



# Supportive Supervision of Frontline Health Workers:

A Case Study of Innovations to Improve the Quality of Routine Immunization in Nigeria

© All Rights Reserved 2022

Solina Centre for International Development and Research

**Authors**

Muyi Aina, Uchenna Igbokwe, Raihanah Ibrahim, Ayomide Fasan, Adetola Oladimeji, Osezefe Ehimen, Adebayo Wahab, Blessing Ajie, Rabiu Fogge, Usman Matazu

**Collaborators**

Victor Ajieroh, Dr Babagana Kundi Machina, Dr Rilwanu Mohammed, Adamu Abdulahi, Umar Danlami, Muhd Ali, Jibreel Muhd, Ahmed Muazu, Dr Habila Ismaila



*Yobe*



*Bauchi*

# Table of Contents

<b>Background</b>	1
<b>Synopsis of innovation tested</b>	2
<b>Lessons and recommendations for designing supportive supervision models for RI and PHC programs</b>	3
<b>Case Study A: Yobe State</b>	4
Designing a new approach to conducting RISS	7
Piloting the RISS Innovation in Damaturu LGA, Yobe State	8
Did the pilot of the revised strategy in Damaturu LGA, Yobe State work?	9
Challenges	10
<b>Case Study B: Bauchi State</b>	11
The focused RISS approach in Bauchi State	12
Designing the focused RISS strategy in Bauchi State	13
Piloting the focused RISS strategy in Bauchi State	15
Did the pilot of the focused RISS strategy in Bauchi State work?	16
Challenges	17
<b>Case Study C: Health facility Adoption</b>	18
Health facility adoption and Mentoring Model in MoU states	19
How was the SCIDaR-led facility mentoring model implemented?	20
Did the SCIDaR-led facility adoption and mentoring model work?	21

# Background

A competent and motivated workforce is crucial for the success of a healthcare system. Supportive supervision is an effective approach to consistently improve health workers' performance<sup>1</sup>. Supportive supervision fosters improvements in health workers' performance by providing knowledge and skills to health workers to ensure their efficient functioning<sup>2</sup>. This approach strengthens the relationships within the system, addresses problems at the site, optimises resource allocation, and promotes teamwork and communication.

Nigeria has implemented a focused supportive supervision strategy for routine immunization. The National Routine Immunization Supportive Supervision (RISS) framework provides clear guidance on the approach for the routine assessment of health facility performance, identification of bottlenecks, and implementation of corrective actions while imparting knowledge to health workers during supportive supervisory visits<sup>4</sup>. Similar to all other Nigerian states, the six MoU states adopted and institutionalized this framework across all levels of the routine immunization program.

The 2018 revised RISS framework<sup>4</sup> provided a standardized facility checklist and an optional capacity building flowchart to assess a facility's immunization program performance and competence across five thematic areas: vaccine management, data management, community engagement, financial management, and service delivery.

RISS visits to health facilities are scheduled by the Supportive Supervision Working Group (SSWG), and these visits are carried out by designated local government (LGA) officers and state-level supervisors every month.<sup>4</sup>

However, results from key informant interviews (KIIs), participant observations, and the comprehensive analysis of available data in the MoU states have revealed many issues, such as an inadequate number and poor motivation of supervisors, non-standardized protocols for action planning and monitoring, and gaps in goal setting for planned visits, which have led to suboptimal RISS outcomes and facility performance.

To address these challenges, Solina Centre for International Development and Research (SCIDaR) supported the MoU state to implement the innovations to ensure efficient facility performance management and identify opportunities to optimize the national RISS strategy in a sustainable and cost-efficient manner.

<sup>1</sup> World Health Organisation

<sup>2</sup> Tegegne, S.G., et al. 2018

<sup>3</sup> Marquez, L., & Kean, L. (2002). Making supervision supportive and sustainable: new approaches to old problems

<sup>4</sup> Standard Operating Procedure For The Conduct Of Optimised Routine Immunization Supportive Supervision/ Mentorship

# Synopsis of innovations tested

## **a** Focus on capacity building and joint problem solving rather than facility performance assessment

The traditional RISS strategy is based on a thorough assessment of facility performance which if not coupled with strong accountability and good time management by the supervisor may edge out practical problem-solving and consequent improvement in key facility indices. A key innovation we tested in Damaturu LGA, Yobe state, therefore was to separate capacity building and problem-solving from assessments of service quality at the facilities. In this way, LGA supervisors focused on capacity building and mentoring health workers during their visits, while a separate team of M&E officers conduct unbiased assessments of facility performance at less frequent intervals. In the pilot facilities at Damaturu LGA, overall facility performance improved by 24%, in Phase 1 and 57% in Phase 2 with significant improvements across all themes.

## **b** Prioritization of poor-performing health facilities for focused supervisory visits and continuous mentoring

The SCIDaR team also worked with the SPHCDA to test time-limited focused facility adoption and mentoring to trigger rapid improvements in the performance of target health facilities across six states in Northern Nigeria. The aim was to steer limited resources, especially the insufficient number of supervisors as well as limited funds, toward facilities in need of the most support. The strategy also ensured continued problem-solving during follow-up visits also addressed challenges that could not be resolved during a single visit. In Bauchi specifically, the Supportive Supervision Working Group (SSWG) prioritized 511 of 1071 RI-offering health facilities in Q2 of 2021 based on the key performance criteria. This led to immense cost savings of about 31%. SCIDaR also tested this model across the six states, leading to varying but striking improvements in facility performance across all performance indicators.

## **c** Deployment of easy-to-use, digitized tools to report, track and monitor supportive supervision visits

Another innovation tested by SCIDaR was the transition from using paper-based to electronic capacity-building flowcharts. The aim was to both ease reporting for supervisors and the SSWG as well as to reduce the cost of conducting RISS. At the state level, Bauchi used a data analytic tool to track changes in the performance of supervisors, health workers, and health facilities. Additionally, supervisors commenced use of electronic flowcharts in Bauchi state. These digital innovations helped improve the efficiency of data transmission and reduced printing costs

# Lessons and recommendations for designing supportive supervision models for RI and PHC programs

We have identified key lessons from testing these innovative strategies to improve the quality of RISS in the six Northern Nigerian states, which lessons may also be applied to designing effective supportive supervision for other PHC programs.



