initiatives and projects. Other projects have much more funding and offer more in terms of visible impact, such as providing equipment and additional monetary incentives. Also the IMMbasics project aimed at building a strong foundation from a step-by-step methodical process; not on achieving rapid quantitative results. Consequently, there was concern that others would not pay attention to the project's efforts and achievements without significant gains in immunization coverage early on. However today, RI is not only a part of the agenda, but also there is considerable demand for participation by IMMbasics in various national committees. Also, other states have expressed interest in being a part of the IMMbasics process for strengthening RI. Putting RI on the agenda is no doubt attributed to the diplomacy, the perseverance, and hard work of the IMMbasics project staff. Most importantly, decisions makers are realizing that strengthening RI first requires building a solid foundation, before high immunization coverage can follow.

"*If I were a donor, I would put funds into IMMUNIZATIONbasics because they really are interested in good work being carried out, not in rushing to demonstrate immediate results*."
NPHCDA – Zonal Staff

From its beginning this project was based on four fundamental principles:

1. a truly "Bottom Up" approach;
2. affordable, for future nationwide roll-out by the government;
3. low-tech, needing neither costly equipment requiring maintenance systems, nor capacity beyond that of the average health facility personnel; and
4. emphasis on building a foundation for sustained and effective immunization coverage, rather than a rapid unsustainable rise in reported "results".

The review team concludes that the Project did indeed adhere to these four principles, and thereby IMMbasics Nigeria provides a way forward for the Government of Nigeria, future projects, and partners. This way forward can not only strengthen RI through out the country, but also serves as a step toward revitalizing PHC in Nigeria. Decision makers and project planners must realize that immunization is indeed a part of PHC. They must also recognize that the components of REW and the process developed to make REW operational in Nigeria are not exclusive to immunization, but rather represent the needs of any public health intervention.

All programs require: (1) effective planning and management, (2) access to quality services, (3) effective monitoring and supervision, (4) community participation, and (5) capacity building. The process which has been developed in Sokoto and Bauchi States can also be applied for strengthening other public health interventions.

However, the two-and-one-half years lifespan of this project was not sufficient for all of the five REW components to achieve full maturity in the two states. More work remains to effectively consolidate the process in these two states, and to expand the effort to other States. The Team encourages the Federal Government of Nigeria, USAID and other partners to continue to support the effort to strengthening RI in Sokoto and Bauchi States, as well as to utilize the tools, methods and approaches developed by the IMMUNIZATIONbasics Nigeria project on a national scale, for strengthening both RI and PHC in Nigeria.

ANNEXES

ANNEX A: Review Team Members

ANNEX B: State Maps

ANNEX C: LGAs and HFs Visited

ANNEX D: Project Review Introduction Sheet and Interview Guidance

ANNEX E: Review Team Guide – National Level

ANNEX F: Review Team Guide – State Level

ANNEX G: Review Team Guide – LGA Level

ANNEX H: Review Team Guide – Health Facility Level

ANNEX I: Review Team Guide – Community Level

ANNEX J: Persons Interviewed

ANNEX A: REVIEW TEAM MEMBERS

Project Review Team

- Auwal U. Gajida - Bayero University , Kano (Review Team Leader)
- Suleyman H. Idris - HOD, Dept of Community Medicine ABU , Zaria
- Mark Weeks - International Public Health consultant
- Jenny Sequeira - Technical Officer IMMbasics Arlington, VA, USA
- Abubakar M.Maishanu - IMMbasics Country Representative
- Folake Kio- Olayinka - IMMbasics Deputy Country Representative
- Eugene C.U. Onwuka - IMMbasics National Program Officer
- Ann Akparanta – IMMbasics Finance and Admin Assistant, (Review Logistics Coordinator)

Bauchi

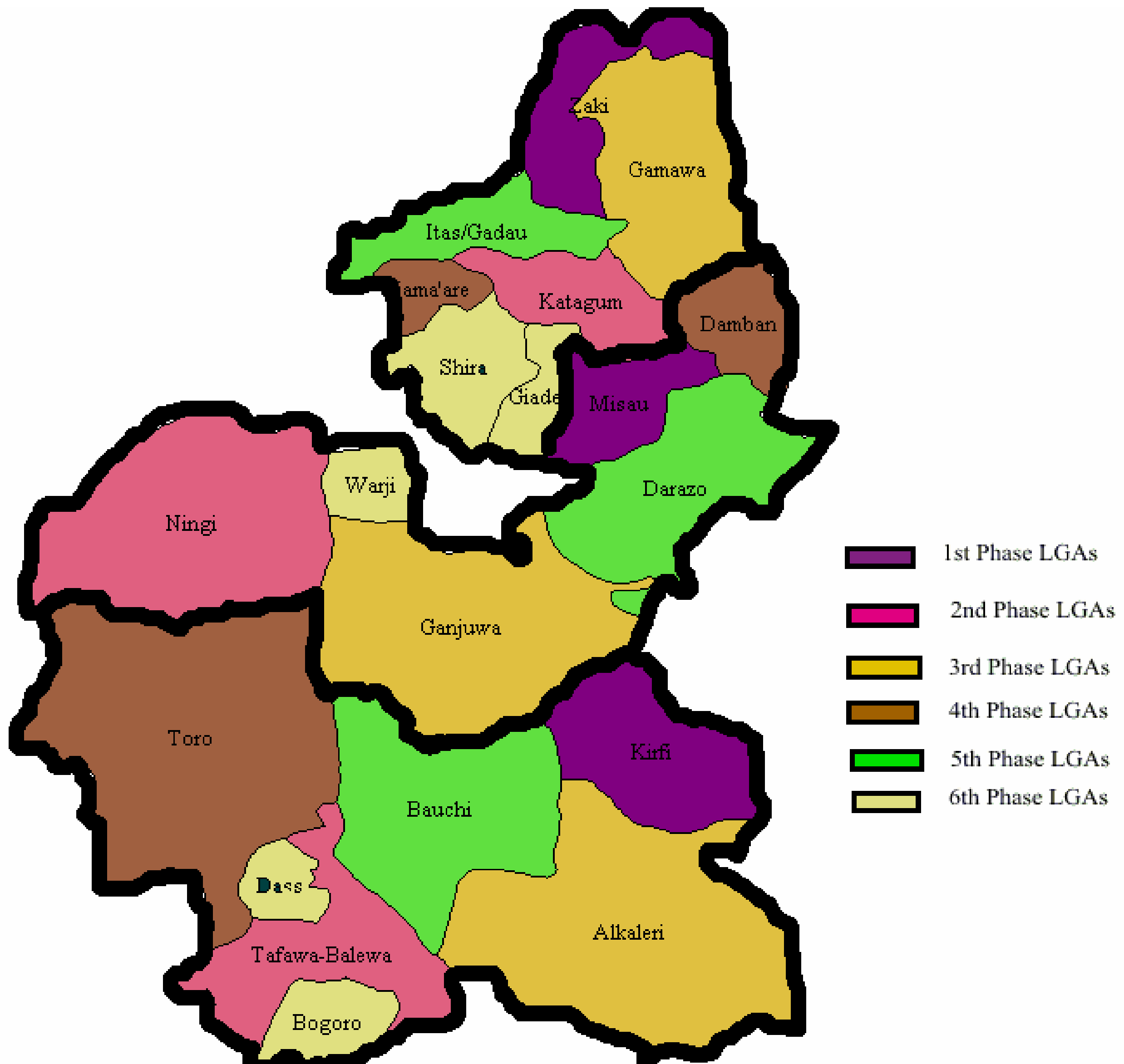
- Executive Chairman - BaSPHCDA and senior staff (participated in briefing and debriefing), including Local Government Zonal Coordinators who participated as state level review team members
- Lawal Hadejia – NPHCDA NE Zonal Coordinator
- Amos P. Bassi - IMMbasics State Coordinator
- Peter Joshua – IMMbasics LGA Zonal Coordinator
- Abubakar Mu'azu – IMMbasics LGA Zonal Coordinator
- Ahmed Na'iya – IMMbasics LGA Zonal Coordinator
- Masduk Adbulkarim – IMMbasics M&E Officer
- Hassan Ado – IMMbasics Finance and Admin Assistant

