



TURNING DATA AND DATA SYSTEMS INTO ACTION: REACHING AND MONITORING ZERO-DOSE CHILDREN IN NIGERIA

Webinar Transcript

[00:00:00.00]

>> Good morning, good afternoon to everyone who has joined. We will get started in just a minute or two. In the meantime, if you'd like to introduce yourself, please do that in the chat box.

Good morning, good afternoon, everyone. I think I'm going to go ahead and get started. My name is Grace Chee. I'm really happy to introduce today's webinar, "Turning Data and Data Systems into Action: Reaching and Monitoring Zero-Dose Children in Nigeria." I am the project director for the MOMENTUM Routine Immunization Transformation and Equity project, a USAID-funded project that works toward a world where all people eligible for immunization, but particularly the underserved, marginalized and vulnerable populations, are regularly reached with high-quality vaccination services. We're really happy to develop this webinar today in partnership with the Zero-Dose Learning Hub. The Zero-Dose Learning Hub is funded by Gavi and led by JSI Research and Training Institute, and together we're four country hubs in Bangladesh, Mali, Nigeria and Uganda. The consortium captures and shares evidence about how to reach zero-dose children.

Before I start, I wanted to do some quick housekeeping and review the Zoom environment for today's webinar. So, we will be offering simultaneous translation in French for this webinar. You can access the French-speaking channel by clicking on the interpretation icon at the bottom of your Zoom screen and choosing your language there. You can choose to listen to the webinar in either English or French. Please use the Q and A button that's located at the bottom of your Zoom window to ask any questions during the presentation, or if you need help with the technology, you can use the chat feature to introduce yourself and share any thoughts that you have about the ... share your thoughts during the presentation but please don't use that to ask questions. When you ask questions in the Q and A button, they're only visible to you, our presenters and to our technical support team. So, if you have any problems, any technical difficulties, our support team will respond to your question privately. We'll also be collecting questions from our speakers, and we'll save them for the discussion period following the presentation. This webinar is being recorded, and after today's event you'll receive an e-mail with a link to the recording. And also, if there are any questions that come up that don't get answered during the Q and A session, we'll forward them to the presenters and share any responses by e-mail to all participants.

We have two great speakers today who we introduced just before their presentations. Right after the presentations, we are honored to have Rebecca Fields, who will join us to provide her feedback and observations. And then we'll end with about 15 minutes to answer your questions. Our two speakers have joined our webinar today, but I wanted to let you know that we recorded the presentations ahead of time in case of technical difficulties. So, you'll be hearing prerecorded presentations, but they will be live during the Q and A session so please make sure to ask any questions that you might have.

[00:05:00] First, I would like to turn it over to Heidi Reynolds from Gavi, leading the Zero-Dose Learning Hub to introduce the project and offer [Indistinct 00:05:09] ... Please, Heidi.

>> Thanks, Grace. Hello, everybody. Thanks a lot for joining us today. I'm really looking forward to this presentation. I just wanted to say a few words before we start about the Zero-Dose Learning Hub. Under the Zero-Dose Learning Agenda for the Gavi 5.0 strategic period, the Learning Hub is our flagship project, which is taking place in Bangladesh, Mali, Nigeria and Uganda with the objective to use evidence to better understand the factors influencing implementation and performance, approaches to identify and reach zero-dose in underimmunized children and missed communities. Today, we get to highlight some of the work from the Learning Hub in Nigeria, which is led by AFENET, which is the African Field Epidemiology Network, with their partner AHBN, African Health Budget Network. And today, our speaker, Adam, is going to be discussing specifically some activities to improve monitoring of reaching zero-dose children at the ward level using a lot quality assurance sampling approach, which then provides data on coverage and demand and gender factors, which is used to improve performance. It's my pleasure to present Adam Attahiru, MPH, as a Senior Monitoring, Evaluation and Learning Specialist with AFENET Nigeria working on the Zero-Dose Learning Hub. He brings over 8 years of extensive experience in monitoring and evaluation and public health practice. His expertise includes designing and implementing M&E frameworks, data analysis and applying evidence-based approaches to improve public health outcomes. And with that, we will turn it over for Adam's presentation. Thank you.