## 1

**Lengthy tools are a barrier to qualitative supportive supervision.**

Lengthy checklists deter supervisors from focusing on quality supervision. This is especially the case when payments to supervisors hinge on the completion of these extensive supervisory tools, which incentivizes the performance assessment component of supervision rather than facility-based problem-solving. When checklists are shorter (See third case study titled [SCIDaR-led health facility adoption and mentoring model in MoU states](#)) or eliminated altogether (See first case study titled [The RISS innovation in Damaturu LGA, Yobe State](#)), supervisors have more opportunities to focus on problem-solving and capacity building for facility staff.

## 2

**Transitioning to problem-solving during supportive supervisory visits requires strong accountability systems and capacity building for supervisors.**

Due to many factors, especially unfamiliarity with the new models of supportive supervision, LGA supervisors may fail to transition fully to effective problem solving and efficient knowledge transfer, thus leading to marginal or no improvement in facility performance. The Bauchi state-revised RISS strategy (See second case study titled, [The focused RISS approach in Bauchi State](#)) highlights the importance of a structured accountability framework for supervisors and repetitive training such that these supervisors are capable of leading problem solving, supporting health workers on site, and transferring capacity effectively.

## 3

**Prioritizing poor-performing health facilities may lead to reduced workload and cost efficiency in resource-limited settings.**

With the Bauchi pilot and the SCIDaR-led facility mentoring model (See second and third case studies), the planning processes for supportive supervision cycles the identification and selection of poor-performing facilities were adapted to ensure that the least-performing, and thus, the most indicated, facilities were targeted for improvement. This approach not only improves outcomes but also reduces the workload for supervisors and costs for the state. In addition, prioritizing poor-performing health facilities in cycles of focused mentoring and capacity building stands the chance of leading to statewide improvement.

## 4

**Adopting a human-centred approach in supportive supervision may lead to improvement in the user experience of supervisors and health workers.**

The adoption of digital innovations such as electronic capacity-building flowcharts, data analytics tools, and weekly feedback mechanisms has resulted in significant improvements in the user experience of supervisors. With electronic systems, supervisors completed supervisions quicker and addressed specific problems during visits. Additionally, the revised strategy that emphasised a collaborative and positive approach to mentoring health workers, has resulted in a more supportive and empowering work environment. With the LGA supervisors serving as mentors that motivate rather than criticise health workers, the relationship between the two parties became more positive and collaborative. This contributed significantly to building the capacity of health workers by promoting a culture of continuous learning and improvement, and ultimately improved the quality of care provided to caregivers.



# Case Study A

Yobe State

# The RISS innovation in Damaturu LGA, Yobe State

The Yobe State Emergency Routine Immunization Coordinating Centre (SERICC), with its commitment to achieving improved RI coverage, commenced the implementation of the updated national RISS strategy in 2017. However, in 2020, the Yobe team wanted to jumpstart further improvements in the RI program. In partnership with the implementing partners, Yobe SERICC conducted a comprehensive review and redesign of the RISS strategy and piloted it in Damaturu LGA.

Damaturu is the capital of Yobe State and also serves as an LGA. The city has 11 wards that are divided into 28 villages and settlements and a mix of urban and rural areas. Damaturu has an area of 2,366 km<sup>2</sup> and a population of 124,000, accounting for 3.6% of the population of Yobe State.

A review of Yobe's RISS revealed weak supervision skills, poor motivation, and conflicting priorities among LGA supervisors as major challenges. Issues with the cumbersome nature of the checklists and deprioritization of capacity building and mentoring in favor of the checklist-assisted assessment were prevalent in this framework.

Up to 60% of LGA supervisors did not follow up on agreed action points from previous engagements and forwent opportunities to improve RI service delivery in health facilities.

The RISS strategy was, thus, to be revised with the objective of improving health facility performance by optimizing capacity transfer during each supervisory visit. The revised strategy had at its core the refocus on capacity building, and joint problem-solving with health workers rather than an emphasis on the performance assessments of health facilities. The underlying assumption was that improving health workers' capacity would accelerate RI program performance and overall coverage outcomes.