Sokoto

- Commissioner of Health
- Shafa'atu Umaru Abache - Ministry of Women's Affairs Sokoto
- Auwal Ibrahim - IMMbasics State Coordinator
- Halima Abubakar – IMMbasics LGA Zonal Coordinator
- Abdullahi Aliyu – IMMbasics LGA Zonal Coordinator
- Zainab Mohammed – IMMbasics LGA Zonal Coordinator
- Salihu Abubakar – IMMbasics Finance and Admin Assistant
- Akeem Ganiyu – IMMbasics Data Consultant

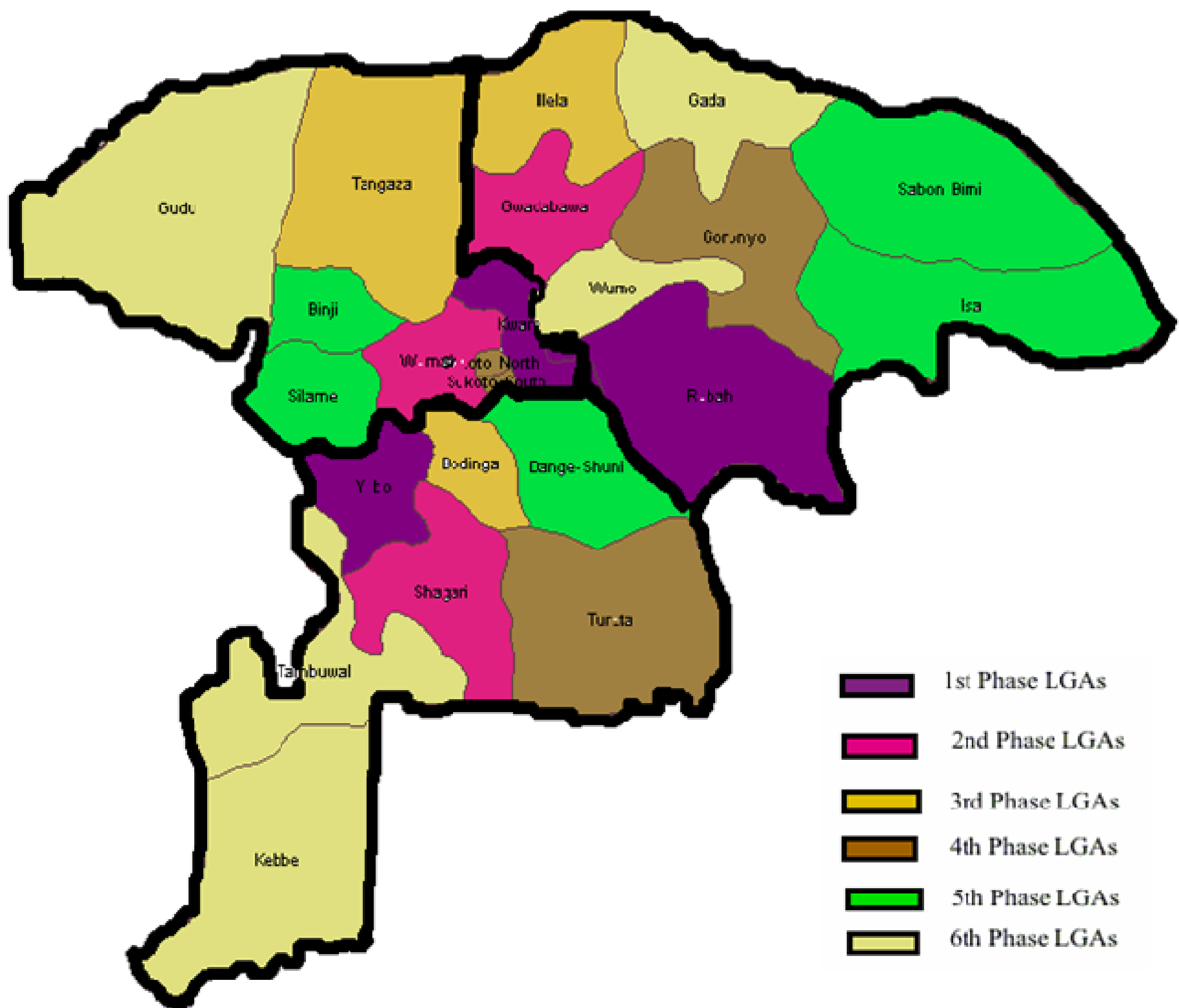
ANNEX B-1: BAUCHI STATE MAP WITH PROJECT LGA PHASES

This map shows the IMMbasics project phased entry strategy, which initiated activities in an average of 3 LGAs (at least one LGA per Senatorial Zone) per quarter throughout the lifespan of the project. (Phase 1 started in February 2007, Phase 6 started in June 2008.)



ANNEX B-2: SOKOTO STATE MAP WITH PROJECT LGA PHASES

This map shows the IMMbasics project phased entry strategy, which initiated activities in an average of 3 LGAs per quarter (at least one LGA per Senatorial Zone) throughout the lifespan of the project. (Phase 1 started in April 2007, Phase 6 started in September 2008.)