>> Hi, everyone. I am Adam Attahiru. I'm presenting on the decentralized immunization monitoring on behalf of the Zero-Dose Learning Hub. This is a project that is funded by Gavi and has been implemented in Nigeria by the African Field Epidemiology Network in close collaboration with the National Primary Health Care Development Agency. As a way of background, the trend of routine immunization in Nigerians remains suboptimal, which means that [Indistinct 00:07:37] coverage estimated at 57 percent percent in 2020 as reported by [Indistinct 00:07:42]. Recent [Indistinct 00:07:44] estimate reported Nigeria being home to about 2.1 million zero-dose children. So, if we improve the coverage of routine immunization, the National Routine Immunization Working Group developed a zero-dose operational plan and the Identify, Enumerate and Vaccinate strategies for 100 districts with a high number of zero-dose children across 18 states to effectively monitor and measure the progress and the implementation of these strategies. AFENET, in close collaboration with JSI and the [Indistinct 00:08:17] developed and piloted the Decentralized Immunization Monitoring in Kumbotso local government where it was then piloted. And subsequently it was implemented in Bauchi, Borno, Sokoto states. The aim of the DIM was to better understand the performance of routine immunization at the LGA while establishing some baseline for key performance indicators in each of these LGAs. The specific objectives including one to estimate antigen-specific coverages, which can be used for monitoring to understand drivers of low uptake among these districts and then to use the LQAs approach to identify low-performing wards and, lastly, to [Indistinct 00:09:05] submit these findings at the subnational level to key decision-makers. The team adopted approaches relating to the behavioral and social drivers of vaccination framework, which was developed by the World Health Organization and approved by the Strategic and Advisory Group of Experts on Routine Immunization to understand contextual structures affecting the uptake of vaccination approaches. As you can see, these are the five key components of the BeSD framework, looking at Thinking and Feeling, Social Processes, Motivation, Practical Issues as well as the uptake of recommended vaccines. To achieve the set immune objective, we adopted a cross-sectional design approach.

[00:10:00] This study was conducted in two districts across each of the four states where we have presence, which is Kano, Sokoto, Borno and in Bauchi. We targeted caregivers and children aged 0 to 23 months of age. We're looking at two different cohorts, 0 to 11 and 12 to 23 months. We adopted the classic LQAs approach at the LGA level using the LGA as the Catchment Area and the Wards as the Supervision Areas. To select interview locations, we retrieved a master list of settlements from the LGA team. The list was desegregated by wards and also the number of estimated

number of households in each of those settlements. And we're using the population proportionate to size. Nineteen settlements were randomly selected. In each of the 19 settlements selected, we adopted segmentation approach. To achieve this, we worked with the local guide identified by the gatekeepers during the advocacy at the settlements level and the gatekeepers [Indistinct 00:11:05] in development of a road map which will eventually divided into segments using the number of households in each of those segments. We adopted the use of the [Indistinct 00:11:19] random number in the selection of the specific settlements where the data-collectors works and in that selected settlement, households were selected. And in selected households, one caregiver from the target population that's 0 to 11 months and 12 to 23 months were sampled. And the next closest house was visited for sample the remaining eligible child. A total of 230 data collectors were identified, recruited and were trained for a period of 2 days. Two data collectors were deployed to each of the wards, and they worked for a period of 6 days with an average workload of three settlements per day. All data collected were documents using electronic data [Indistinct 00:12:03] that is the Open Data Kits. Findings, the sample size of 4,028 set out was successfully achieved and across the 106 as we initially planned. The average age of the caregiver sample was 28 years with a standard deviation of 6 years. Ninety-eight percent of the caregivers were mothers and were found to be predominantly Muslims and were married. The prevalence of zero-dose was found to be about 31 percent with vaccination variation across different LGAs. This proportion was found to be higher than Sokoto State's.

It was also found that 84 percent of caregivers had no formal education and earned about three times less than non-zero-dose caregivers. The object of prenatal care was also found to be lower amongst zero-dose caregivers with about 71 percent delivering at home and 45 percent having no contact for antenatal care at all. These slides highlight the performance of immunization across four states. Out of the 4,028 caregivers that were sampled, 2,934 have ever received vaccination, leaving about 27 percent of the children that have never received any form of vaccination. Card retention, our most-ever vaccinated was relatively high at 88 percent, with Kano having the highest number. Penta one coverage on youth cohorts 10 weeks to 23 months stood at 66 percent who had penta three coverage, that's 18 weeks to 23 months, was bound to be 52 percent. To allow comparison with other surveys, [Indistinct 00:13:57] surveys such as the next [Indistinct 00:13:58] one week, we analyzed the same cohort of 12 to 23 months as well. Coverage was, however, found to be less than the national target of 80 percent across different the antigens. Now when compared with world estimate, penta one and penta three was still found to be lower than the reported penta one and penta three coverage at 60 percent and at 62 percent.