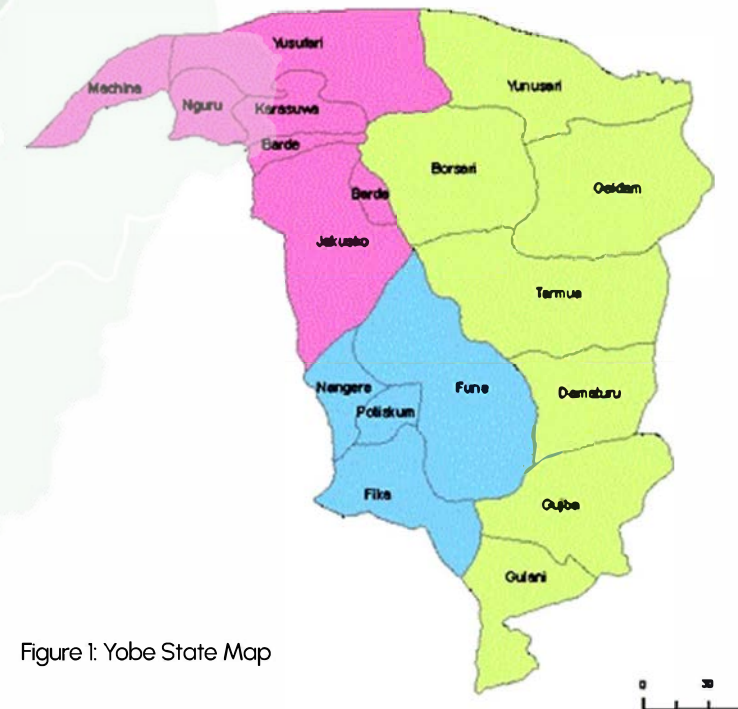


Figure 1: Yobe State Map



## The strategy is guided by a simple theory of change that will stem from implementing 3 key interventions

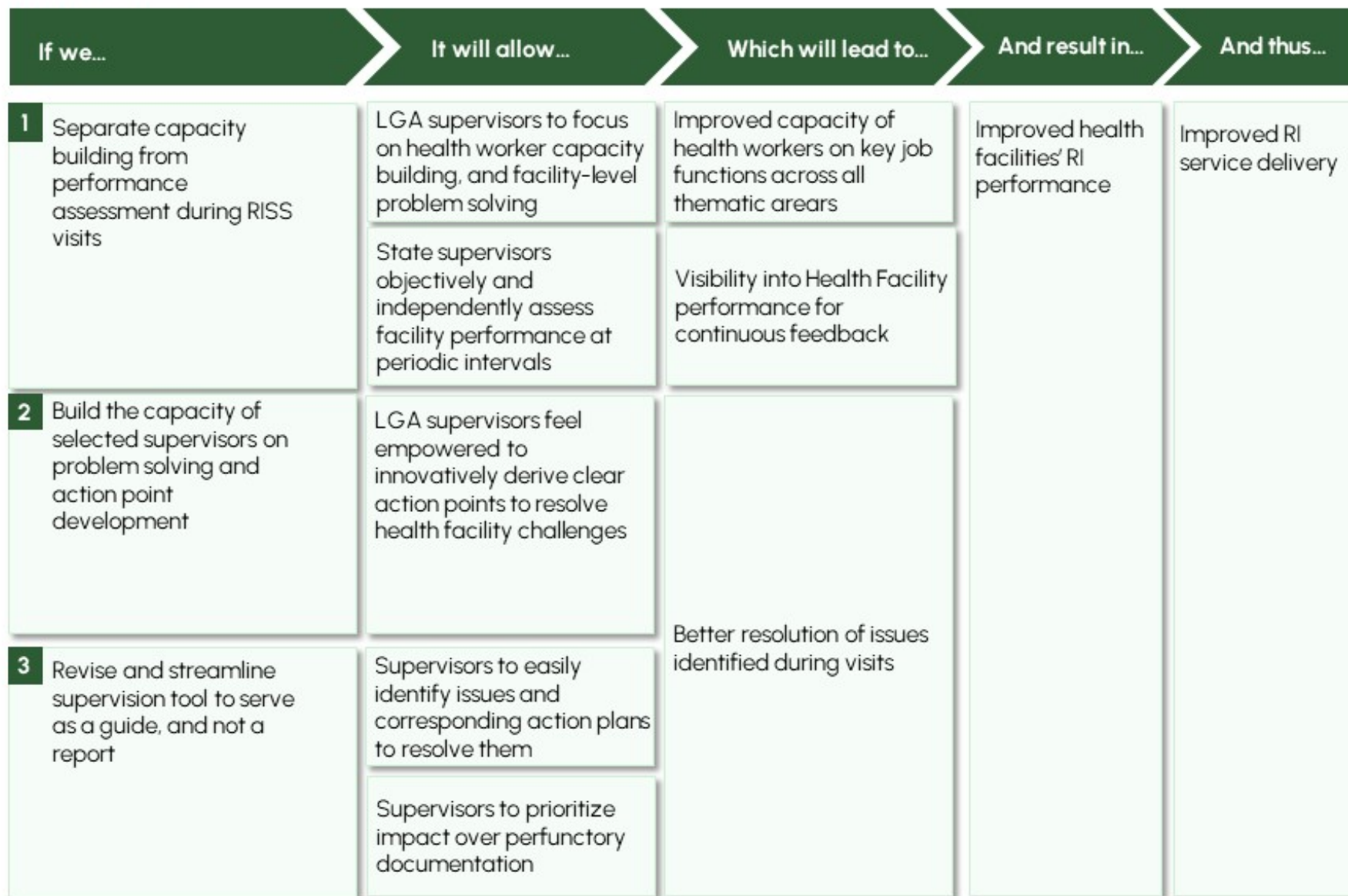


Figure 2: Theory of Change for the Revised RISS Strategy

# Designing a new approach to conducting RISS

The SCIDaR, in partnership with the Centre for Disease Control - African Field Epidemiology Network (CDC-AFENET) and United Nations Children's Fund (UNICEF), supported Yobe SERICC in applying human-centered design approaches to identify and address the causes of suboptimal RISS implementation. In Q3 of 2020, the team engaged with and interviewed key LGA supervisors and healthcare facility workers to identify key challenges and extend recommendations to address those challenges.

The recommendations included decoupling capacity building from health facility service quality assessments, allowing LGA supervisors to focus on capacity-building, and mentoring health workers during each visit (Figure 3). A separate team conducted unbiased assessments of facility performance every quarter. Unresolved issues were reported to the LGA team and tracked through regular updates at the coordination meetings. The new strategy also included a tracking system for the implementation of agreed action points from the last visit, providing accountability to ensure that facilities executed the agreed-upon action points on a monthly basis.

To evaluate the effectiveness of the new strategy, the state and LGA M&E officers assessed facility performance through frequent spot checks and quarterly reviews of the RISS data.

To monitor the implementation of this new strategy, Open Data Kit (ODK) data collection tools were used in place of paper-based reporting to improve data integrity through the verification of submitted facility geo-coordinates and improved data transmission and collation efficiency. The collected data were plugged into the RISS analytical dashboard, which generated reports on RISS performance and shared the findings with relevant stakeholders in order to inform the

data-driven decision-making regarding RI programs in the state. Nine indicators were selected to routinely assess the performance of critical actors, namely, supervisors, health workers, and M&E officers, in implementing the new strategy (Figure 4). The M&E framework also tracked improvements in health facility performance.