ANNEX C: LGAs AND HEALTH FACILITIES VISITED

STATE	LGA	Project Phase of LGA	HEALTH FACILITIES
BAUCHI	Dass	6	Durr Model PHC
			Dott Maternity
			Town Maternity, Dass
	Ganjuwa	3	Kafin Madaki Maternity
			Sabon Kariya Maternity
	Giade	6	Faguji Maternity
			Town Maternity, Giade
	Jama' are	4	Jurara Maternity
			Hanafari Maternity
			Area Health Office, Jama'are
	Kirfi	1	PHC Kirfi
			Bara Health Center
	Misau	1	Hardawa Maternity Center
			Misau Town Maternity
	Toro	4	Narbodo Area Health Office
			Toro District Hospital
	Warji	6	Katanga PHC Center
			Tiyin Model PHC Center
	Zaki	1	Town Maternity, Katagum
			Sakwa Maternity
SOKOTO	Binji	5	Binji Dispensary
			Inname Dispensary
	Bodinga	3	Bodinga Town Dispensary
			Danchadi PHC Center
			Sifawa Dispensary
	Illela	3	General Hospital, Illela
			Ambarura Dispensary
	Kebbe	6	Margai Dispensary
			General Hospital, Kebbe
	Rabah	1	Gidan Buwai Dispensary
			General Hospital, Rabah
	Shagari	2	PHC, Shagari
			Runjin Kaka Dispensary
	Tangaza	3	Gidan Madi PHC
			Rini Health Facility
	Wammako	2	Wammako Upgraded Dispensary
			Arkilla Basic Health Center
	Wurno	6	Mamuma Dispensary
			General Hospital, Wurno

ANNEX D: PROJECT REVIEW INTRODUCTION SHEET & INTERVIEW GUIDANCE

INTRODUCTION

IMMUNIZATIONbasics began implementing a project to strengthen routine immunization (RI) in Bauchi and Sokoto states in early 2007. The project works with government agencies and international partners at the national level and in the two states down to health facility level, with a focus on operationalizing the Reaching Every Ward (REW) approach.

The project is engaged in strengthening the RI system, by which we mean the routine and timely delivery of all antigens to infants. The project works together with State and LGA teams to implement affordable, low-cost and sustainable approaches; rather than short term unsustainable campaigns such as NIDs, LIDs, and IPDs.

The project is conducting an end of project review to assess progress made towards strengthening routine immunization systems in Bauchi and Sokoto states. We are here to also learn how the strengthening approaches can be improved and sustained beyond the project life span (July 2009). The review includes approaches such as: supportive supervision, planning and management of resources, monitoring and use of data, community linkages, increasing access to immunization services, capacity building, and partner coordination.

GUIDANCE FOR GROUP MEMBERS

This is a review of the IMMUNIZATIONbasics project. It is not a formal evaluation of the overall immunization program. The review is essentially a qualitative one but with some quantitative components. The emphasis is to learn how the RI system has been improved and insight on how it can be further strengthened after project closure.

The questionnaire is designed with mostly open-ended questions. Create an open and friendly environment that puts the respondents at ease and encourages them to do most of the talking. The group leader introduces the team members and the purpose of the interview (page 1). The group splits up to interview different respondents. The interviewer completes one section. Don't bombard the respondents with too many questions or try to find fault. You are there to listen and observe, not to make corrections. Ask them to explain what they are doing and how they are trying to improve the routine immunization program and services.

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

You will use a daily personal log to structure your important observations and capture your key findings. This is not to be submitted. Each evening, the group will discuss the day's findings and prepare a daily group summary (in bullet format which quantifies observations from LGAs and health facilities where appropriate). Each group will use this summary as you de-brief with the state team and prepare the overall state report. Each group has a leader. In consultation with group members, the leader is responsible for the overall direction, quality of the work, keeping things on track, ensuring participation by all group members, guiding the field work, following the review methods, responding to any group concerns and solving problems that may arise. Each evening, the group leader facilitates a discussion and recording of the day's key findings and suggestions. At the end of the field work, the leader will summarize the group's findings by LGA in brief written form (not exceeding 6 pages and in not more than 5 - 8 power point slides).

At the state and national levels, a harmonized report (PPT) along the thematic areas will be presented.

ANNEX E: NATIONAL LEVEL GUIDE

IMMUNIZATIONbasics Project Review Thematic Area

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

GENERAL INTRODUCTION

IMMUNIZATIONbasics began implementing a project to strengthen routine immunization in Bauchi and Sokoto states in early 2007. The project works with government agencies and international partners at the national level and in the two states down to health facility level, with a focus on operationalizing the Reaching Every Ward (REW) approach.

The project is engaged in strengthening the RI system, by which we mean the routine and timely delivery of all antigens to infants. The project works together with State and LGA teams to implement affordable, low-cost and sustainable approaches; rather than short term unsustainable campaigns such as NIDs, LIDs, and IPDs.

The project is conducting a review to take stock of progress to date in strengthening routine immunization systems in Bauchi and Sokoto states.

We are here to learn how the strengthening approaches can be improved and expanded (in the context of increasing the number of HFs providing RI, number attending RI sessions, number of regular RI outreaches). We are also looking for your advice on how the existing approaches can continue beyond the project's end date of July, 2009 and on how the approach and lessons learned can be communicated in the future, and without financial support from IMMbasics. The review includes approaches such as:

- supportive supervision
- planning and management of resources
- monitoring and use of data
- community linkages
- increasing access to immunization services
- capacity building
- partner coordination

QUESTIONS

1. *State our RI specific role and how we define RI.* Describe collaboration between IMMbasics and your organization/agency *(probe: content, frequency, results describe any difference seen in the last six months)*
2. Are there any recommendations concerning collaboration in RI strengthening for future projects and RI partners? *(probe, content, process, communication)*
3. What more needs to be done to strengthen routine immunization?
4. How can the approach and the lessons learned from the IMMbasics project continue to be communicated and adapted nationally?

Thank the respondent(s) for their comments and time.

ANNEX F: STATE LEVEL GUIDE

IMMUNIZATIONbasics Project Review Thematic Area

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

Planning and management of resources	Who to Interview
1. Has the IMMbasics project influenced the development of your current State RI annual plan? If so, please describe how? What have you been able to accomplish so far? *(Probe: look for evidence of active use of the State plan for RI activities? e.g. state map, quantified resources, support supervision plan for LGAs; probe understanding of LGA's planning and management of HF supervision, vaccine distribution plan, activities operational in the last quarter.)* What have been the constraints, challenges? 2. What kind of resources for implementation of the RI plan has been identified recently? *(clarify resources for RI, not immunization in general, also "Implementation" has IPD connotation, so make sure RI context is clear; terminology is important in all questions [especially IPD vs RI nuances]; remember difference between budget allocation vs released especially at lower levels)* ~~3.~~ What are the challenges *(Probe 2008 annual plan to see what was accomplished, what was not and why, remember difference between budget allocation vs released especially at lower levels)*	ECBaSPHCDA/State Director of Primary Health Care (DPHC) RI Focal person, Other Directors (in SPHCDA) DirPHC, SIO, CCO, (SMOH), DirPHC (SMOLG) For all questions in this section
Increasing access to immunization services	**Who to Interview**
1. Have there been any recent changes in the number of HFs providing fixed routine immunization services, in the past 12 months? How do you know? What has been done? 2. Which LGAs in your state have the poorest access; how do you know/decide? *(probe for data, is this documented or only the interviewees impression?)* 3. What have you tried since September 2008 to improve access; what worked, what didn't work; what barriers did you face? *(if respondent has not been interviewed before, probe for last 12 months)*	ECBaSPHCDA, RI Focal person, Other Directors (in SPHCDA) DirPHC, SIO, CCO, SMOH, DirPHC (SMOLG)
Monitoring and use of data for action *(can state explain their data & how it is used)*	**Who to Interview**
For below, look for evidence of data analysis e.g. disaggregating of RI and IPD data, EPI monitoring charts, prioritization of LGAs, appropriate filing of data, charts/results of supervision, including feedback to LGA policy makers, service providers & communities 1. Has RI coverage been going up or down over the past year? How have you used this information to improve immunization coverage? 2. Where are your areas of lowest coverage rate? (*define low coverage in light of relativity at this level, high vs lower in the area)?* How do you know? *(documented or personal impression ?)* What are the possible reasons for areas with low coverage and have you implemented special activities in these areas to improve the situation? If so, describe activities. 3. Where are your areas where the most unimmunized live, children never immunized (without DPT1)? How do you know? *(Impression or supported with monitoring data?)* What have you done to decrease the number of unimmunized	DirPHC SPHCDA, DirPHC SMOH SIO, CCO State RI data Officer (include assistant if available)