Moving on to the behavioral and social drivers of priority indicators, analysis showed that about 68.5 percent of zero-dose caregivers are not willing to get their children vaccinated despite having good knowledge of where to get their children vaccinated. Vaccine confidence and trust in healthcare workers was also found to be high among zero-dose children at 57 percent and 45 percent, respectively. The ability to pay for vaccination was found to be high across both cohorts with someexception in Sokoto and Bauchi.

[00:15:00] Looking at the proximity of the zero-dose caregivers to a functioning health facility, it was found that about 57 percent of the zero-dose caregivers actually live within a short or trackable distance to the health facility, as shown in the next slide. This slide shows the geospatial analysis of Kumbotso local government as the case study. On this map, we have three distinctive features. The first feature is the ward boundaries, the level [Indistinct 00:15:32] Kumbotso local government. The geocoordinates of caregivers in red and in green, the green depicting non-zero-dose caregivers where the red depicting zero-dose. And lastly, the geocoordinates of health facilities with 5-kilometer radius as [Indistinct 00:15:51]. It can be seen that almost all the zero-dose live within 5-kilometer radius of a functional health facility, signifying that access in Kumbotso local government might not be an issue. For the last objective of this assessment, that is to identify low-performing wards who adopted the standardized LQAs table. This table shows the decision values for specific sample size and target coverage. As you can see for the study, we have adopted a sample size of 19, and the target or the national coverage target of 80 percent across all the antigens. Therefore, if you triangulate this together, we realize that the traditional [Indistinct 00:16:37] comparison at the ward

level could be [Indistinct 00:16:40] as you have compared the actual data in the next slide. To identify [Indistinct 00:16:47] lots, we aggregated a number of children who have received specific antigens and compared this number to the decision rule of 13. Lots of antigens that performed greater than the decision rule of 13 were therefore colored in green as accepted, while those that were [Indistinct 00:17:08] colored as red. That is a rejected lot. Cells shaded in green are accepted, while the red are rejected and the number of children counted for each of those antigens. As we can see, there is an increase in the number of rejected lots as the vaccination progresses. This shows that some of the children were dropping off as the vaccination progresses, and it can also be seen that two wards, or again, Unguwar Rimi and Kumbotso wards, had the least performance in Kumbotso government while Naibawa, Panshekara, Guringawa and Chalawa at least had some good number of accepted lots. This information is therefore used at both the LGA level and at the state level to identify and prioritize the type of interventions that will be implemented at the different levels. So therefore, interventions that will be applied to Unguwar Rimi and Kumbotso will be quite different from the intervention that will be implemented in Naibawa, Guringawa and other wards. However, it can be seen, as well, that for [Indistinct 00:18:26] to all the wards filled the lot.

So, a uniform approach would therefore be applied to all of the wards with this regard. Using this approach, we prioritized 72 out of the 106 wards with different intervention and target population for different interventions. So, we believe that this will allow LGA and decision-makers to focus more on the areas where we have more issues. We had some challenges implementing this activity. All the zero-dose and partially immunized children that were identified were referred to a health facility, and their learnings were shared with the LGA team. However, the team was unable to track uptake of this vaccine. It would have been very nice to have a mobile team accompany the survey team so that those children can be imminently vaccinated. Other challenges encountered include issues with the Master Lists of settlements that were provided as well as the fact that the survey was implemented predominantly in the Northern part of the country, limiting us with opinions of Muslim-dominated results and were unable to explore other opinions of other religions.

[00:20:00] As a way of recommendation, we feel there is a need to scale up this intervention, especially in zero-dose-implementing states, for proper monitor and tracking the reduction in number of zero-dose. We also feel that there should be targeted outreaches while improving on the dialog and the sensitization, especially to the head of households for permission-seeking at the household level. So, this is the conclusion of my presentation. Here are some pictures of the activity during implementation. Thank you very much for having me over.

>> Well, thank you very much for that excellent presentation. It was very interesting to see how you used the data from the LQAS sampling methods to prioritize the wards that needed more assistance, and also it would be great to know more about how you differentiate ...to improve performance in those wards.