## The revised RISS strategy differs significantly from the old strategy across various themes

	Old RISS strategy	Revised RISS strategy
<b>Approach</b>	<ul style="list-style-type: none"> <li>Selected supervisors to visit the health facilities to administer the National RISS checklist and build the capacity of the health workers during each visit</li> <li>The supervisors optionally use a flowchart to support the capacity building of health workers during each visit</li> </ul>	<ul style="list-style-type: none"> <li>Select supervisors visit the health facilities to support HF's improvement on specific thematic areas (using a comprehensive flowchart) and building HW capacity</li> <li>The capacity building team will also be required to paste the HF performance on the wall after each visit</li> <li>A different set of supervisors visit facilities to assess the performance using a modified checklist</li> </ul>
<b>Frequency of visits</b>	<ul style="list-style-type: none"> <li>One LGA visit per month per HF</li> <li>One joint monitoring visit with the LGA team to HF</li> </ul>	<ul style="list-style-type: none"> <li>One capacity-building-focused visit per month</li> <li>One performance assessment visit per quarter</li> </ul>
<b>Supervision team</b>	<ul style="list-style-type: none"> <li>State and LGA supervisors</li> </ul>	<ul style="list-style-type: none"> <li>Capacity building is conducted by the LGA supervisors only</li> <li>Performance assessment is conducted by the State team only</li> </ul>
<b>Tools</b>	<ul style="list-style-type: none"> <li>National checklist</li> <li>Flowchart (Optional)</li> </ul>	<ul style="list-style-type: none"> <li>Modified RISS checklist (<i>Selected priority indicators and included action items for each indicator</i>)</li> </ul>

Source: Team analysis

Figure 3: The revised RISS strategy approach differs from the traditional RISS strategy

# Piloting the RISS innovation in Damaturu LGA, Yobe State



Source: SCIDaR

9 indicators will be used to routinely assess the performance of LGA to HF RISS across all levels using information from submitted retirements

Theme	KPI	Frequency	Source	Tool required
Supervisee performance	• % of action points from last visit completed by next visit	Monthly	RISS checklists	LGA RISS dashboard
	• HF performance based on analysis of entries on the RISS checklist			
Supervisor performance	• % of planned visits conducted	Monthly	RISS checklists	LGA RISS dashboard
	• % of completely filled RISS checklists and flow charts submitted before the deadline	Monthly		
	• % change in HF performance	Quarterly		
LGA coordinator	• % of HFs visited during the month	Monthly	RISS retirements, RISS dashboard	Retirement validation tools, State RISS dashboard
	• % of complete RISS reports submitted on time			
Zonal/ state RISS coordinator	• % of planned spot check visits conducted	Quarterly	RISS retirements, SERICC meeting minutes	Retirement validation tools, State RISS dashboard
	• % of times in a quarter in which RISS reports were presented to SERICC			

Figure 4: The M&E framework for the revised RISS performance

To kick off the pilot, preassigned state supervisors conducted a baseline assessment of the performance of 15 health facilities via physical facility visits and desk reviews of existing administrative immunization data (e.g., penta vaccination rates and vaccine wastage rates) from the DHIS2 platform. Of the total health facilities assessed, 14 poorly performing facilities were selected for the first phase of the pilot, while the last facility was deprioritized as a result of prevalent security threats in the community.

In preparation for the pilot, the Yobe SERICC team organized capacity-building sessions on the components of the revised RISS strategy and the usage of the revised tools for the LGA supervisors. The RISS strategy was launched in January 2021, following LGA supervisor training on tools and their respective roles.

## Did the pilot of the revised RISS strategy in Damaturu LGA, Yobe State, work?

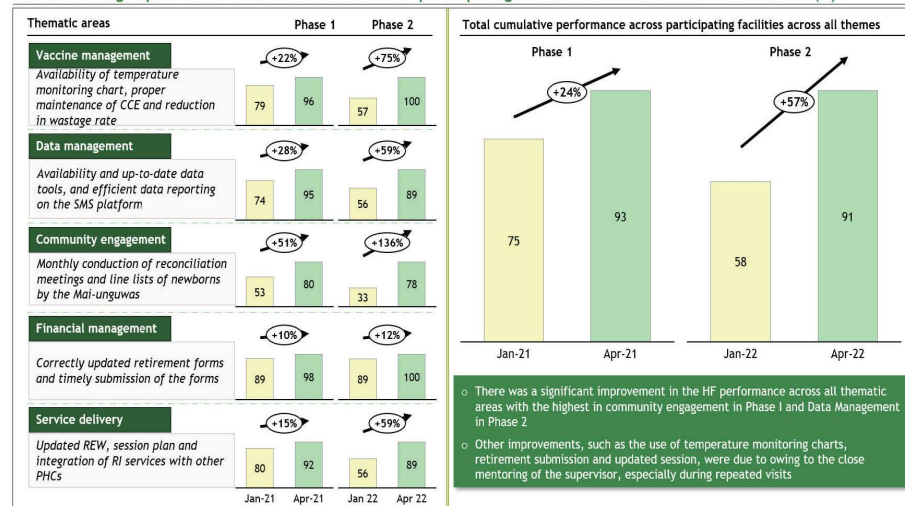
The revised RISS strategy in Yobe State was implemented for eight months, and the outcomes were evaluated via an end-line assessment using a checklist and KIIs. The results showed an overall improvement of 24%, in phase 1 and 57% in phase 2, with significant improvements across all thematic areas in participating health facilities (see Figure 6).

This success was largely attributed to the focus on capacity building and joint problem-solving during visits, as well as the employment of easy-to-use tools and proper planning of visits. Health workers expressed satisfaction with the revised strategy and reported visible improvements in facility performance, clarity of action points, and acknowledgement of the improvements by supervisors.

According to Musa Shaibu, the RI focal person at Maissandari PHCC, the significant improvement of the health facility where he worked due to the innovation was largely because the LGA supervisors no longer needed to assess facility performance and fill out long checklists but could fully focus on capacity building and joint problem-solving with facilities to resolve issues during supervision.