children? 4. Has dropout gone up or down over the past year? What have you done to decrease the number of children who drop out from completing the required immunizations?	
RI Supportive Supervision	Who to Interview
1. What do you think of the approach being taken for SS? Has it helped you? If yes how/why? In what ways is the approach different from what you may have been doing in the past? *(probe for use of check list; NOTE: answer to this question may fill in points below)* 2. How many supervisory visits were planned and how many were conducted in the last six months? What are the barriers? *(probe for evidence to show that supportive supervision is conducted by the state to each LGA at least quarterly, try to quantify according to information on file)* 3. What has been the trend in supervision frequency by the state, especially over the past 6 months? Increased or decreased? How do you know? *(verify with reports on file)* Do you use information collected on the check list? If so, how? 4. Are you starting to see any differences in LGA planning and management performance? If yes, how did that happen? 5. How many supervisory visits have been conducted without IMMbasics over the past 6 months? *(quantify)* If yes, did you face any challenges and what were they? If none, how do you plan to continue with the visits without IMMbasics support? *(NOTE: depends on LGA phase)* 6. Is there a budget with a line item for supervision for 2009? Who determines whether funds will be released? Are the funds released timely and sufficient? Have more funds been released than before? *(document increase or decrease)* 7. *If involved with RI supervision and not an immunization-focal staff:* Are there any benefits to you to participate in immunization supervision even though your area of focus is not immunization? *(Probe if it helped in any way)* 8. How do you give feedback to the LGAs on support supervision results? 9. What ways can the support supervision process be improved?	DirPHC SPHCDA, DirPHC SMOH SIO, CCO, ZCO, RI focal person Respondents Other than SIO, CCO DirPHC SPHCDA, DirPHC SMOH SIO, CCO, ZCO, RI focal person
Strengthening Community Linkages	Who to Interview
Have you done anything over the past 6 months to involve communities in RI? If so, describe. *(probe existence and then use of VDCs, WDCs, CBOs, NGOs, key/traditional leaders)*	DirPHC SPHCDA, DirPHC SMOH SIO, CCO, ZCO, RI focal person
Capacity Building	Who to Interview
1. What key areas do you think capacity has been built by the project? What has been done in the last six months and how do you think you and the state have benefited from it?	DirPHC SPHCDA, DirPHC SMOH SIO, CCO, ZCO, RI focal person

Partner Coordination (SPHCDA/SMOH, MOLG, WHO, UNICEF, EU PRIME, COMPASS)	Who to Interview
1. *State our RI specific role and how we define RI.* Describe collaboration between IMMbasics and your organization/agency *(probe: content, frequency, results? describe any difference seen in the last six months)* 2. Are there any recommendations concerning collaboration in RI strengthening for future projects and RI partners? *(probe content, process, communication)* 3. What needs to be done to strengthen the RI in the context of REW in the state? *(probe planning & management of resources, increasing access, monitoring for action, supportive supervision, community links)* 4. How can the approach and the lessons learned from the IMMbasics project to be sustained? 5. What role can the state play in future coordination of RI activities?	State coord, Prog Officer, SPM, DirPHC SMOH, MOLG DirPHC SPHCDA, STL for all questions; all partners (ask other sections, but highlight questions are here)
6. Can you describe the involvement of MOLG in strengthening RI activities in last 12 months? *(probe interaction between IMMbasics project and MOLG)*	MOLG only

Thank the respondent(s) for their comments and time.

Questions for IMMbasics staff

Thematic Areas	Questions	Who to Interview
Planning and management of Resources	How have the project approaches evolved over time? -In what ways? -Why did they change? -What was the result of these changes? What are the advantages and disadvantages to the phased approach that the project implemented? What can be done to encourage the State and LGAs to continue the activities which you have helped to implement (Planning, SS, capacity building, monitoring, etc.)	The State Coordinators & LZCs Abuja staff
Increasing access to immunization services		
Monitoring and use of data		
RI supportive Supervision		
Strengthening Community Linkages		
Capacity Building		
Partner Coordination		

ANNEX G: LGA LEVEL GUIDE

IMMUNIZATIONbasics Project Review Thematic Area

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

Planning and management of resources	Who to Interview
1. What have you been able to accomplish so far in 2009 work plan? (*look for evidence of active use of LGA plan for RI activities?*) e.g. list of settlement/target pop, catchment area map, supervisory work plan to HFs, vaccine distribution plan, report receipt monitoring, man power distribution list (qualification/skills, gender) evidence of RI budget and fund release, are outreaches (*not IPDs*) conducted, are there plans for outreaches (*probe budget vs, funds released*) 2. How has the project influenced your RI planning? ~~3.~~ What kind of resources and challenges for implementation *(non IPD)* of the RI plan were identified?	PHC Coord, Councilor Health, LIO, CCO, M&E, Health – Educator

Increasing access to immunization services	Who to Interview
1. Have there been any recent changes in the number of HFs providing fixed routine immunization services, in the past 12 months? How do you know? What has been done? 2. Which Ward in your LGA has the poorest access; how do you know/decide? *(probe for data, is this documented or only the interviewees impression?)* 3. What have you tried since September 2008 to improve access; what worked, what didn't work; what barriers did you face? *(if respondent has not been interviewed before, probe for last 12 months)*	PHC Coord, Councilor Health, LIO, CCO, M&E, Health – Educator