>> So just a reminder to everyone on the webinar, please type any questions that you have in the Q and A box. So so next, I'd like to introduce our next speaker, Dr. Sa'adatu Ibrahim Ringim. She is the Jigawa State Immunization Advisor for the MOMENTUM Routine Immunization Transformation and Equity Project. She has over 2 decades of extensive experience working in immunization, malaria, disease surveillance and notification and nutrition and breastfeeding programs. She's worked on projects with USAID, UNICEF, NWHO in the areas of integrated family health care services, immunization, child health and polio. So, Dr. Sa'adatu will present on how data from the digital routine immunization supportive supervision checklist, DHIS2 and immunization registries are used together to monitor and meet zero-dose and underimmunized children in [Indistinct 00:22:00]. So, let's pass it over to Dr. Sa'adatu.

>> Good morning and good afternoon. I'm Dr. Sa'adatu Ibrahim Ringim from Nigeria. I work for JSI on the MOMENTUM Routine Immunization Transformation and Equity Project. I'm based in Jigawa state of Nigeria. This is the outline of the presentation, and I'm sharing our work on triangulating data to monitor and reach zero-dose and underimmunized children in Jigawa. The project in Nigeria, the project works towards the overall goal of improving routine immunization outcomes and zero-dose reduction through these objectives of strengthening leadership and

coordination, improving service delivery, strengthening community engagement and linkage to primary health centers, improving data quality. We are in five of the 36 states of Nigeria, and Jigawa is one of them. This is just to share a little of the profile of Jigawa State and relating to routine immunization indicators. Jigawa has a population of slightly below 300,000, and its indicators are penta one, penta three and [Indistinct 00:23:29] from the national indicator [Indistinct 00:23:33] survey on below 80 percent. More than 60 percent of the settlements in the state are more than 2 kilometers from the health facilities, and there are about 776 health facilities [Indistinct 00:23:50]. Now to discuss the use of routine immunizations supportive supervision to expand data on zero-dose and underimmunized children, the routine immunization supportive supervision is a statutory responsibility of government staff that work on the routine immunization program. It has an open data kit-based tool, which is used for supervision. The tool has prompts that guide the supervisor to check different aspects of vaccination session. It is a critical approach to building the capacity of the health worker that is the supervisee, and those that conduct the supervision are the state team and local government area team of that working on that routine immunization program. And they conduct it every month, and they have a plan of a number of facilities to visit for the month based on guidance by data.

[00:25:00] Responses of all the health facilities are collated, and the feedback is directly given to the health worker on site or the particular facility that benefits from routine immunization support mission checklist. Analysis of the submission is done on a monthly basis, and feedback is provided to [Indistinct 00:25:20] unit. The support for routine immunization supportive supervision checklist has two components: the health facility component, which is the operational component, and the community survey component. The health facility component examines identifying information on the health facility, the findings, observation during session, data management, how we [Indistinct 00:25:46] and it has a little section on exit interviews with patients and caregivers while the community survey component has a simple tool for sampling eligible children within the catchment community of the health facility just to access the reach of children by the health facility. The analysis of submissions for quarter one and two of 2024 of routine immunization supportive supervision was conducted. About 3,821 of them identified 1,744 children not immunized and 3,721 children partially immunized, which were also reached with vaccines. A major limitation of the community survey component is that resources are only adequate to reach settlements that are close to the facility because of the far and difficult areas for the supervisors and the resources available. The project customized the community survey to enhance the reach of additional settlements and children using the RISS visit or integrated with other immunization activities such as National Immunization Plus Days and the outbreak response vaccination. This checklist is also on ODK, and the expanded community survey component samples additional two settlements, so a total of 30 children are checked from three settlements within the facility attachment communities under immunization status. Identified zero-dose and underimmunized children are reached with vaccines and followed up through the health ambassadors and records on the tickler box for subsequent doses in the facility.

This, some of the results of result of the expanded community survey, leveraging of diphtheria outbreak response that held in the state and national immunization process and also [Indistinct 00:28:17] zero-dose LGA-supported health facilities. And some of the zero-dose children identified regions where especially immunized children from the total number of sample children. Now, looking at triangulating across data source, the use of data from DHIS, RI settlement register and the RI ODK checklist actually provides ways of projecting from the DHIS2 coverage based on targets to identify where the missed children are based on the analysis. And then into the register at facility level to identify which settlements are contributing for the number of zero-dose children identified from DHIS2 analysis and then the RISS ODK checklist now reaches out through settlement to really identify and show reach of those children that are missed as well as partially immunized. The integrated disease surveillance and response data is an additional data source for the guide, reach for zero-dose and underimmunized children. These are steps to identifying and reaching zero-dose and underimmunized children. Once zero-dose and underimmunized child is identified, if he is located in a fixed post settlement, he is required to the fixed post if the session is ongoing as the community survey is happening and immunized.

