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One LGA Approach:

Implementing a focused program management intervention at a sub-regional level in Nigeria

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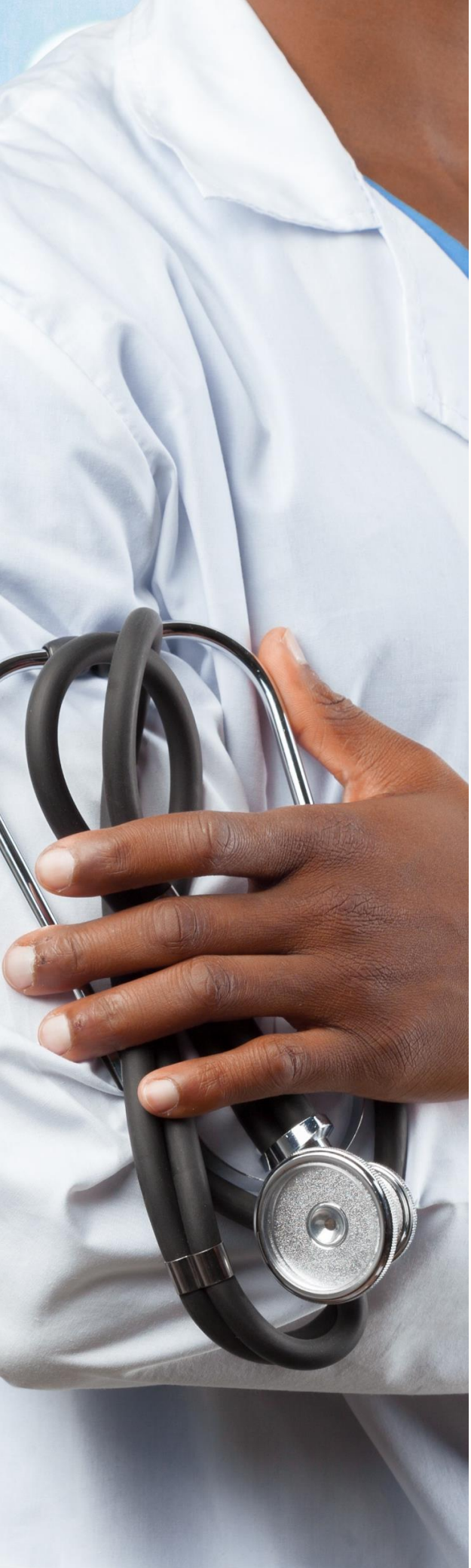
Section A
BACKGROUND



Overview

Without adequate vaccination, a large percentage of under-5 children are susceptible to vaccine-preventable diseases and ensuing mortality. In Yobe state, poor immunization coverage is a major public health concern. In 2013, only 11% were immunized with Penta 3 (NDHS 2013). Even fewer children (8.7%) had the Penta 3rd dose in 2016 (2016/17 MICS). However, by 2018, the figure had increased to 29%, which is still far off from the national average. A variety of issues plagued the health system in the state, including inadequate funding, suboptimal coordination and accountability and weak capacity of managers. Routine immunization was particularly plagued by systemic inefficiencies in the supply chain, data management, and conduct of immunization service by health workers; against the backdrop of poor community awareness and weak motivation to demand vaccines.

In 2015, the Yobe immunization landscape was significantly redefined when the state government signed an MoU with the Bill and Melinda Gates Foundation (BMGF), and The Aliko Dangote Foundation (ADF) to collaboratively contribute monies into a basket account to fund the state's RI program and garner high-level political participation in immunization activities. These critical inputs were complemented by high-quality technical and management support from partners to the Yobe State Primary Health Care Development Agency (YSPHCDA). Since then, the state began to achieve sustained progress in immunization performance such that by 2018, Yobe state was named the most improved state in RI coverage in the country after reaching 29% RI coverage compared to just 9.7% two years prior. However, the needle wasn't moving fast enough as a large percentage of children were still without coverage against vaccine-preventable diseases.

1 WHO, UNICEF, CDC-AFENET, SCIDaR, and CHAI

This prompted an internal analysis conducted by the Solina Center for International Development and Research (SCIDaR) and the YSPHCDA in 2019 which revealed that interventions that had been implemented till then had effectively strengthened the capacity at the state level which catalysed the observed improvement in RI coverage, however, the capacity of LGAs and health facilities program managers, who are at the forefront of delivering RI interventions, remained suboptimal. In contrast to the state level, there was poor coordination of available partner resources at the Local Government Area (LGA) level, as well as a poor use of data in identifying and solving problems. It became evident that sustaining the rapid improvements and driving further change in the state would require targeted capacity strengthening in program management and problem-solving at the LGA frontlines where day-to-day operations were implemented. Thus, SCIDaR collaborated with Yobe State Emergency Routine Immunization Coordination Centre to design and test the One LGA approach program, a capacity-building and system-strengthening intervention focused solely at the LGA level, which was piloted for 6 months in the Damaturu LGA of Yobe state.

Damaturu Profile

Damaturu is the capital of Yobe state as well as a local government area. It covers an area of 2,366 km2 and is home to an estimated population of 124,000 people, which is 3.6% of the entire population in Yobe (MNCH2). Located between Maiduguri and Potiskum, it is impacted by an influx of displaced people from unsafe areas. It has eleven wards and four districts. These districts comprise of 28 villages and a heterogeneous mix of urban and rural settlements. Damaturu has 24 functional HFs, accounting for 4% of total HFs in the state.

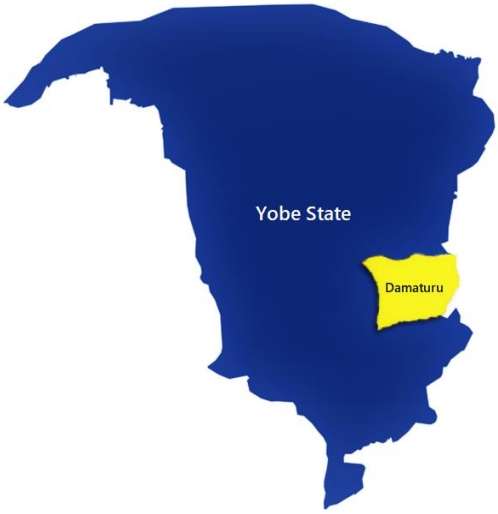


Fig 1: Map of Damaturu in Yobe state

Damaturu is the capital of Yobe state as well as a local government area. It covers an area of 2,366 km2 and is home to an estimated population of 124,000 people, which is 3.6% of the entire population in Yobe (MNCH2). Located between Maiduguri and Potiskum, it is impacted by an influx of displaced people from unsafe areas. It has eleven wards and four districts. These districts comprise of 28 villages and a heterogeneous mix of urban and rural settlements. Damaturu has 24 functional HFs, accounting for 4% of total HFs in the state.