“  
Definitely, routine immunisation supervision has improved so much and greatly influences our daily routine. I can say this because I was around when the traditional RISS strategy was in place. Previously, I did not fill my chart but because when the revised RISS strategy commenced, the LGA supervisors taught me to fill the chart without pointing accusing fingers or finding faults. Our supervisors now are like mentors to health workers. They not only mentor but also motivate us by commending our efforts on the job as well. I can say they treat us like children while building our capacity as well. The revised RISS strategy is highly commendable.” – **Musa Shuaibu, RI Focal person, Maissandari PHC**

Charts showing improvement in selected indicators for participating health facilities for Phase 1 and Phase 2 (%)



SOURCE: Yobe state RISS performance dashboard, Performance assessment checklist, Team analysis

Figure 6: Charts showing improvement in selected indicators for 15 participating health facilities for Phase 1 and 9 participating HF in Phase 2 (%)



Figure 7: Mohammed Sherif, the RI officer (2) conducting supervision at Maissandari PHC where Musa Shuaibu is the RI focal person

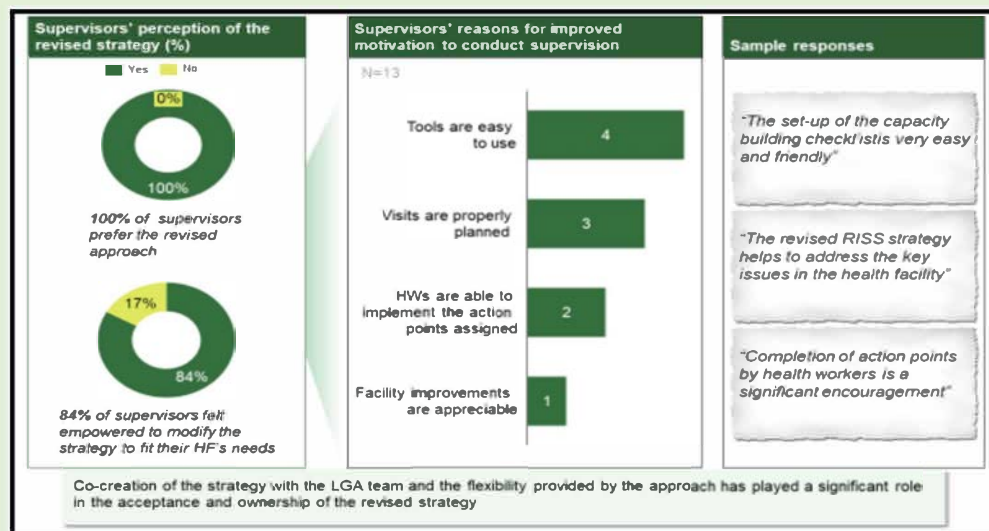


Figure 8: An analysis of the KII responses revealed a preference for the revised RISS strategy among supervisors



Figure 9: Saratu Yakubu of Gwange PHC at her interview session

Saratu Yakubu, who is in charge of the immunization section of Gwange PHC, also attested to the great improvements in RI coverage as a result of the implementation of the revised RISS strategy. She explained that more women now came to receive immunization than before as a result of health workers' increased advocacy and mentorship.

*"Before the implementation of the revised RISS strategy, we used to have a large number of defaulters. Now, with capacity building conducted by the RISS supervisors, several stakeholders have been further empowered to drive an increase in immunisation coverage. For example, women testify at the facility that their husbands now remind them to go for immunisation. Even some of the Voluntary Community mobilizers (VCMs) who go house to house to encourage and inform people in the community to bring their children for immunisation have become supervisors. The RISS revised strategy is very useful as we see more participation from community members."* - Mrs Saratu Yakubu, Gwange PHC

## Challenges

Despite the effectiveness of the revised RISS strategy and general recommendations for the adoption at a large scale, some limiting factors that pose challenges during strategy implementation remain. It is difficult to assess high-risk locations due to compromised security, difficult and hard-to-reach geographical terrains, inefficient systems to remotely prompt health workers within our context to implement action points between visits, and increased human and financial resource requirements to conduct frequent spot checks to health facilities.

A woman in a light-colored headscarf is pointing her right hand towards a large chart or poster on a wall. The chart appears to be a data visualization, possibly a bar chart or a line graph, with some text above it. Another woman, wearing glasses and a dark headscarf, is looking towards the chart. The background is a wall with several other posters or notices pinned to it. The entire image has a green tint.

# Case Study B

Bauchi State

# The focused RISS approach in Bauchi State

Bauchi State is located in the northeastern region of Nigeria and has 20 LGAs and 55 ethnic groups. In 2017, the population of Bauchi was estimated to be approximately 7.3 million<sup>5</sup>.

Like Yobe State, the Bauchi SERICC adopted the RISS strategy. However, regular LGA-HF RISS visits have not led to improved service delivery and operations at health facilities because of the suboptimal conduct and quality of RISS visits by LGA supervisors.

A review of routine RISS data in 2020 revealed that while 90% of the visits were conducted as planned, only 49% of the visits were valid (see Figure 11). A valid visit, according to the Bauchi RISS framework, must last for at least three hours.

The review found that 62% of the invalid visits lasted less than one hour, which is insufficient for supervisors to effectively conduct all required supervision activities, such as engaging with health workers to identify and resolve issues and conducting community visits

Additionally, 50% of these invalid visits were conducted by the LGA PHC teams responsible for leading the intervention and holding other supervisors accountable. Similarly, Bauchi SERICC also found an overriding focus on facility performance assessment rather than health worker capacity-building and joint problem-solving during visits.

These issues with the quality of the implementation of the intervention highlighted the need to revise the RISS strategy implementation end-to-end, specifically by re-modelling the people, processes, and tools and instituting stronger accountability measures to help achieve the original objectives.



<sup>5</sup> Nigeria Population and Development: Bauchi State Fact Sheet

## Designing the focused RISS strategy in Bauchi State

To redesign the RISS strategy, Bauchi SERICC undertook comprehensive diagnostics to identify underlying issues and co-create solutions to address these issues. The diagnostic was performed through KIIs with the LGA supervisors, participants' observation during RISS visits, review of logbooks at health facilities, and data analyses to determine the trends in RISS conduct and health facility performance. The diagnostics team uncovered problems with the RISS tools and accountability structures. Supervisors described the RISS checklist as too long and time-consuming, leading to more time spent on health facility performance assessment. Although data on GIS coordinates were obtained by supervisors for each visit, there was no system in place to routinely analyze this data, validate the conduct of visits, and use insights to foster accountability.

Given these challenges, the Bauchi SERICC optimized the conduct of RISS in the state by revising its RISS strategy with the support of SCIDaR and other implementing partners, including USAID-IHP and UNICEF, who provided technical support through the state M&E working group. The Bauchi SERICC team had two related objectives: first, improving the quality of LG-HF RISS visits, and second, reducing the cost of conducting RISS in the face of shrinking fiscal space for PHC during the COVID-19 pandemic.