Monitoring and Use of Data for Action *(explain their own data and how they use it)*	Who to Interview
1. How has RI coverage been this year compared to last year? How have you used this information? *(Track this part with phase of LGA)* 2. Where are your areas where the most unimmunized live, children without DPT1? How have you used your information to reduce the number of unimmunized children? 3. Has dropout gone up or down over the past year? What areas have the highest drop out rates? What have you done to reduce drop out rates? -*(ALL OF ABOVE: look for evidence of data analysis in the LGA e.g. EPI monitoring charts, prioritization of HFs, appropriate filing of data, charts/results of supervision)* *4.* What efforts have been made to address data quality? What changes have you observed since you started making efforts to improve? *(Probe if data quality spot checks done in health facilities?)* *5.* Does the LGA have a functional (current map, when last was it updated?) LGA map; if yes, how is the LGA using it? *(sight the map; should show HFs providing RI)*	PHC Coord, Councilor Health, LIO, CCO, M&E, Health – Educator for all questions

RI Supportive Supervision	Who to Interview
1. Describe what happens during an RI supervision visit from the State *(probe when the process started, anything new in how it is being done, use of check list; NOTE:*	PHC Coord, LIO, CCO, M&E, Health –

answer to this question may fill in points below) 2. How many times has a team from the State visited you during the past 6 months for RI supervision? Increased or decreased over the life of the project? 3. How did the visits affect your performance? 4. How do you receive feedback from the state on support supervision results? What kind of feedback do you want? *(probe method, format)* 5. How many times in the past 6 months was self assessment carried out at the LGA? *(evidence of this should be found in the SS summary form, with self assessment marked "SA")* 6. What do you think of the approach you used to conduct supervisory visits to HFs? Has it helped you? If yes how/why? In what ways is the approach different from what you may have been doing in the past *(probe for use of check list; NOTE: answer to this question may fill in points below)* 7. How often is the LGA supposed to supervise each HF? Is that happening? *(quantify the number of actual over number planned visits in last six months if possible)* What are the barriers? *(Probe for evidence to show that supportive supervision is conducted by the LGA to each HF at least quarterly)* 8. Who at the LGA level should be conducting RI supervision to HFs? Who actually conducts supervision? How did they learn to conduct RI supportive supervision? *(probe who trained them, etc)* 9. -What has been the trend in supervision frequency by the LGA over the life of the project? Increased or decreased? What do you do with the check list used during the SS visit? 10. Are you seeing any differences in HF performance with RI service delivery? How do you know? 11. -Have there been supervisory visits conducted without IMMbasics during the past 6 months? If yes, how many, compared with the total number of SS visits during the past 6 months? Did you face any challenges and what were they? *(NOTE: depends on LGA phase)* 12. Is there a budget with a line item for supervision? Who determines whether funds will be released? Are the funds released timely and sufficient? Have more funds been released than before (quantify)? 13. *If not an immunization-focal staff:* Are there any benefits to you to participate in immunization supervision even though your area of focus is not immunization? *(Probe if it helped in any way)* 14. How do you give feedback to the HFs on support supervision results? 15. How often is the check list for self assessment used? *(How many completed check lists are available for the past 6 months, compared with number of documented visits?)* What have been the benefits of the self assessment forms? *(Probe: review the self assessment forms in the LGA and look at progression of scores)* 16. What ways can the support supervision process be improved without IMMbasics?	Educator, MCH Coord

Strengthening Community Linkages	Who to Interview
Are communities involved in improving routine immunization? If yes, describe specific actions. Describe any future plans for strengthening community linkages.	PHC Coord, LIO, CCO, M&E, Health - Educator, MCH Coord
Capacity Building	**Who to Interview**
1. Did you participate in any training supported by IMMbasics? *If yes:* in what ways, if any, did it help you in your job? What gaps were there in the training? *(probe: content and process areas)* How was follow up done? 2. What key areas do you think capacity has been built by the project? What has been done in the last six months and how do you think you and the LGA have benefited from it? What are the remaining gaps in capacity? 3. What new things have you learned from the IMMbasics' supported training? *(probe what knowledge and skills have been gained in RI)* How has the new knowledge affected your performance? Are there any additional areas of training needed besides data management?	PHC Coord, LIO, CCO, M&E, Health - Educator, MCH Coord for all questions

Thank the respondent(s) for their comments and time.

NOTE FOR THE INTERVIEW TEAMS

LGA observations to quantify during your field visits

1. Number of LGAs visited with vaccine distribution plans on the wall (according to LGA visit)
2. Number of LGAs visited with consistent financial support in past 6 months for: support supervision, vaccine distribution, generator, and outreach (quantify for each area)
3. Number of LGAs who said that funding has been increased for RI over past year (probe for figure)
4. Number of LGAs and number of health facilities visited with up to date monitoring charts on the wall (Feb. 09)
5. Number of support supervision visits to the LGA where check list was used during previous 6 months (by phase) compared to total number of support supervision visits
6. Number of support supervision visits to the LGA done without IMMbasics where check list was used *(ask only in early phase LGAs)?*
7. Number of times LGA conducted self assessment in the past 6 months using the supervision check list *(verified by SA on the SS summary form)*

ANNEX H: HF LEVEL GUIDE

IMMUNIZATIONbasics Project Review Thematic Area

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

Planning and Management of Resources	Who to Interview
1. Please tell us about the micro planning process for your HF *(clarify that the plans are for RI not SIAs/IPDs; use of catchment area map, target population, list of settlements, community involvement*) How have you used your plans? 2. What kind of resources and challenges for implementation of the RI micro plan were identified?	Health facility I/C, RI Service provider
Increasing access to Immunization services	**Who to Interview**
1. How many times are RI services provided in a months? How many times are RI services provided in the last six months? *(outside of IPDs, record on tally sheet)* 2. What have you tried to improve access and attendance at RI sessions; what worked, what didn't work; what barriers are you facing? *(probe for outreaches, planned vs conducted)* 3. Are there settlements that you are not reaching; how are you or do you plan to reach them? *(probe: why aren't they being reached)*	Health facility I/C, RI service Provider
Monitoring and use of data for action *(purpose is to determine whether they can explain their own data and how they use it)*	**Who to Interview**
(Look for evidence of data analysis, e.g. EPI monitoring charts, appropriate filing of data, charts/results of supportive supervision; as well as functional catchment area map) 1. Are up to date monitoring data and a catchment area map displayed or on file in the health facility. *(record the most recent month data are available)* 2. What is your RI coverage? (*ask for 2007 cumulative, 2008 last quarter cumulative, compare with same period in 2007*) How have you used this information? 3. Has RI coverage been going up or down over the past 6 months? How do you know? *(From own impression or from data)?* How do you use your monitoring information and map? 4. Where are your areas of lowest coverage rate? (*define low coverage in light of relativity at this level, high vs lower in the area)* How do you know? *(From own impression or from data)?* What have you done for the low coverage areas? 5. Has dropout gone up or down over the past year? How do you know? *(From own impression or from data)?* Have you done any special activities to reduce drop out? If so, describe. 6. What do you need to do to increase coverage? *(probe: role of DPT1, DO, left out in increasing access?)* *7.* What efforts have been made to improve data quality? *(Probe if data quality spot checks done in health facilities, flow of information, look at EPI tally sheets, registers, summary report and archived availability of reports)*	Health facility I/C, RI service Provider