Coordination of the PHC program at the LGA level

The primary healthcare system, consisting of all the PHC facilities and the target population within a LGA, is coordinated by the LGA team headed by the Director of Primary Health Care. With regards to the routine immunization program, the team is composed of the LGA cold chain officer (LCCO), LGA immunization officer (LIO), routine immunization officer (RIO), and LGA monitoring and evaluation officer (M&E officer). The One LGA intervention focused on strengthening the capacity of these officers to lead the RI program.

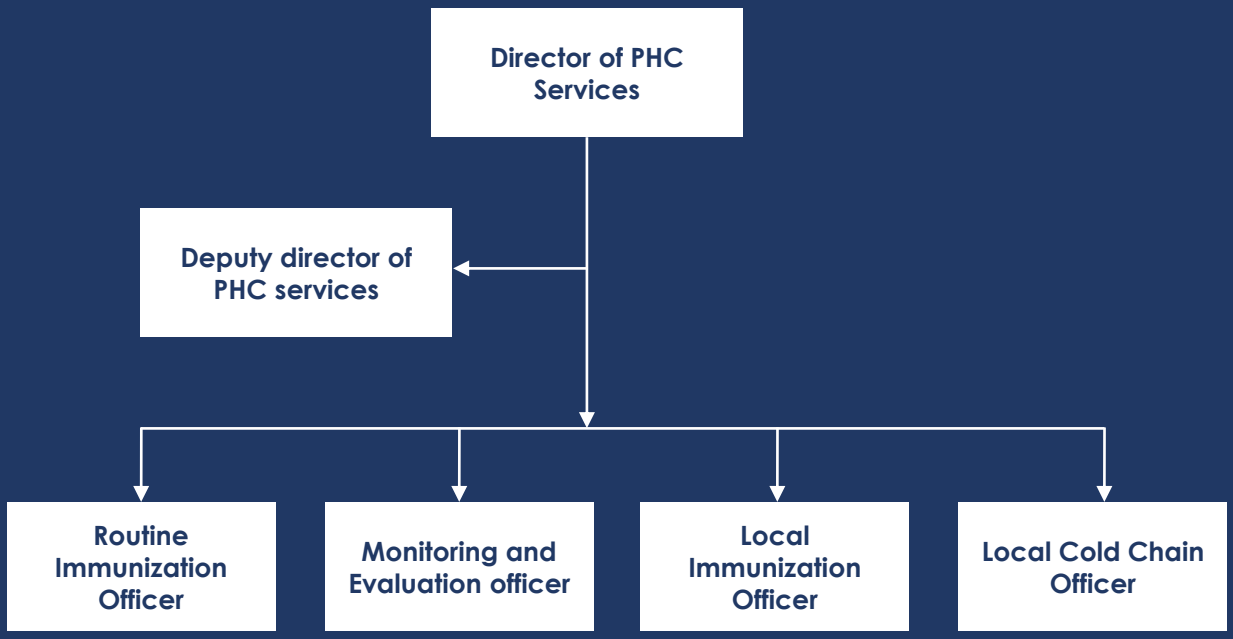


Fig 2: LGA Team

At the health facility level, each PHC is led by the officer-in-charge while the routine immunization unit is led by the RI-in-charge who leads the routine immunization providers in her/his unit. Each health facility have a team of voluntary community mobilizers attached whose role is to leverage their relationships and ties within the community to create demand for all PHC services including RI. The One LGA intervention focused on strengthening the capacity of the OIC and the RI-in-charge in problem-solving, using readily available data and resources, to improve the uptake of immunization within their catchment area.

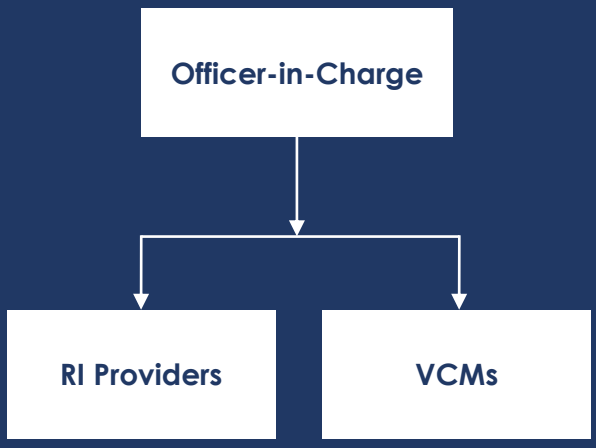


Fig 3: Health Facility Team

The design of the One LGA approach

To design the strategy, Yobe SERICC employed a human-centred design approach by involving the LGA team and the RI providers in developing the methodology. The objectives and desired outcomes of the strategy were set as summarized in Figure 4. The One LGA support approach aimed to build leadership and management capacity at the LGA level in a hands-on manner. The expected overall outcome was improved RI coverage and outcomes in the state.