To achieve these objectives, the Bauchi SERICC revised the planning approach for monthly RISS visits. Rather than planning for all health facilities to be visited, the state identified and prioritized the worst-performing health facilities across all 20 LGAs in Bauchi State. In Q2 of 2021, 511 of 1071 RI-offering health facilities were identified and prioritized based on the following criteria: adequate number of fixed and outreach sessions (<50%), high penta vaccine wastage rate (>25%), high penta dropout rate (>10%), and congruence between co-administered antigens in facility data records.

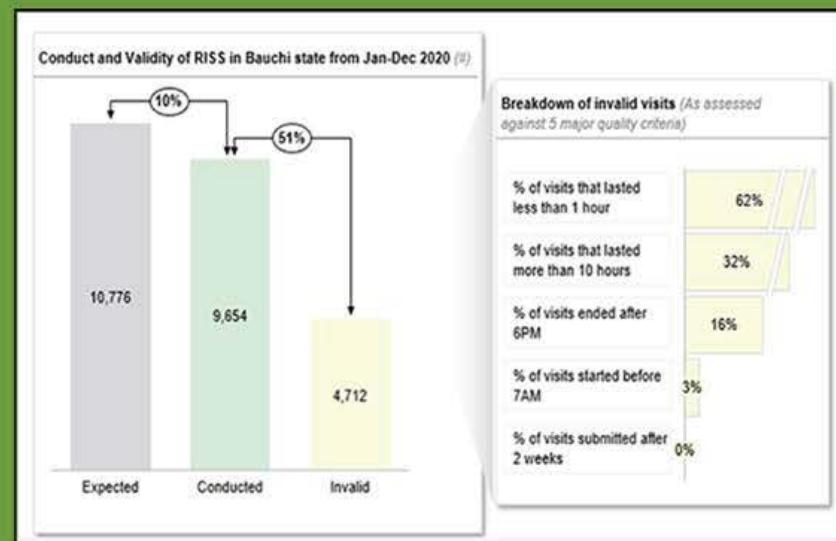


Figure 11: More than half of the visits conducted from January to December 2020 were invalid in Bauchi State

Types of defaulters	Non-conduct of RISS visits	Data falsification / invalid visits
<b>1 One time defaulter</b>	<ul style="list-style-type: none"> <li>PMs and LGA PHC Director to provide feedback and support to supervisor to forestall recurrence</li> <li>Issue <b>first warning</b> and monitor closely</li> </ul>	<ul style="list-style-type: none"> <li>PMs to provide feedback and name-shame during state-level review meeting</li> <li>Issue <b>first warning</b> and monitor closely</li> <li>Withhold transport payment for visit</li> </ul>
<b>2 Repeat (second time) defaulter</b>	<ul style="list-style-type: none"> <li>Issue <b>final warning</b> and notify EC, SPHCDA</li> <li>Notify LGA PHC Director that he will be held responsible if third time default occurs</li> <li>Send reminder email to the supervisor and LGA team to ensure conduct of visits</li> </ul>	<ul style="list-style-type: none"> <li>Issue <b>final warning</b> and notify LGA PHC director and EC, SPHCDA</li> <li>Name shame during state-level review meeting</li> <li>With-hold transport payment for visit</li> </ul>
<b>3 Repeat (third time) defaulter</b>	<ul style="list-style-type: none"> <li>Disqualify supervisor from RISS</li> <li>Notify EC, SPHCDA to <b>issue query</b></li> <li>Engage with LGA PHC director to identify a competent supervisor to replace defaulter</li> </ul>	<ul style="list-style-type: none"> <li>Disqualify from supervision</li> <li>Notify EC, SPHCDA to <b>issue query</b></li> <li>With-hold transport payment for visit</li> </ul>

Figure 12: Image describing the sanctions for RISS supervision defaulters



Scenario	Description	Action
Major improvement recorded. Performance target met	Health facility has met performance targets set at the beginning of the quarter, on track to join the "high-performing" class	<ul style="list-style-type: none"> <li>Issue material / monetary reward to HW and RISS supervisor to encourage good performance</li> <li>Exclude Hs from next set of prioritized HFs for successive quarter's RISS</li> </ul>
Minor improvement recorded; satisfactory	Health facility has made improvements, however, did not meet target set at the beginning of the quarter; HF has moved to the "average-performing" class	<ul style="list-style-type: none"> <li>Re-assess supervisor for competency, identify weak areas and support to improve</li> <li>Exclude Hs from next set of prioritized HFs for successive quarter's RISS</li> </ul>
Improvement recorded; Off-track	Health facility has not made any significant improvement throughout the quarter. HF is still within the "poor-performing" class	<ul style="list-style-type: none"> <li>Re-assess supervisor for competency, and remove if found incompetent</li> <li>Pay supervisor only 50% of transport fees for the third month</li> <li>Visit HF (from state-level) to understand reasons for poor performance</li> <li>Re-include HF in the next set of prioritized HFs for following quarter's RISS</li> </ul>

Figure 13: Image describing the rewards for RISS supervisor defaulters

Similar to the Damaturu pilot, Bauchi SERICC excluded assessments of facility performance to improve the focus on capacity building during LGA health facility RISS visits. Evaluations of the performance of health facilities will now be conducted quarterly by the state M&E team. In addition, the state transitioned from the use of paper-based to electronic

capacity-building flowcharts to improve the efficiency of submissions by LGA teams and reduce printing costs. Furthermore, the provision of feedback to health facilities by supervisors was also instituted by adopting a weekly feedback mechanism for the conduct and quality of visits, while health facility performance feedback was conducted monthly during the state-level review meetings.

Bauchi SERICC instituted accountability for the strategy by engaging the LGA and SPHCDA leadership to get buy-in and ensure the setup and implementation of sanctions and rewards. The chief change made was the switch from paying for the conduct of visits in advance to paying supervisors for validated visits after conducting the activity. Additionally, sanctions were instituted for the non-conduct of RISS visits or data falsification, including queries from the executive chairman (EC), SPHCDA, or delisting officers from the list of qualified supervisors after three offences (see Figure 12). However, a health facility that has met the performance targets set at the beginning of the quarters is on track to join the "high-performing" class and would be excluded from the next set of prioritized health facilities for successive quarters (see Figure 13).