RI Supportive Supervision	Who to Interview
1. Describe what happens during an RI supervision visit from the LGA *(probe when the process started, anything new in how it is being done, use of check list; NOTE: answer to this question may fill in points below)* 2. What do you think of this approach? Has it helped you? How? In what ways is the approach different? *(probe for use of check list; NOTE: answer to this question may fill in points below)* 3. What has been the trend in supervision visit frequency from the LGA in the last two years? Increased or decreased? (document number of visits by LGA phase) 4. How did the visits affect your performance? 5. How do you receive feedback from the LGA on support supervision results? What kind of feedback do you want? *(probe method, format)* 6. Does the HF use the check list for self assessment? If so, how often *(probe # of times done in past 6 months)*? What have been the benefits? *(Probe: review the self assessment forms in the HF and look at progression of scores if time permit)* 7. What ways can the support supervision process be improved? 8. Is there a supervisory log book? *(look at last entry and review substance of comments; probe with staff on feedback of comments; has it been maintained? Also look at supervisory check lists from past and compare with log book if time permit)*	Health facility I/C, RI service provider
Strengthening community linkages	
Probe: evidence of community awareness on RI services; evidence of increased demand by the community for services; evidence of community involvement/participation in conduct of RI services at the HF) Clarify IPDs vs RI definitions; definition of outreach in RI-only context 1. Are you involving communities more in routine immunization to improve routine immunization services? If yes, what are you doing? *(probe existence and then use of VDCs, WDCs, CBOs, NGOs, TBAs, key/traditional leaders)* 2. What are your thoughts on other ways the community can participate in RI?	Health facility I/C, RI service Provider
Capacity building	
1. Did you participate in any training supported by IMMbasics? *If yes*: in what ways, if any, did it help you in your job? *(probe: content and process areas)* How was follow up done? *IF NOT participated, how long have they been there…probe capacity level, attrition rates, etc)* 2. What new things have you learned from the IMMbasics' supported training? *(probe what knowledge and skills have been gained in RI)* How has the new knowledge affected your performance? Are there any additional areas of training needed besides data management? 3. What key areas do you think capacity has been built by the project? What has been done in the last six months and how do you think you and the LGA have benefited from it? What are the remaining gaps in capacity?	Health facility I/C, RI service Provider

Thank the respondent(s) for their comments and time.

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NOTE FOR THE INTERVIEW TEAMS

HF observations to quantify during your field visits

1. Number of health facilities visited with vaccination sessions 4x per year (according to health facility), 2008
2. Number of health facilities visited with vaccination session plans on the wall (according to health facility visit)
3. Number of health facilities visited actively involving the community in RI during the past 6 months, by type and number of activity
4. Number of health facilities and by frequency of sessions per month providing outreach in past 6 months.
5. Number of health facilities with supervision log book in use.
6. Number of support supervision visits to the HF done without IMMbasics where check list was used *(ask only in early phase LGAs, verified by HF SS summary form or copy of check list left behind)?*
7. Number of times HF conducted self assessment in the past 6 months using the supervision check list *(verified by Self Assessment "SA" on the SS summary form)*

ANNEX I: COMMUNITY LEVEL GUIDE

IMMUNIZATIONbasics Project Review Thematic Area

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

SELECTION CRITERIA: communities where the project has conducted or supported specific community linkages activities (each IMMbasics State Coordinator should provide this information to the teams)

Planning and Management of Resources	Who to Interview
Probe: evidence of community awareness on RI services; evidence of community involvement/participation in conduct of RI services at the HF; Clarify IPDs vs RI definitions; definition of outreach in RI-only context 1. Please tell us if you were involved with any HF planning exercises 2. Are there any contributions (financial or in kind) that you/community give to help improve routine immunization services?	Key leaders, community members, CBOs, TBAs, CCs, others
Increasing access to Immunization services	Who to Interview
Probe evidence of increased demand by the community for services 3. Does your community/group collaborate in any way with the HF to increase people's awareness of RI services? *(probe if they are involved with health education, messages, announcements, etc.)*	same as above
Monitoring and use of data for action	Who to Interview
4. Is your community/group active in sharing community information with HFs? *(probe defaulter tracking, new deliveries, immigration/emigration)* 5. Is your community leader/group active in sharing HF RI data with the broader community?	Same as above
Strengthening community linkages	
6. Are HFs involving your community/group in improving routine immunization services? If yes, what are they doing? *(probe existence and then use of VDCs, WDCs, CBOs, NGOs, TBAs, key/traditional leaders)* 7. What are your thoughts on other ways that your community/group can participate in improving RI services?	Same as above
Capacity building	
8. *Ask only in Sokoto LGAs that participated in project training:* What are some ways that the project has contributed to capacity building/training for your community/group? 9. What recommendations do you have for future projects to improve your community's/group's capacity in RI?	Same as above

Thank the respondent(s) for their comments and time.

ANNEX J: LIST OF PEOPLE INTERVIEWED

Abuja: list of people interviewed

S/NO	Person Interviewed	Location	Organization	Designation
1	Dr. Adamu Nuhu	Abuja	NPHCDA	Deputy Director, RI
2	Dr. M. Z. Mahmud	Kano	NPHCDA	NW Zonal Coordinator
3	Dr. Lawal Hadejia	Bauchi	NPHCDA	NE Zonal Coordinator
4	Dr. Boubakar Dieng	Abuja	UNICEF	EPI Team Leader
5	Dr. Alex Gasasira	Abuja	WHO	EPI Team Leader
6	Dr. Mizan Siddiqi	Abuja	COMPASS	Senior Child Survival and Immunization Advisor
7	Dr. Abba Zakari	Abuja	EU-PRIME	Team Leader
8	Dr. Ben Anyene	Abuja	PRRINN	Abuja Representative