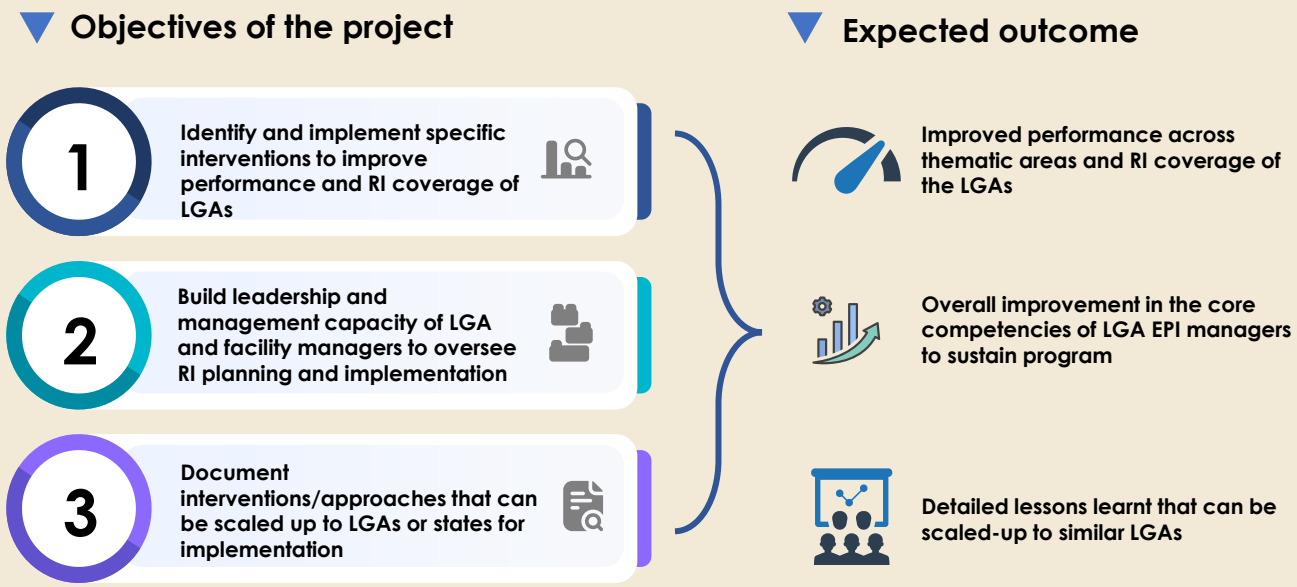


Fig 4. Objectives of the One LGA Approach

The methodology for the One LGA Approach

SCIDaR supported Yobe SERICC to embed a management partner (MP) within the Damaturu LGA team. The MP first conducted a baseline diagnostic across all the thematic areas of the RI program in the LGA - governance, financial management, service delivery, vaccine supply chain, community engagement and monitoring and evaluation. This diagnostic was used to develop a roadmap for capacity improvement within the LGA team. (Figure 5) This diagnostic was reviewed with the LGA team to collaboratively develop and implement solutions over the period of the intervention.

Thematic area	Focus	Indicator	Score	Target
Service delivery	REW microplan	% HFs with updated REW microplan	100%	100%
	Session conduct	% planned outreach settlements reached	76%	100%
	LQAS-RI feedback	% of post-LQAS action points completed	-	100%
M&E	RI data quality	% annualized penta 3 coverage[1]	137%	<100%
RISS	Facility performance	% HFs that scored >80% on the grading scale[2]	-	100%
Vaccine supply chain	Stock availability	% HFs that recorded stock-out during sessions	13%	0%
	Vaccine wastage	% wastage rate of PENTA vaccine	-4%[2]	15%
Community engagement	Defaulter tracking	% Penta 3 drop out	14.5%	5%
Leadership and governance	LERICC functionality	% Proportion of LERICC meeting held	50%	100%
		% Proportion of action points completed	-	100%

Specifically, to strengthen governance and coordination, the MP supported the regular conduct of LERICC meetings which improved the coordination of all RI activities and partners in the LGA. To reduce the high number of dropouts in the LGA due to the weak defaulter tracking system, the MP supported HF-specific problem-solving which led to the identification of context-appropriate defaulter tracking and social mobilization initiatives. At the LGA level also, the MP supported the team in establishing a functional performance management system for improved insight into the performance of the RI program.

The team proposed interventions to address identified challenges across the different thematic areas

Thematic area	Challenges	Interventions
A Service delivery	▪ Poor optimization of fixed sessions e.g. lack of service integration ▪ Sub-optimal coverage of outreach settlements	▪ Support HWs to integrate other PHC services to drive demand for RI ▪ Institute HF specific interventions to cover all outreach settlements monthly
B Community engagement	▪ High number of drop outs in the LGA due to weak defaulter tracking system ▪ Sub-optimal social mobilization for fixed and outreach sessions	▪ Develop and implement HF specific defaulter tracking and social mobilization initiatives
C Vaccine security	▪ Stock out of vaccines at high volume HFs due to poor planning ▪ High vaccine wastage rates at LGA and HFs due to poor vaccine data management	▪ Review stock allocation based on consumption in high volume HFs ▪ Monitor HF stock level weekly and provide prompt top-ups ▪ On-the-job mentoring for HWs on adequate vaccine data management
D Monitoring & evaluation	▪ Consistent reporting of over 100% Penta 3 coverage on DHIS2 due to sub-optimal data management practices across HFs	▪ On-the-job mentoring for HWs on data management ▪ Strengthen data validation using panel review before upload to DHIS2
E Supportive supervision	▪ Poor quality of RISS visits conducted by supervisors ▪ Non-completion of action points by HWs	▪ Develop and institute a HF grading system to track and improve facility performance ▪ Establish RISS findings as standing agenda at LERICC meetings

Building the capacity of the LGA management team was a priority in order to sustain progress beyond the period of the intervention. Therefore, the MP provided on-the-job capacity building to the LGA team in effective problem-solving, coordination, planning and implementation of locally owned, context-appropriate interventions as well as performance management.

Duration of intervention

The One LGA approach was implemented in Damaturu LGA from October 2019 to April 2020.

Monitoring and evaluation approach

To monitor the outcomes, a monitoring framework was developed consisting of indicators that were useful in tracking performance improvement. During the course of implementation, attention was paid to identifying local, context-specific innovations that were deployed within health facilities and by the LGA team to improve the performance and RI coverage of LGAs. Insights from these small-scale innovations at the LGA and facilities have broad implications for the overall state RI program.

Section B
INNOVATIONS

1 Boosting uptake of vaccination services by strengthening community engagement and service provision

Prior to the commencement of the strategy, Damaturu LGA updated the REW micro-plan for all 16 facilities. The REW micro plan revealed that most of the settlements in the LGA were within 2km of health facilities. However, Penta drop-out rates within the LGA were suboptimal where children were not completing the full immunization schedule. When children are not fully vaccinated with the 3rd Penta dose and the measles vaccine, there is still a high chance of disease outbreaks and preventable morbidity and mortality.