## Piloting the focused RISS strategy in Bauchi State

In April 2021, Bauchi State commenced the implementation of the targeted RISS strategy (see Figure 15) to optimize RISS visits to improve the performance of health facilities while managing the cost implications. Following the identification of prioritized health facilities and the development of the schedule of visits by the SSWG, LGA supervisors commenced RISS visits guided by the ODK RISS checklist and flowcharts.

The Bauchi RISS State Coordinator opined, "In addition to the government staff, we have partners who support the supervision. The state pairs the local government supervisors with partner staff as a joint visit. After we administer checklists, the supervisory team comes back to the local government to debrief on the findings from the conducted visits to see where the facilities are lagging and identify cross-cutting issues. For example, if the team observes that the cross-cutting challenges are around the cold chain, the RI LGA supervisors will focus on that issue during the next cycle of supervision." - Adamu Abdullahi, State RISS Supervisor, Bauchi State.

At the end of the monthly visits, the SSWG and State Finance Unit analyze the submitted

checklist and flowcharts for the conduct, validity, and implementation of accountability measures for defaulters by paying only supervisors with valid visits.

Furthermore, the SSWG conducts quarterly

evaluations of interventions to ascertain the percentage incline or decline against baseline selection indicators. In addition, to address cost, the state fast-tracked the discontinuation of the use of paper-based flowcharts to enable the ease of analysis,

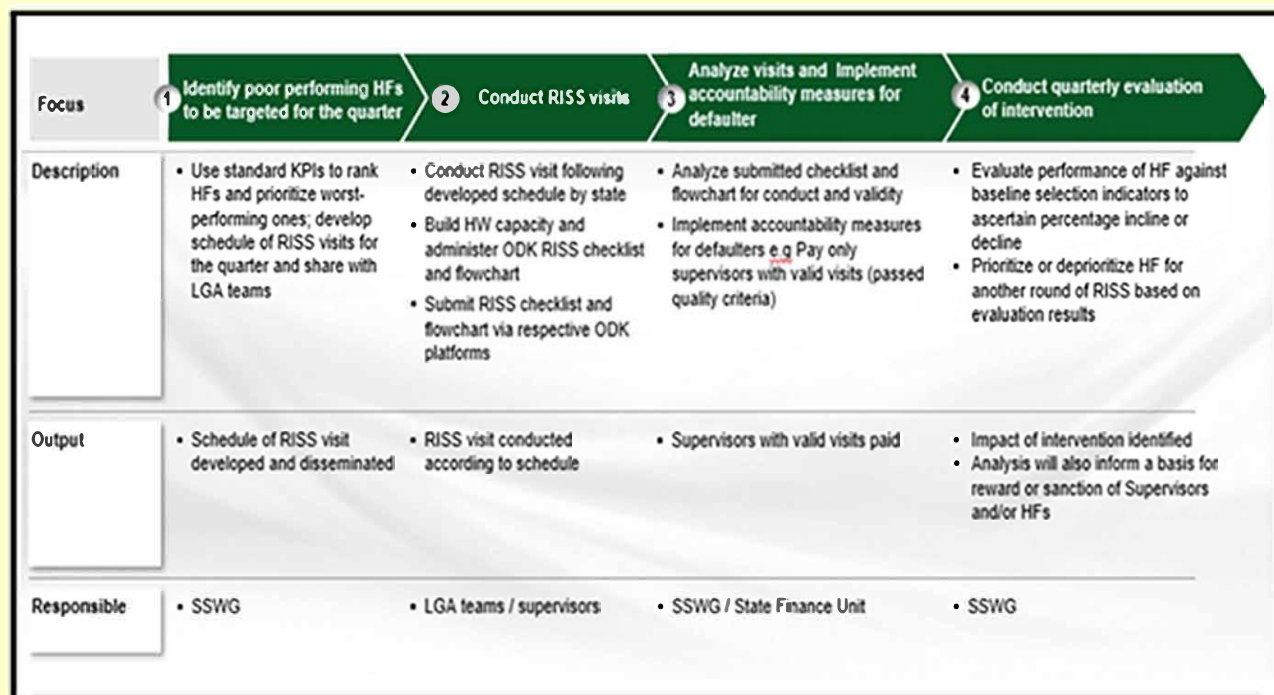


Figure 15: Bauchi State implemented the strategy by following a four-step process

## Did the pilot of the focused RISS strategy in Bauchi State work?

Bauchi SPHCDA successfully implemented four quarterly cycles of the focused, innovative RISS approach by June 2022. The state team then assessed the outcomes to understand the effects on effectiveness and cost, as well as to guide further optimization of the state's RISS strategy.

There was a 31% decrease in the total cost of RISS visits during the implementation of the strategy compared to the amount previously disbursed due to the prioritization of health facilities to be visited and accountability measures implemented to pay supervisors with a valid visit. (See charts showing budgeted and disbursed RISS funds pre and post the intervention in Appendix B.)

In terms of facility performance, five indicators were examined: service delivery, vaccine use, and data quality. The most significant improvements were observed for vaccine use and service delivery. There was a 10% reduction in wastage rates of the penta vaccine and a 6% reduction in drop-outs among children who received the penta vaccine. Data reporting on vaccine use and conduct of fixed and outreach sessions remained steady. A marginal 2% increase was observed in the number of valid RISS visits conducted during the implementation period. (See the chart showing the proportion of valid and invalid visits after strategy implementation in Appendix C.)

Interviews conducted with the main actors involved in the strategy revealed the various success factors and challenges experienced during implementation.