Bauchi: list of people interviewed

S/NO	Person Interviewed	State	Organization	Designation
1	Dr Musa Mohammed	Bauchi	BaSPHCDA	Executive Chairman
2	Alh. Baba Lamido	Bauchi	BaSPHCDA	SIO
3	Alh Yunusa	Bauchi	BaSPHCDA	Zonal Coordinator (North)
4	Alh Alkali Usman	Bauchi	BaSPHCDA	DDPHC (partner relation)
5	Iliya Dakama	Bauchi	BaSPHCDA	DDDC
6	Rahinat Aliyu Tilde	Bauchi	BaSPHCDA	SMO
7	Alh Bako Madachi	Bauchi	MOLG	DPHC
8	Dr. Khalid	Bauchi	WHO	Zonal Coordinator
9	. Mr. Iyabosa	Bauchi	UNICEF	VSO
10	Mohd Sa'id Ahmed	Bauchi	Dass LGA	DDPHC
11	Yusuf Y Umar	Bauchi	Dass LGA	LIO
12	Iliyasu Dauda	Bauchi	Dass LGA	CCO
13	Mrs Dinatu S. Abbas	Bauchi	Dass LGA	Health Educator
14	Yahaya Ibrahim	Bauchi	Dass LGA	M&E Officer
15	Dauda Abdulkadir	Bauchi	Dass LGA	RI Service Provider, Durr Model PHC
16	Sabitu Yusuf	Bauchi	Dass LGA	RI Service Provider, Dott Maternity
17	Iliya Jinkiri	Bauchi	Dass LGA	Secretary, VDC Dott
18	Deborah G Abbas	Bauchi	Dass LGA	In Charge (I/C), Town Maternity Dass
19	Sabo Mohd Abdullahi	Bauchi	Kirfi LGA	DPHC
20	Musa Mohd Kaloma	Bauchi	Kirfi LGA	LIO
21	Lawan Garba	Bauchi	Kirfi LGA	CCO
22	Suleman Abdu Kirfi	Bauchi	Kirfi LGA	Health Educator
23	Haruna Abubakar	Bauchi	Kirfi LGA	RI I/C, PHC Kirfi
24	Shagari A. Mato	Bauchi	Kirfi LGA	RI Service Provider, PHC Kirfi
25	Bakoji Chindo	Bauchi	Kirfi LGA	RI I/C Bara Health Centre
26	Ezekiel Rimi	Bauchi	Kirfi LGA	RI Focal Person, Bara Health Centre
27	Sama'ila Yusuf	Bauchi	Giade LGA	DPHC
28	Garba Isah	Bauchi	Giade LGA	DDPHC
29	Mustapha Shehu	Bauchi	Giade LGA	LIO
30	Bello Adamu	Bauchi	Giade LGA	CCO
31	Mary S. Kalma	Bauchi	Giade LGA	I/C, Faguji Maternity
32	Lydia Pass	Bauchi	Giade LGA	RI Service provider, Faguji Maternity
33	Babayo Abba	Bauchi	Giade LGA	RI Service provider, Faguji Maternity
34	Ngozi Uzoh	Bauchi	Giade LGA	I/C, Town Maternity Giade

35	Isyaku Gambo	Bauchi	Giade LGA	RI Service provider, Town Maternity Giade
36	Alhaji Shehu Yakubu	Bauchi	Ganjuwa LGA	DPHC
37	Sulaiman Bello	Bauchi	Ganjuwa LGA	DDPHC
38	Ibrahim Danladi	Bauchi	Ganjuwa LGA	LIO
39	Auwal A. Lawal	Bauchi	Ganjuwa LGA	Ass. CCO
40	Naomi Kamakam	Bauchi	Ganjuwa LGA	I/C, Town Maternity Kafin Madaki
41	Halima Ahmed	Bauchi	Ganjuwa LGA	RI Service provider, Town Maternity K/Madaki
42	Patricia Iroja	Bauchi	Ganjuwa LGA	I/C, Sabon Kariya Maternity
43	Bala Madaki	Bauchi	Jama'are LGA	DDPHC
44	Badamasi Ladan	Bauchi	Jama'are LGA	LIO
45	Shehu Baure	Bauchi	Jama'are LGA	CCO
46	Muktar Mohd	Bauchi	Jama'are LGA	District Coordinator
47	Bilkisu Abdullahi	Bauchi	Jama'are LGA	I/C, Jurara Maternity
48	Amina Bulama	Bauchi	Jama'are LGA	I/C, Hanafari Model PHC
49	Ajiji Sadiq	Bauchi	Jama'are LGA	I/C, Govt Area Office
50	Isa Sani	Bauchi	Jama'are LGA	Service Provider, Govt Area Office
51	Abdu Umar	Bauchi	Jama'are LGA	Service Provider, Govt Area Office
52	Fatima Ishaka	Bauchi	Jama'are LGA	Service Provider, Govt Area Office
53	Ahmad Sale	Bauchi	Jama'are LGA	Service Provider, Govt Area Office
54	Kabir Mohd Lawan	Bauchi	Zaki LGA	LIO
55	Talle Mohd	Bauchi	Zaki LGA	CCO
56	Abba Tata	Bauchi	Zaki LGA	Health Educator
57	Sulaiman Ahmad	Bauchi	Zaki LGA	Service Provider, Town Maternity Katagum
58	Binta Mohd	Bauchi	Zaki LGA	Service Provider, Town Maternity Katagum
59	Zainab Musa	Bauchi	Zaki LGA	Service Provider, Town Maternity Katagum
60	Kubura Adamu	Bauchi	Zaki LGA	I/C, Sakkwa Maternity
61	Adamu Hassan	Bauchi	Zaki LGA	Service Provider
62	Garbu Sale	Bauchi	Toro LGA	DPHC
63	Maidawa B. Musa	Bauchi	Toro LGA	DDPHC
64	Abdullahi Sulaiman	Bauchi	Toro LGA	LIO
65	Samina Mohammed	Bauchi	Toro LGA	CCO
66	Salisu Abubakir	Bauchi	Toro LGA	DSNO
67	Hannatu Ibrahim	Bauchi	Toro LGA	Health Educator
68	Kande Jande	Bauchi	Toro LGA	CNO I/C, Nabordo Area Health Office
69	Adamu Chiroma	Bauchi	Toro LGA	RI Service provider, Nabordo Area Health Office
70	Mohammad Nasir	Bauchi	Toro LGA	I/C, Toro District Hospital
71	Susan Izang	Bauchi	Toro LGA	RI Service Provider
72	Halima Bappha	Bauchi	Misau LGA	DPHC
73	Ajiya Ahmed	Bauchi	Misau LGA	LIO
74	Garba Shehu	Bauchi	Misau LGA	CCO
75	Musa Mohammed	Bauchi	Misau LGA	M & E/Disease Control
76	Mohammed Magaji	Bauchi	Misau LGA	LGA Supervisory Councilor for Health
77	Ibrahim Abdul Dachi	Bauchi	Misau LGA	Asst. I/C, Hardawa Maternity Center
78	Hajara Bashar	Bauchi	Misau LGA	I/C RI, Hardawa Maternity Center
79	Tsalla Abubakar	Bauchi	Misau LGA	Misau Town Maternity, JCHEW
80	Nafisatu Haruna	Bauchi	Misau LGA	Misau Town Maternity, CHEW
81	Umar Hashimu	Bauchi	Warji LGA	LIO
82	Ayuba Musa	Bauchi	Warji LGA	TB/Leprosy Surveillance
83	Saidu Nuhu	Bauchi	Warji LGA	Katanga PHC Center, EHT

84	Christopher Adamu	Bauchi	Warji LGA	Katanga PHC Center, EHT
85	Suleiman Kasim	Bauchi	Warji LGA	Tiyin Model PHC Center, EHO