This necessitated a fresh focus on community engagement via collaboration with the World Health Organization's hard-to-reach (WHO HTR) team and UNICEF's Voluntary Community Mobilizers (VCMs) to localize advocacy and sensitization in the communities. This approach helped break socio-cultural, religious, and trust barriers that often come with non-localized community engagement outreaches.

The LGA team and the HF personnel developed various strategies to address social and cultural drivers of vaccine hesitancy as a strategy to tackle Penta 3 dropout rates. In many health facilities, the MP worked with the LGA team to redesign the existing defaulter tracking system addressing facility-specific issues, and leveraging relationships between the facilities and communities.

Through the implementation of the one LGA program, 9 out of 16 health facilities were able to reduce their dropout rates, bringing the overall rate in the LGA from 14.5% in October 2019 to 5% by February 2020 thus achieving the set target.

Great results when we listen to the community: How a PHC improved RI coverage by becoming responsive to the community

Maisandari PHC in Damaturu LGA serves 23 settlements in Yobe state. It is one of the larger health facilities in the LGA, responsible for providing an annual cohort of 4,044 children with quality vaccination services. Musa Shuaibu is the RI focal person at the facility for over 5 years. He explains that prior to the intervention, Maisandari PHC had recurring issues with vaccine dropout rates and low service patronage. Typically, only 16 beneficiaries received vaccinations each week before the intervention, which is significantly less than the expected weekly vaccinations of 77 children from the facility's catchment communities. However, on average, 65 (+306%) children are now vaccinated weekly at the PHC because of the new systems instituted at the PHC.

This was achieved when the RI team in Maisandari PHC used information uncovered in dialogues with community members to make simple changes in service provision. The facility leveraged 3 channels to engage the community - weekly community outreaches, mobile outreaches and community advocacy facilitated by the 10 Voluntary Community Mobilizers (VCMs) attached to the 23 settlements.

Via these routine engagements, the RI team discovered the specific concerns against vaccination within the communities they served and used this information to formulate appropriate advocacy and communications information provided via various channels. Some of the fears the caregivers had included vaccine side effects and pain from multiple, same-day injections.

Caregivers specifically feared returning home with a "sick and crying" child who was healthy before receiving a vaccine. Through the community visits, the RI team educated caregivers about the side effect of vaccines like mild fever, redness, and/or swelling of injection spots. The targeted information provided placated fears and encouraged caregivers to return to the clinic for follow-on vaccinations for their kids.

In addition, at these outreaches, referral slips were given to identified pregnant women encouraging them to seek vaccination for newborns when they give birth. This provided a link to immunization for women who deliver at home. To date, at least 7 newly delivered women are referred weekly from the antenatal clinic to the RI clinic.

Musa Shuaibu opined that the support received during the One LGA Approach program implementation was very beneficial to the Maisandari PHC. Reminiscing about the "One LGA Approach" He enthusiastically declares with a big smile on his face that "Before we were not engaging the community in our daily routine services. He (the MP) introduced peer learning and the ways we can engage the community" According to him, community engagement and peer learning were all innovative systems that the One LGA Approach helped redesign and strengthen.

Fig 5: Musa Shuaibu, RI Focal Person Maisandari PHC, Damaturu Yobe 2020

From the community, by the community, for the community: Leveraging VCMs for targeted defaulter tracking

Voluntary Community Mobilizers (VCMs) are essential to health interventions at the much smaller Mairi PHC in (southern/northern/eastern?) Damaturu. VCMs are funded by UNICEF and the collaboration between UNICEF and the YSPHCMB ensures the strong contribution of VCMs to the RI program across the state.

Zara, one of the VCMs at Mairi PHC, dons the unique hijab made for VCMs inscribed with the logos of UNICEF and BMGF. She has been a VCM for 8years. In Mairi, she works with Jamunsu, who has been a VCM for 7 years. Together they cover 6 settlements within the catchment area of Mairi clinic.

In addition to joining RI outreaches with the mobile outreach team, they go from house to house advocating, sensitizing, and teaching women about the importance of RI.

As women and members of the community, the VCMs are perfectly positioned to navigate what may become cultural and religious barriers for others.

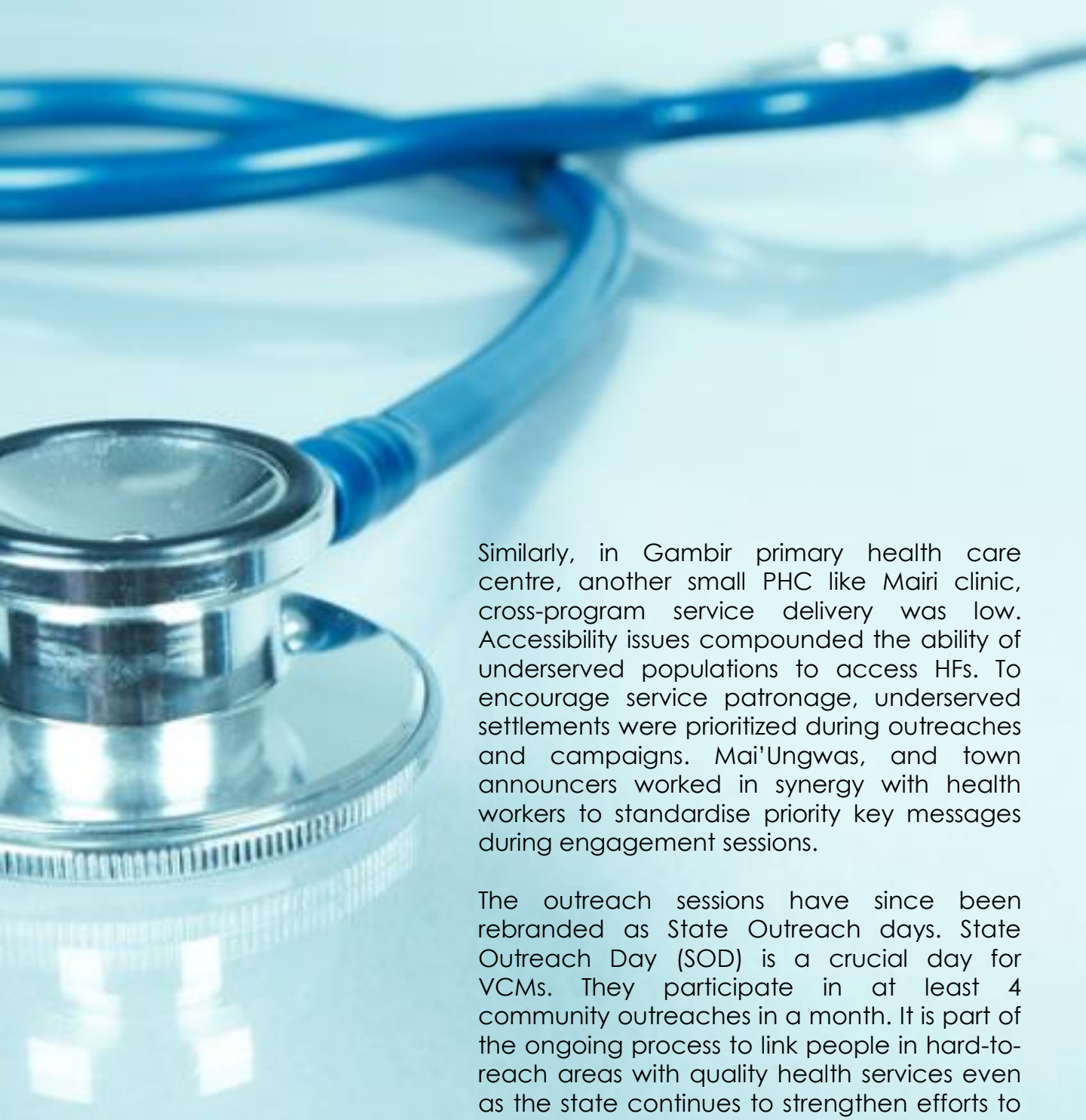
The One LGA approach enabled RI providers to leverage the unique advantages of the VCMs for targeted defaulter tracking. Health workers were retrained to identify defaulters from the immunization register on a weekly basis and to share this list with VCMs like Zara and Jamunsu who visit defaulting mothers in their homes to ask why they miss a session. These VCMs were equipped with the information they need to answer questions and mobilize defaulters, with great results seen.