[00:30:00] However, if he's identified in an outreach settlement, which is supposed to be farther away from the facility, and caregivers may not be able to reach the facility. The list of the identified children is compiled, submitted to health worker, and outreach sessions are planned, and children are reached. In all these two cases, [Indistinct 00:30:33] children identified as missed or underimmunized from outreach of each settlement. They are linked to community health ambassadors and documented in their registers for support also [Indistinct 00:30:47]. This dashboard is showing the number of penta one unimmunized in 27 local government areas of Jigawa State looking at January to June data. And LGAs having underimmunized children are further supported. For example, in this second dashboard, Jahun LGA has its analysis of data, its [Indistinct 00:31:18] data. In health facilities with higher number of zero-dose children identified, and therefore they're supported to do the settlement analysis. Now, having identified zero-dose children [Indistinct 00:31:35] outreach supported by our project and from June to August, 801 outreaches supported, and almost 8,000 children were reached with various antigen across the state. Talking about improving data reviews at the health facility and LGA level, the RISS checklist section on data allows supervisors to conduct data quality checks on the previous month. The monthly health facility data quality spot checks in support of the project in selected health facilities also helps in reviewing and triangulating different data tools to ensure quality and correction on the DHIS2.

The revised National Data quality assessment tool application was [Indistinct 00:32:29] support Jigawa as one of the states where the pilot also [Indistinct 00:32:33] area that was used to support the state in improving data quality. Then the [Indistinct 00:32:40] data validation and RI program review meetings held also provide an opportunity and feedback from supervisions provided and health facilities, helps to review their performance. The performance projected at RI review meetings and from RISS finding informs decisions on which health facility to be targeted for following month RISS and community survey engagement. Just to share lessons learned so far from this report to the state by the project, actions taken on-site to close both operational gaps and reach identified zero-dose and underimmunized children with vaccines, importance of triangulating data and using the data, that is even good, reliable data is not helpful if it is not used. Supporting data use at lower levels allows more tailored and timely response that is at the facility level. Data and data analysis are only as good as the follow-up. In the end, results come from improving service, more engagement with communities and more outreach services. Institutionalizing accountability for routine immunization supportive supervision is a good strategy to addressing zero-dose and underimmunized children using the community survey component. Approaches to identify and reach underserved settlements will vary across states, LGAs and the contexts. It will require flexibility, innovation and the expertise of organizations to work in a range of fields to improve RI program. And lastly, it requires LGA leadership, civil society organizations and other relevant stakeholders to address underimmunized communities. Thank you.

[00:35:00] >> Thank you, Dr. Sa'adatu, for that excellent presentation and sharing those lessons. It was very interesting to hear about how Nigeria I using multiple data sources to locate region monitors, zero-dose and underimmunized children and then also about how data from the monthly review meetings are used to inform which facilities to target for future supportive supervision. So, before we move to our Q and A, I wanted to invite Rebecca Fields, who is the technical director for the MOMENTUM Routine Immunization Transformation and Equity Project to provide her observations and takeaways from the presentations. So please ...

>> Thank you very much. Thanks, Grace, and a big thank-you to both Adam Attahiru and Sa'adatu Ibrahim Ringim for really excellent presentations that put such an emphasis on how data are not just collected and analyzed but also used. And we heard about very different ways, different methods for the data collection analysis and use and how they focused on identifying and reaching zero-dose and underimmunized children. From Adam, we heard about the technique of lot quality assurance sampling and using it in sort of novel ways, both to estimate coverage but also applying the method to understand the behavioral and social determinants of immunization in line with the [Indistinct 00:36:21] model. And in doing so, they were able to identify not just the low-performing wards in terms of zero-dose and underimmunized children, but really gain an in-depth understanding of community perceptions of

vaccines and vaccination and reasons why vaccination services would or would not be used. And particularly interesting was the way that they used lot quality assurance sampling to examine and then contrast and compare the perceptions of vaccination among all respondents in the survey versus just those caregivers of zero-dose children. And there was one particular slide that he showed that gave these comparisons and really well worth another look because it showed that there were some distinctions between zero-dose families, zero-dose respondents and the full range of respondents. Some responses were very similar, and others were very different. So, for example, among the families of zero-dose children, respondents from zero-dose children, there were lower levels of trust, higher challenges in terms of affordability, a lower perceived value overall of vaccination. On the other hand, the knowledge among zero-dose families of where immunization services can be obtained was relatively high. So that kind of information really helps to focus and sharpen vaccination strategies to really reach those zero-dose and underimmunized children and families.