Sokoto: list of people interviewed

S/NO	Person Interviewed	State	Organization	Designation
1	Dr A M Gandi	Sokoto	SMOH	Director of PHC
2	Alhaji Garba Khadi	Sokoto	SMOH	Deputy Director of PHC
3	Alh Halliru A. Galadanchi	Sokoto	SMOH	SIO
4	Hassan Mohammed	Sokoto	SMOH	CCO
5	Aliyu Abubakar Abdullahi	Sokoto	WHO	RI Focal Person
6	Shafa'atu Umar Abache	Sokoto	MOWA	Assistant Director of Child welfare
7	Alh Jinaidu Mohammed	Sokoto	SMOLG	Director of PHC
8	Musa Yahaya	Sokoto	UNICEF	RI Focal Person
9	Yusuf Argungu	Sokoto	COMPASS	PEO
10	Nurudeen Lawal	Sokoto	EU-PRIME	State Coordinator
11	Alhaji Hassan Shehu	Sokoto	Rabah LGA	Director of PHC
12	Mohd Usman Rabah	Sokoto	Rabah LGA	LIO
13	Abubakar Dogo Rabah	Sokoto	Rabah LGA	Health Educator
14	Nasiru Majikira	Sokoto	Rabah LGA	CCO
15	Abubakar Maidamma	Sokoto	Rabah LGA	M&E Officer
16	Zuwaira Mohd Moyi	Sokoto	Rabah LGA	MCH Officer
17	Tanimu Aliyu Kurya	Sokoto	Rabah LGA	Hon Councilor for Health
18	Salamatu Ahmed	Sokoto	Rabah LGA	RI Service Provider, General Hospital Rabah
19	Ige Umar	Sokoto	Rabah LGA	RI Service Provider, General Hospital Rabah
20	Lawali Habibu	Sokoto	Rabah LGA	RI Service Provider, Gidan Buwai Dispensary
21	Umar Aliyu	Sokoto	Illela LGA	Director of PHC
22	Mohammed Sama'ila	Sokoto	Illela LGA	LIO
23	Yahaya Bawa	Sokoto	Illela LGA	CCO
24	Isiya Umar	Sokoto	Illela LGA	DSNO
25	Shu'aibu Hassan	Sokoto	Illela LGA	Hon Councilor for Health
26	Bashir Sani	Sokoto	Illela LGA	RI Service Provider, General Hospital Illela
27	Mustapha Ibrahim	Sokoto	Illela LGA	RI Service Provider, Ambarura Dispensary
28	Alh Garba Aliyu	Sokoto	Tangaza LGA	Director of PHC
29	Ahmed Abdullahi	Sokoto	Tangaza LGA	LIO
30	Aminu Yusuf	Sokoto	Tangaza LGA	CCO
31	Abubakar Umar	Sokoto	Tangaza LGA	Health Educator
32	Kabir aliyu	Sokoto	Tangaza LGA	M&E Officer
33	Sani Garba	Sokoto	Tangaza LGA	RI Service Provider, Rini Dispensary
34	M Aliyu	Sokoto	Tangaza LGA	I/C, Gidan Madi PHC clinic
35	Abdullahi Hassan	Sokoto	Wurno LGA	Director of PHC
36	Yusuf Buhari	Sokoto	Wurna LGA	LIO
37	Sambo Idris	Sokoto	Wurno LGA	CCO
38	Umar Isma'ila	Sokoto	Wurno LGA	Health Educator
39	Mohammed A. D/Buda	Sokoto	Wurno LGA	M&E Officer
40	Chika Ibrahim	Sokoto	Wurno LGA	I/C, Marnuna Dispensary
41	Abubakar Ibrahim	Sokoto	Wurno LGA	RI Service Provider, Marnuna Dispensary
42	Nura Aminu	Sokoto	Wurno LGA	RI Service Provider, Genral Hospital Wurno
43	Abdullahi Yusuf	Sokoto	Wurno LGA	Marnuna Community Leader
44	Shehu Marafa	Sokoto	Shagari LGA	LIO

45	Umaru Mohammed	Sokoto	Shagari LGA	CCO
46	Sahabi Danmama	Sokoto	Shagari LGA	Health Educator
47	Maccido Abdullahi	Sokoto	Shagari LGA	District Coordinator
48	Altine Mode	Sokoto	Shagari LGA	District Coordinator
49	Mustapha Umar	Sokoto	Shagari LGA	RI Service Provider, Shagari PHC
50	Habibu Musa	Sokoto	Shagari LGA	RI Service Provider, Shagari PHC
51	Sahabi Aliyu	Sokoto	Shagari LGA	RI Service Provider, Runjin Kaka Dispensary
52	Isma'ila Hamisu	Sokoto	Kebbe LGA	LIO
53	Hassan A. Musa	Sokoto	Kebbe LGA	CCO
54	Bala Danmesheka	Sokoto	Kebbe LGA	DSNO
55	Hassan Musa	Sokoto	Kebbe LGA	Health Educator
56	Maimuna Muhammad	Sokoto	Kebbe LGA	RI Service Provider, Gen. Hospital Kebbe
57	Muhammad Hassan	Sokoto	Kebbe LGA	I/C, Margai Dispensary
58	Abdullahi Umar	Sokoto	Kebbe LGA	RI Service Provider, Margai Dispensary
59	Bello Giwa	Sokoto	Bodinga LGA	DPHC
60	Adamu Abubakar	Sokoto	Bodinga LGA	LIO
61	Kabiru Garba	Sokoto	Bodinga LGA	CCO
62	Shehu Aliyu	Sokoto	Bodinga LGA	Health Educator
63	Bawa Giwa,	Sokoto	Bodinga LGA	I/C, Bodinga Town Dispensary
64	Abbas Yahaya	Sokoto	Bodinga LGA	I/C, Sifawa Dispensary
65	Umar Bala	Sokoto	Bodinga LGA	RI Service Provider, Sifawa Dispensary
66	Amina Usman	Sokoto	Bodinga LGA	RI Service Provider, Sifawa Dispensary
67	Muslimu Adamu	Sokoto	Binji LGA	DPHC
68	Mohammed Nabunkari	Sokoto	Binji LGA	LIO
69	Mode Bako	Sokoto	Binji LGA	DSNO
70	Abbas Garba	Sokoto	Binji LGA	CCO
71	Bello Mohammed	Sokoto	Binji LGA	Assistant CCO
72	USman Abdullahi	Sokoto	Binji LGA	CD
73	Hassan Maitangaza	Sokoto	Binji LGA	CD
75	Hadiza Sani	Sokoto	Binji LGA	I/C & RI Provider, Binji up-graded Dispensary
76	Aliyu Sani Dogon Daji	Sokoto	Binji LGA	Service Provider, Inname Dispensary
77	Mohammed Usman	Sokoto	Wamako LGA	DPHC
78	Umar Rubah	Sokoto	Wamako LGA	LIO
79	Abaku Armanu	Sokoto	Wamako LGA	CCO
80	Falilat Ibrahim	Sokoto	Wamako LGA	I/C, Wamako up-graded Dispensary
81	Aishatu Sulaiman	Sokoto	Wamako LGA	RI Service Provider, Wamako Dispensary
82	Hadiza Galadima	Sokoto	Wamako LGA	I/C, Arkila Dispensary