Fig 6: Zara and Jamunsu, Voluntary Community Mobilizers, Mairi PHC, Damaturu, Yobe 2022

"When we were first employed, in the settlement we currently work, the residents never used to go for RI or ANC, they didn't use the hospital for anything. But when we started supporting them, they have been accepting interventions now because we have been mobilizing and orienting them. Usually, the problem we encounter is when the children are given Penta injections, and then they cry for (a) long (time), the parents refuse to take them back, but we always explain the benefits of the injection, so they return to take other doses.

In the clinic, we were taught how to use the tickler card to record. When we check the register to identify defaulters, we call the VCMs of the settlement (where the defaulter lives) to tell them a particular child that lives in a particular house has missed his/her dose. Then, the VCM goes to the house and brings the child and their parents to get their shots. Even people that were not cooperating before have started accepting immunization" Zara Goni, VCM, Mairi CLinic

Prioritizing underserved communities with community engagement



Similarly, in Gambir primary health care centre, another small PHC like Mairi clinic, cross-program service delivery was low. Accessibility issues compounded the ability of underserved populations to access HFs. To encourage service patronage, underserved settlements were prioritized during outreaches and campaigns. Mai'Ungwas, and town announcers worked in synergy with health workers to standardise priority key messages during engagement sessions.

The outreach sessions have since been rebranded as State Outreach days. State Outreach Day (SOD) is a crucial day for VCMs. They participate in at least 4 community outreaches in a month. It is part of the ongoing process to link people in hard-to-reach areas with quality health services even as the state continues to strengthen efforts to improve RI coverage in all its LGA areas. The data from Damaturu shows progressive growth as a testament to the collaboration of all parties involved in RI planning and execution.

Bidirectional, intra-facility referrals improve RI uptake

Even though published literature have repeatedly shown that cross-program collaborations and interdepartmental coordination increase service delivery uptake within health facilities, Nainawa health facility in Damaturu LGA did not enjoy these benefits as there was little collaboration between the malnutrition clinic, outpatient ward and antenatal clinic within the health facility. Although having a similar target population and pool of eligible clients meant clients could be referred during clinic visits, this was barely the case.

This gap was identified during facility-specific problem-solving identified this gap and various strategies were put in place to achieve integration and intra-facility referrals. Service integration was pursued by placing technical staff in relevant PHC programs like CMAM and ANC, to immunize eligible clients from those program flows. IEC materials were developed and displayed in strategic units of the health facilities to keep the knowledge and the importance of RI fresh and important in the minds of service users.

All around the clinic, clients eligible for vaccination saw key messages and were referred by health workers in those

departments to the RI clinic when needed.

The key messages for RI programs were also reviewed to include a new key message. Through this service integration and referral, health workers administered vaccines to new clients who may not come directly to the immunization clinic. Hence, prospective targets for RI who use other services in the health facility were reached.

This form of collaboration implemented between various department heads improved the uptake of RI. Fatima Adamu, the RI focal person says that the referrals from other clinics were a great contribution to improved coverage in the PHC. The other health workers outside of the RI program were happy to support the referral initiative because they understand that getting more people vaccinated means more people get to live free of vaccine-preventable diseases. Referrals from RI clinics to other clinics like nutrition have also helped improved demand generation and service delivery in the PHC.

Fig 9: Fatima Adamu - the RI Focal Person at Nayinawa PHC, during a vaccination session Damaturu, Yobe, 2022

2 Improving data management to optimize data-driven decision making

Unreliable data limits the ability of program managers to make data-driven informed decisions to improve the RI program. In Damaturu LGA, quality issues were routinely found in the administrative data reported on DHIS2. For example, there was a consistent reporting of >100% Penta 3 coverage on DHIS2 due to sub-optimal data management practices across HFs. There were also discrepancies between data sets of children immunized and doses of vaccine used. Some of the data issues stemmed from the poor recording by the health workers into the paper-based records at the health facilities. On the other hand, errors also occurred when data was being transferred by LGA M&E officers from these facility tools into the national DHIS2 platform at month's end.

The MP's approach to addressing the data problems was therefore two-pronged - on-the-job mentoring for health workers on data management as well as strengthened data validation using panel review before uploading to DHIS2.