And then from Dr. Ringim, we learned about the use of routine immunization, supportive supervision in Jigawa State and how it includes not just a facility-based review of performance but also that community survey element that she noted. And she also pointed out that there's both a limited community survey and an expanded version. And she also did a great job in highlighting how different types of data, different sources of data relevant to immunization have been triangulated and brought together to help identify the local government areas and wards that are most in need of targeted planning and delivery of vaccination services for the zero-dose children. Now, one complication that she noted was that sometimes the different sources of data don't agree with each other. They don't always depict the same situation. So that requires the types of processes she described, further analysis and some real judgment calls on the parts of health officials to use those data to target services.

One thing that struck me in hearing the presentations was that it does require resources to carry out data collection and data analysis and use exercises. And one point that struck me that Dr. Ringim brought out was that the routine immunization supportive supervision, it's a government responsibility. It does include that community survey and the expanded survey. But she also mentioned that those community surveys are not always carried out due to lack of resources, lack of transportation, relatively lower priority and motivation placed on them. It does require the transport. It does require high motivation and time and effort on the part of health workers, health personnel, to go out to settlements that are at some distance from facilities. But if you only go to the nearby health facilities and don't go to those ones that are at a greater distance, then there [00:40:00] is a risk of overlooking those settlements that are at a further distance and where access is likely to be a bigger issue. And also, if those children are not captured in that community survey, if they're not identified, then there's the risk, as well, that they won't be reached. And if they're not identified in the first place and their numbers are underestimated, that risks giving rise to a more optimistic picture of coverage and performance across the LGA or ward than might actually be the case.

One last point that I just want to bring up is that it's interesting to compare the methods used by both speakers in terms of their objectives. What were they trying to achieve? And this, in turn, has some implications for the frequency with which they may be used. So, Dr. Ringim, for example, described methods to use data that are generated on an ongoing basis coming from supportive supervision to RISS, coming from IDSR, coming from settlement, registers and so forth. So, these are data that are generated on an ongoing basis and therefore can be used to inform continuous monitoring, continuous planning, continuous updating of plans. The use of lot quality assurance sampling that Adam described, especially examining the perceptions of zero-dose families, is particularly useful in a formative research sense of informing and refining strategies including those for social and behavior change. Again, that contrast in data, in findings between the full set of respondents and those who were zero-doses of particular interest and provides very, very useful information for sharpening strategies. So those were a few of my takeaways from the sessions, from the presentations, those excellent presentations. And now, Grace, I'm going to give it back to you for the Q and A part of the session. Over to you, Grace.

>> Thank you, Rebecca, for those insightful remarks. I'm going to pick up on one of those and also tie it together with one of the questions that's in our Q and A box, and I want to encourage others to also continue to put your questions into the Q and A box. And that's about ... The question comes from Carol Hoaks, and it's about whether it would be possible if supervisors made it to the hard-to-reach areas and did the community survey there in those very far away, hard-to-reach areas, which, Rebecca, you and Dr. Sa'adatu pointed out was difficult even for the supervisors to get to. It might help the people feel ... recognize the importance of immunization that someone made an effort to move to those areas. So maybe I'll first ask Dr. Sa'adatu to answer that and then also Adam, whether he would like to come in, as well.

>> Thank you very much. Good morning. Good afternoon, once again. Indeed, supervisors find it difficult to reach, so one innovation that is done in Jigawa, for example, is supervisors from the LGA are usually domiciled in different communities in the LGA's different wards. And the [Indistinct 00:43:42] persons also under the charges of the facilities so they are made responsible to reach out to any settlement that is identified in the registers of the facility as likely having missed children to conduct community surveys there. And these are some of the ways that those distant and hard to reach settlements are actually reached using the limited resources. And with the existing community structures, especially the innovation that Jigawa has of [Indistinct 00:44:28] is the Hausa Tam, meaning health ambassadors for each settlement, they work ... The supervisors work hand in hand with those [Indistinct 00:44:38] who have registers that they track children and the status of immunization.

[00:45:00] As soon as the child is born, he's registered in the health ambassador's register, and so they work with them to create awareness, to enlighten them so that they can track their communities' use of their existing structures like the traditional [Indistinct 00:45:02] woman mobilizers to create awareness, move house to house and so be able to reach caregivers and their children. These are some of the ways that actually one [Indistinct 00:45:18] using health workers close to their communities to conduct surveys as well as engaging with the community structures in those settlements to organize their wards to access [Indistinct 00:45:35] and immunization.

>> Thank you for that answer. Adam, do you want to add anything here?

>> Yes. Thank you, Grace. Can you hear me?

>> Yes.

>> Yeah, so for the implementation of the LQAs, I think one innovative strategy we adopted was the inclusion of the LGA team into the supervisory team. So, most of the settlements that were visited were actually visited by the LGA and the state team. I feel that's really improved ... It really strengthened the capacity of the LGA team because they were able to identify real-time what the problems were on the field, and immediately most of them were swinging into action. I remember this particular community that was visited, and the whole ... There was a block rejection. The whole community do not actually believe in vaccination, and they don't allow any sort of vaccination to happen there. Fortunately for us, we work together with the incidents manager of the Emergency Coordination Center, EOC, and immediately swooped into action and was able to resolve that issue. We also encountered some measles cases during the LQA's approach in the field, and the LGA team used this opportunity to actually sensitize and ensure that those children that we identified that were actually zero-dose got vaccination within the shortest possible time. So as Dr. Sa'adatu said, there may be some logistical challenges, but the LGA team, once they have the opportunity, are really ready and willing to go over but to ensure that these children actually get immunization at the end of the day. Thank you and over.

>> Thank you, Adam, for providing that additional information. I'm going to move on to our next question, which I will paraphrase a lot. It comes from Adam, and he is asking about the role of gender in immunization. So, he's wanting to see whether there are additional indicators to gather around gender barriers in immunization. Any suggestions

beyond gender-desegregated vaccination data and maternal education levels? I wonder if each of you could speak to that and also maybe talk a bit more about other gender-related barriers and other interventions that are being used to address these barriers. Maybe first I'll let Dr. Sa'adatu speak.

>> Thank you, Grace, and thank you for the question. Just to highlight, the issues in Jigawa, it's a state in the Northwestern part of Nigeria, predominantly Hausa communities as well as Fulanis and Muslims. So, one key gender issue is about the concept that it has to be sought by the mothers from their household heads. That's the heads of household, the fathers, and there's a lot of activity towards awareness creation to men in the state and through the religious bodies, too, in the mosques, worship places ... the gatherings to create awareness, to have men have open invitation passes for women to access immunization for their children and have been informed of the importance of vaccination. It tells us noncompliances do exist, and quite a number of them are related to lack of access to other health-related services. And once identified, they are addressed, and quite a number of them also are related to other beliefs, traditional beliefs.

[00:50:00] And they are usually addressed. The state has been able to map across all the 27 LGAs, so noncompliant settlements and also sporadic households within settlements that are noncompliant, and they are providing a lot of community engagement activities, education and information on importance of immunization to be able to get caregivers to access service for their children. So it is really on the decline, issues of noncompliance, but they do exist. But there are becoming a few issues of outbreaks are used to provide information on need for ... children to be vaccinated, and caregivers have live examples that if the child is not vaccinated, this is likely to happen if disease outbreak and the rest of them. So, we are getting compliant households and caregivers by degree.

>> Okay. Thank you for that. Adam, do you want to come in here to speak about gender-related issues and gender indicators?

>> Yes, Grace. Thank you for that. I think that was a very excellent question, and these we have seen firsthand on the field. During the field data collection, we have aware of a question and asking the caregivers of, what are some of the key gender issues that they encounter that prevent them from accessing care both for themselves as well as for the children? And one key issue that came up repeatedly was the fact that a lot of them, predominantly in the North, that they need to seek permission from their husbands, which is a cultural norm also from the religious perspective of wife gets permission before going out, and for them to get the children vaccinated, they have to seek for the permission of the husband. And this was a finding that we find to be very significant, and we're working with the team to ensure that we incorporate this into the demand generation activities towards targeting the heads of households who give this permission for the children to actually get vaccination. We've been targeting the caregivers with these key messages on RI, but I think it's time we make a shift from these caregivers directly to the head of households who actually give the permission. Another key issue around gender is the power for them to make also decision based on the income they earn and also the level of education. It think this is also ... Even though it's not something that can be addressed immediately but probably for upcoming projects to also look into how to improve the socioeconomic status of zero-dose caregivers and also how to improve on the educational status. We believe that true sensitization of [Indistinct 00:53:27] these two key indices probably helped uptake, both the antenatal, the ... It will reduce [Indistinct 00:53:36] as well as reduce zero-dose across the different states. Thank you.