By learning the processes to validate and triangulate data, the integrity and credibility of data coming from the health facilities have improved.

With strengthened data validation through monthly panel reviews of the data from all health facilities, errors during data transfer have also been reduced.

In addition, a combination of community spot checks to validate immunization numbers in flagged HFs, and review of facility registers was employed by the MP and LGA M&E officer to investigate overreporting concerns. The

GIS estimate of the target population was also found to be 55% greater than the DHIS2 figure and consequentially, there were more children in need than the target population identified by the DHIS2.

Overall, the timeliness of submission and congruence across various data tools have improved greatly. Musa Shuaibu from the Maisandari PHC benefited from the data management training and says that afterwards, he was able to correct some of the errors he had been committing in filling the data registers.

The interventions deployed in Damaturu has had the added benefit of informing data quality improvement strategies at the state level. Dala Sarki (Incident Data Control Room Manager) says that lessons learnt from the data quality improvement in Damaturu LGA is important to the Incident Data Control room in Yobe..

He opined that local staff being part of the strategy design process for the data control room; allowed them to proffer localized solutions to issues that they were privy to spot at the local levels

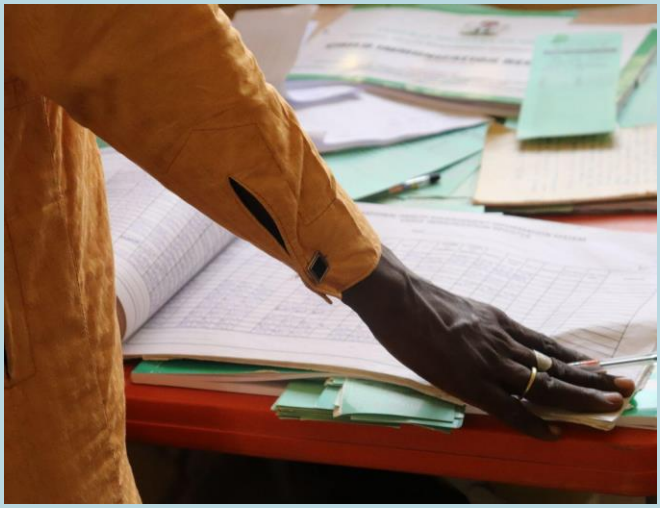


Fig 7: Facility RI Records at Nayinawa PHC, Damaturu, Yobe, 2022

3 Strengthening governance and building management capacity at the LGA to maintain sustainable growth

Improved RI outcomes hinges on strong management capacity and availability of resources to the beneficiaries. The leadership and governance structure at the LGA level is well articulated and has been described in Figure 2 above. The coordinating structure for all RI activities at the LGA level is the LGA Emergency Routine Immunization Coordination Center (LERICC), similar to the SERICC at the state level and NERICC at the national level.

However, LERICC meetings for the coordination of RI activities were infrequent. This affected efficient collaboration between partners and the LGA team and led to poor coordination of resources and activities. The MP worked with the PHC Director to get these meetings back on schedule and consequently, weekly LERICC meetings were held unobstructed leading to strengthened collaboration between partners and the LGA health team. For example, 63% of total LERICC meetings planned were conducted, and 93% of action points were completed between Oct 2019 and May 2020 leading to a regular achievement of the set priorities during this period.

The on-the-job training by the MP positively impacted the performance of the LGA team. For example, health educators tasked with the supervision of community engagement activities in the LGA and support in defaulter tracing were able to make transitions from carrying out their functions with prompting to being able to carry out the activity with complete independence. This transition ensured the prompt execution of activities and resulted in better coverage of local communities. Similar to health educators, the M&E officer was able to independently carry out important activities like the distribution of RI data tools to HFs, review of DHIS data, provision of reports to LERICC, and conduct of LGA review meetings. The LCCO made similar progress with the planning, tracking, and topping up of vaccines to the RI facilities from the cold store.

Fig 8: Mohammed Gureiman, Director of PHC Damaturu LGA, Yobe, 2022

Matazu, a BMGF consultant who worked in Yobe state during that period, attributed the progress in the Damaturu LGA partly to improvements in governance and coordination.

He stated that while many factors were in play, the one LGA approach was a significant contributor to the strengthening of the systems.

The Deputy Director of Immunization and disease control and the Program Manager of SERICC, Mohammed Alli remember scepticism from partners surrounding the ability of the local management body to handle multi-faceted coordination at their levels. Such doubts have been dispelled as the Damaturu LERICC continues to make progress to achieve their goals. He also mentioned that improved capacity in the coordination bodies is a step in the right direction towards the localization of humanitarian efforts in the country. He applauded the impact of the One LGA approach and how it has helped Local personnel to take ownership of coordination.

4 Other system-strengthening innovations

Planning for contingency vaccine top-ups to reduce vaccine stock-out rates at apex and cascade health facilities

Generally, vaccine storage at the health facility level is dependent on the availability of the appropriate cold chain equipment (CCE) to preserve them over extended periods of time. These sorts of health facilities are ward PHCs and are designated as 'apex health facilities. The facilities without the capacity to store vaccines at the required temperature to preserve them are called cascade facilities. They rely on supplies from apex facilities for the number of vaccines they need for each immunization session. The vaccines are stored in cold boxes and do not typically remain viable till the next day and thus need to be returned to the apex facilities.

Prior to the beginning of the intervention in Q2 2019, vaccine stockout rates were quite high in Damaturu LGA. On average, apex facilities only had adequate stock 45% of the time and stocked out 13% of the time. Stock-out rates in cascade facilities were understandably at a similar level of 12.5% during this period.

To address this, and with support from the MP, HF stock levels were monitored weekly, and LCCOs were followed up twice weekly to deliver top-up vaccines to health facilities guaranteeing that Apex facilities had sufficient stock to serve health facilities within their wards. After the 2 quarters of execution, the average stock out rate at apex facilities reduced progressively to 1% and 4% at cascade facilities. Vaccine wastage for Penta, OPV, and BCG was kept under an acceptable margin by optimizing HF practices.

Fatima Adamu shared that the Nyanaiwa health facility hasn't suffered a vaccine stock-out in more than a year. This attested to the effectiveness of the vaccine top-up plan. The plan brought down the percentage of vaccine stock-out rates from 13% to 0% during implementation. Training health workers on the proper handling and storage of vaccines helped reduce the degree of vaccine wastage.