>> Thank you for both those great answers. I want to ask another question. I think this is more directly to Adam, which is, how frequently do you implement the [Indistinct 00:53:56], and is it a cost-effective way to use it to continue to monitor changes? And then a follow-up to that is, how are the findings of the OQASes used? How do you translate this into changes in coverage? That question comes from [Indistinct 00:54:18]. Adam, can you go ahead and respond to those?

>> Sorry. Can you repeat that?

>> Well, there were two questions from [Indistinct 00:54:31]. One was about how frequently you would implement the OQAS and whether this is a cost-effective way to monitor changes in immunization. And then secondly is, how do you translate those findings for the OQAS into results?

[00:55:00] >> Yes. Let me start with the second. I think the implementation or course correction of the findings actually began from the field when the LGA team and the state team actually saw the key findings from the field and were able to actually address some of them. So immediately, the IM gives some instructions to be implemented that the LGA, based on what he saw on the field by themselves, and that's actually informed some changes in how they conduct that supervision and how they also address some of the noncompliance cases. With regards to the formal dissemination, this data was completed ... data collection was actually completed earlier this month with [Indistinct 00:55:43]. So, the plan is for us to disseminate across two levels, three levels. We'll intend to disseminate at the community level where we will have all the religious leaders, because there are cultural issues that needs to be addressed, and we'll wait to be invited in the facility and chances for us to sit and think together how to address some of these issues. We'll also be disseminating at the LGA level where decision maker does it. We feel that decision makers and the program managers. So, we're going to develop a plan to complement the residual plan that they already implemented and believe that together this will make the implementation stronger, and it will also be target oriented using the evidence that has been generated. At the state level, we are going to have a statewide dissemination where all the LGAs can also learn from what we have implemented and the strategies that they need adopt to course correct what they are currently implementing. With regards to costs, I want to assure you that this implementation was ... cost far less than what we usually think the cost of implementing LQAs is because we actually adopted the use of local state [Indistinct 00:57:04] to collect the data, and this was really found to be very cost-effective. The main cost drivers were the [Indistinct 00:57:11] of the data collectors as well as the cost of supervision, transportation, going to ... very far to reach areas to ensure that the team actually comply with the protocol as well as the guidelines that was laid down for implementation. So far, I think it's data that we can use to inform course correction and also to take decision at the different levels that there are. Thank you.

>> Thank you. Thank you, Adam. We only have about 1 minute left, but I thought that there was an interesting question that just came in I wanted to ask both you and Sa'adatu, maybe Sa'adatu first to respond. The question is about Adam had mentioned that we might shift the focus from the caregiver mainly to the decision maker. How would we do that? Sa'adatu, do you want to speak to that, how that has been done in Jigawa?

>> Thank you very much. In terms of shifted the focus to the decision maker, it is about the accountability issues and the focus in terms of technical capacity of doing the analysis. For example, in terms of data and providing some guidance on how to [Indistinct 00:58:44] inform the program implementation. So, for me, that will be the focus for the decision maker in terms of ensuring accountability that every program officer at different level implement what is in their rule or responsibility and also in terms of having the capacity at the state level to provide guidance, mostly state level and then LGA level to provide guidance in terms of how to better-inform the program based on lessons learned and data that has been analyzed to be used for action to close gaps. Thank you.

>> Thank you. Adam, do you want to very quickly address that before we close?

[01:00:00] >> Yes. I think I completely confer with Dr. Sa'adatu. I think to change behavior is not easy. It takes a while. It's a gradual process. However, setting the tone for behavioral change is very important, and we can actually start to ... Gradually and with repeated implementation we believe that the behavior of teaching the people, caregivers, will actually change. With regards to underimmunized children, I sincerely feel that there are contextual factors preventing them and that this, we have noted. And we're working with the LGA team to see how we can mitigate those challenges, and that's the whole essence of implementing this survey, so that we can identify, prioritize potential barriers and see how we can work to mitigate them at the end of the day and provide the opportunity for continuous uptake. Thank you very much.

>> Great. Thank you very much. So, I just wanted to take an extra minute to thank all of our speakers, Adams, Sa'adatu, Rebecca for sharing their time and expertise with us today. We will follow up, as I had said, with any questions that couldn't be answered. You'll see in the ... There's a link in the chat to an evaluation, and we really, really appreciate if you could take 2 minutes to provide feedback on this webinar. It's very valuable to us, and we will be sure to use it to improve future webinars. So, thank you all for joining. We will follow up with an e-mail to today's recording. Have a great day.

>> Thank you, Grace.

>> Thank you, Grace, and bye-bye, everyone.

>> Thank you all. Bye.