Focused supportive supervision to identify and solve individual facility problems

Supportive supervision is a pivotal strategy of the NPHCDA to improve RI uptake in the MoU states. However, the regular LGA–HF RISS visits have not translated to improved service delivery and operations at routinely visited health facilities. Discrepancies between data reported on RISS ODK and the data on the child immunization register posed serious concerns about the effectiveness of supervisory checks.

The MP conducted a diagnostic survey with health workers that suggested that supervisors do not conduct rigorous checks during visits. And without a clear action plan from supportive supervision, action points were largely left uncompleted. Competing activities left little time for proper problem-solving, and capacity-building for HWs.

To address identified challenges, the MP and LGA team redesigned the Supportive supervision framework. The initial RI supportive supervision combined capacity building with health facility service quality assessments into one visit. Not only does this require supervisors to do so much within a limited period of time, but the RISS checklist also had too many questions leaving very little time for supervisors to accomplish anything else. The MP recommended that a divorce of the capacity-building program from the health facility evaluation would allow for a proper assessment of both components.

The separation would enable the LGA supervisors to enforce accountability measures on HFs and focus on capacity building, while an independent team conducts a bias-free assessment of HF performance.

Supervisors in the Yobe LGA are now able to focus on capacity building and problem-solving during their visits. For example, according to Hajara Samaila the O-I-C of Mairi PHC, for many months, a group of marijuana users hung around the Mairi clinic. Their notoriety caused fear amongst caregivers and children and obstructed access to services at the HF. Several attempts to address the issue by the health workers proved abortive. However, after a RISS visit, the supervisor and delegates from the PHC engaged with the community leaders to appeal to and relocate the smokers. The intervention was successful and since, the smokers have vacated the premises of the PHC. Peaceful relocation of said persons led to a noticeable turnaround in willingness to visit the facility and improved service uptake among community members.

Overall results achieved in Damaturu LGA

Throughout the course of implementation, several recommendations have been implemented by the LGA team to improve RI coverage in the LGA. The embedded MP worked directly with the Damaturu LGA team from Sep 2019 to Mar 2020 (6 months) and in that period, achieved key results such as the following: Coordination of RI program is more coherent as evidenced by a 50% improvement in the number of monthly LERICC meetings conducted and completion of work-plan.

Service delivery at health facilities is better in terms of quality and the number of children immunized. In the intervention period, facilities in Damaturu reached an average of 56% more children with Penta 3 than their monthly target. Penta's dropout rate was also brought down below 10% before the disruption by the COVID-19 Pandemic.

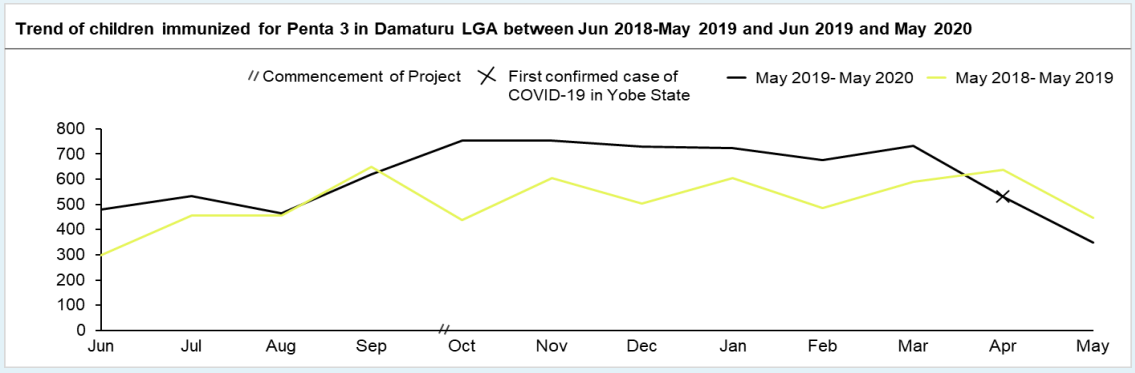


Fig 10: Trend of children immunized for Penta 3 in Damaturu LGA between Jun 2018-May 2019 and Jun 2019 and May 2020

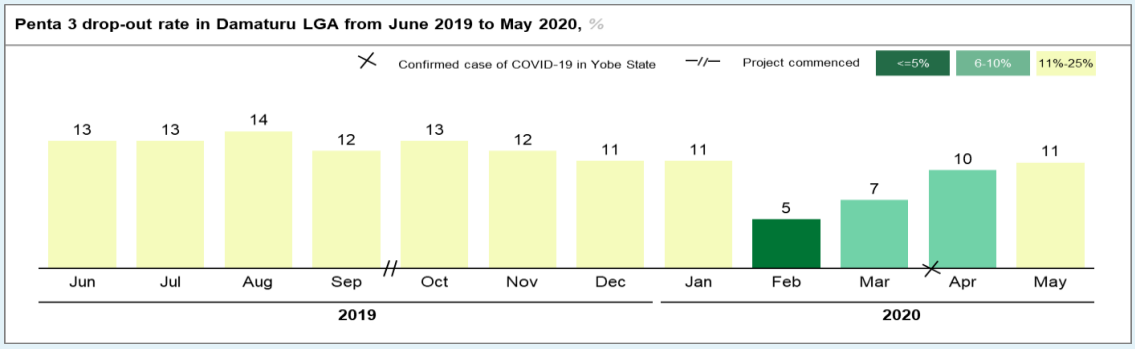


Fig 11: Penta 3 drop-out rate in Damaturu LGA from June 2019 to May 2020

Project commenced | <=5% | 6-10% | 11%-25% | >25% | <0%

Penta 3 drop out rate across facilities in Damaturu LGA between Jun 2019 and May 2020 *(Percent difference)*

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
1. Specialist	26	23	22	21	16	13	8	9	8	8	9	9
2. Mairi HC	12	9	10	7	10	10	11	10	10	10	9	8
3. Damakasu HC	-1	4	10	7	12	14	8	9	10	6	11	13
4. Family sup.	-16	-14	3	1	4	3	3	4	4	3	3	4
5. M/Matari HC	-2	3	2	-2	0	4	1	2	3	3	1	2
6. Murfa PHC	24	18	14	13	11	11	9	7	2	1	3	4
7. Nayinawa	-2	-2	0	0	4	9	8	8	8	8	8	9
8. Dikumaru HC	24	14	10	10	17	18	16	17	19	16	17	16
9. Gambir PHC	26	-19	23	23	22	20	20	19	18	18	21	20
10. Gwange PHC	15	22	16	15	20	21	25	26	24	23	21	22
11. Kallalawa HC	44	44	30	26	21	13	9	10	17	17	13	12
12. Gabai PHC	60	60	48	42	44	41	37	35	33	33	31	30
13. Kukareta PHC	10	10	5	-9	-3	-4	-11	-10	-10	-8	-10	-10
14. M/Sandari	-14	-10	-9	-11	-9	-9	-9	-8	-7	-5	-5	-6
15. Sindiri PHC	-3	13	14	10	10	0	-11	-10	-11	-9	-10	-9
16. Police clinic	-200	-118	-80	-58	-62	-46	-9	3	-5	-13	-7	6

The Penta 3 vaccine stock-out rate came to 0% and wastage rates were kept within the acceptable range, not higher than 7% in March 2020 at the onset of the pandemic.

There was also Improved quality of data reporting. When the DHIS2 data is compared with child immunization registers at sampled facilities, there was high congruence in both data across with the exception of one facility in one month, compared to large discrepancies in multiple facilities before the intervention began.

In addition, the revised RISS strategy designed and deployed during the One LGA Approach project has proved efficient in addressing the deficiency of the previous strategy and has been adopted for use across all LGAs in the state.

Why did the One LGA approach work?

There are various reasons the One LGA approach achieved the dramatic changes in the RI program it did during the 6 months of implementation. There was the value created from the co-creation and collaboration with stakeholders at the state, LGA and HF levels. Getting the buy-in of stakeholders at the state and LGA during the planning phase of interventions (including co-identification of problems and suggestion of possible solutions) improved the commitment of the line managers and ensured optimal implementation. Collaboration among relevant LGA-level partners helped optimize the implementation of interventions by ensuring the availability of resources.

It was also beneficial to the program that there was a MP focused solely on this intervention at Damaturu LGA was vital to enhancing adequate program monitoring with minimal distraction.

Another leverage Yobe SERICC incorporated was the choice of Damaturu LGA as the pilot LGA to try out this intervention. Damaturu, as the capital of Yobe state, was central and allowed for easy supervision of ongoing activities and involvement of the state.

The EPI program in Yobe state had many prior years of support from partners like BMGF, ADF, UNICEF, WHO and several others. The resources provided through these partners at the state and LGA level ultimately created a strong foundation for this innovation.

In addition, many processes and systems already existed at the LGA level which the One LGA approach leveraged on. This included the LERICC platform that had been inaugurated before, strong vaccine supply chain systems and several others.
Intrinsic to the program itself, however, was the responsibility the intervention conferred on the frontline workers at the lower levels of care to innovate and solve the problems they faced, in a coordinated fashion and armed with better problem-solving and performance management capabilities provided by the MP.

Challenges experienced

The COVID-19 outbreak in 2020 caused a decline in achieved results. Lockdown measures, disruption of the supply chain, and fears about the outbreak had a negative effect on the previously obtained results. However, resilience in the strengthened systems enabled a bounce back in results despite the initial setback caused by the global pandemic.

Security concerns in some facilities in Geidam and Yusufari areas made it difficult to execute the one LGA intervention in these areas. Health worker attrition at health facilities also impacted the project, leading to capacity loss. To mitigate this, however, new staff were trained on the new procedures during their resumption.

Lessons Learnt

Each of the success stories from One LGA intervention reveals striking innovations that were tested and found success at the local level. First, it is clear that health facilities can better harness community resources available within their catchment area to drive better demand and improve engagement and advocacy.

The improvement in vaccine stock-out rates due to tweaks in the supply chain processes within Damaturu reveal the value of contingency top-ups in between delivery cycles.

The modified RISS visits focused supervisors on problem-solving rather than routine facility assessment, revealing how supportive supervision can be modified for optimal effect across the state.
An overall lesson, however, is the proof of the possibility of resolving intractable issues with the EPI program in Nigeria at a much lower level than is currently targeted with most interventions in the country. With improved coordination and capacitated health workers at the LGA and the health facility, context-specific innovations that would optimize outcomes can be discovered and implemented.

Recommendations

States hoping to implement a similar strategy would need to achieve strong buy-in at the state and LGA levels as this intervention requires collaboration and ownership at all levels to succeed. To accomplish good buy-in, in-depth situation analysis will be required to uncover systemic failures and strong links to inadequate capacity at lower levels.

During implementation, maintaining buy-in and sustaining the provision of resources may be easier if the human-centred design approach is used consistently. Stakeholders at all levels need to be involved in problem identification, ideating and implementation processes.

Routine tracking of the approach via strong performance management tools and processes is also important. In addition to measuring outcomes across all thematic areas, efforts should be made to study and record the various innovations being implemented across the various health facilities and at the LGA level.

Scale-up and implications for other programs

A scale-up strategy for a state like Yobe with 15 other LGAs and an expanded focus on other PHC programs would be no mean feat. There are multiple considerations and questions as the state balances resources available and feasibility. If the vision is to capacitate program managers and frontline workers across other priority programs and in all other LGAs, it would be important to conduct this in a phased manner thus minimizing the cost of failure. To reduce the cost of hiring and deploying MPs, the state may consider a leadership and management program for identified staff at the LGA level. Such trained staff could then be supported to provide the hands-on capacity-building and performance management support that each LGA would require for transformational changes.

Gallery

Fig 13: Fixed RI sessions at the Damaturu LGA PHC Headquarters

Fig 14: Health Worker filling the NHMIS data registry

Fig 15: RI Unit, Mairi PHC

Fig 16: RI Focal Person, Mairi PHC

Fig 17: Mother's waiting for vaccination at the Nyainawa PHC

Fig 18: A mother showing the vaccination card of her child to a health worker at the Nyainawa Health Facility

Fig 19: LERICC Coordination Meeting

Fig 20: LERICC Coordination Meeting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