*"The implementation of the revised RISS strategy has been incredibly successful. It is very, very good and has improved routine immunisation coverage. We conduct meetings to strategize, develop a work plan for every RISS supervisor and identify select health facilities for visitation ever month. You know, after doing that, every supervisor will go to their designated facilities to observe health*

*workers and correct any identified gap. There was poor RI coverage earlier because people do not go to where they were sent for support supervision leading to a wide gap in vaccine wastage. However, now with the supervisor consistently going to the health facilities for visitation, there has been so much improvement."* - **Muftau Usman, Bauchi LGA RIOI**



Figure 16: Muftau Usman, Bauchi LGA RIOI sharing the successes of the focused RISS strategy

# Challenges

Some challenges experienced at the state level during the implementation of the focused RISS strategy were the poor enforcement of the agreed accountability measures due to a lack of political will by responsible administrators and at the agency level was the coordination of multiple activities. Supervisors complained about delayed payment as well as technical issues with visit validation and financial disbursements.

LGA officers stressed that these direct disbursements discouraged some supervisors, stating that while this post-visit validation was a welcome innovation, the additional check protracted the payment timelines in comparison to the previous direct cash exchanges made by the PHC accountant upon submission of the checklist. Bauchi SERICC is working to fast-track supervisor payments by automating validation mechanisms and exploring seamless/instant payment methods to address these concerns.

Moreover, the state RISS supervisor identified some other challenges, ranging from human resource attrition to the high cost of implementation of the focused RISS strategy.



Figure 14: Adamu Abdullahi, State RISS Coordinator, Bauchi State

*"While I recommend the adoption of the revised RISS strategy for scale-up implementation in other states, I would advise that the challenges that come with the strategy are addressed. Currently, in Bauchi, we are making recommendations for adoption. A few of these challenges include the high cost of implementation.*

*Additionally, the attrition of health workers is another challenge. Every day, health workers retire; some get higher opportunities while some relocate or leave for personal reasons. Hence, there is a need to keep training and retraining as people come and leave the workforce." - Adamu Abdullahi, Bauchi State RISS coordinator (see Figure 14).*



# Case Study C

Health facility adoption

# Health facility adoption and mentoring model in MoU states.

The SCIDaR implemented an approach to improve healthcare facility performance across six states in Northern Nigeria from Q4 of 2020 to Q4 of 2021. The project team used a facility adoption and mentorship approach to address the challenges of supportive supervision in MoU states.

First, to plan for facility visits, the approach prioritized poor-performing health facilities, such as the Bauchi-focused RISS strategy, to steer limited resources to facilities that need the most support. Field consultants then adopted these health facilities for at least three months to provide continuous mentoring, address the problem of poor action point follow-up, and ensure that complex problems can be addressed within three months. This approach allowed for quick cycles of change within the facility and community and the ability to discard, adapt, or adopt tailored solutions as needed.

Regarding the tools used, the SCIDaR developed and deployed an<sup>6</sup> **abridged checklist** that guided supervisors (SCIDaR consultants) to assess and provide mentoring across all five thematic areas. The short length of the checklist has been tested throughout the implementation to ensure easy completion within an hour at each facility. A key attribute of the checklist that assures problem-solving at health facilities with its use, besides its brevity, is the inclusion of probing questions for the best practices in cases where the health facilities are performing well, and the checklist probes to uncover the root causes of suboptimal poor performance. These help supervisors explore behaviors, trends, and internal and external factors that lead to facility-level outputs and outcomes and, thus, effectively guide health workers in site-level problem-solving and system optimization.

The overall objective of the SCIDaR-led health facility strategy was to strengthen the RI program performance by directly impacting health facility performance through targeted supportive supervision and capacity building for health workers.

<sup>6</sup> <https://docs.google.com/spreadsheets/d/IF5-AMqxHbZDOuqCWOEUNJtnP7r9wY6mv/edit#gid=340685273>

## How was the SCIDaR-led facility mentoring model implemented?

As part of SCIDaR's technical assistance and performance tracking efforts at the facility level, SCIDaR consultants worked with LGA teams to test this unique approach between Q4 of 2020 and Q4 of 2021 across all six states in Northern Nigeria MoU states. The facility mentoring model involved the deployment of a consultant-LGA supervisor pair to visit each health facility successively over a quarter.

At the start of each quarter, the SCIDaR team worked with relevant state and LGA teams to assess health facility performance in each state and select the poor-performing facilities. The indicators for selection varied for LGAs and health facilities (see Figure 19)

In addition to the criteria in Figure 19, the team prioritised health facilities in regions that were safe and accessible, in line with state security guidelines. Every quarter, each supervisor was assigned to visit two facilities at least once a month, from a total of six to eight facilities adopted for mentoring in each state per quarter. Visits were scheduled during ongoing RI sessions for the direct observation of processes and on-site troubleshooting. Members of the LGA team were co-opted to participate in the visits to ensure ownership, drive accountability, and facilitate resource mobilisation within the LGA towards implementing

agreed-upon resolutions. At the end of the month, reports from visits were collated and discussed in a program-wide problem-solving session for accountability, cross-learning, and further

problem-solving across teams. The teams also emphasised the use of Plan-Do-Study-Act (PDSA) cycles to address issues identified during facility visits.

Indicators	Description	Poor performing facilities	High performing facilities
<b>Local Government Area (LGA) selection</b>			
<b>Community Engagement</b>	<ul style="list-style-type: none"> <li>Reconciliation meeting</li> <li>Referral of identified defaulters</li> </ul>	<50%	>80%
<b>Vaccine Supply Chain Management</b>	<ul style="list-style-type: none"> <li>Wastage rate for a minimum of three (3) antigens</li> <li>Availability of vaccines and child health card for three (3) consecutive months</li> </ul>	<ul style="list-style-type: none"> <li>Below the acceptable standard</li> <li>Stock out</li> </ul>	<ul style="list-style-type: none"> <li>Above the acceptable standard</li> <li>No stock out</li> </ul>
<b>Service Delivery</b>	<ul style="list-style-type: none"> <li>LQAs score in the two most recent rounds</li> <li>1OIRIS implementation</li> </ul>	<ul style="list-style-type: none"> <li>Below the acceptable standard</li> <li>No</li> </ul>	<ul style="list-style-type: none"> <li>Above the acceptable standard</li> <li>Yes</li> </ul>
<b>Health facilities selection</b>			
<b>Financial Management</b>	Timely and complete submission of retirement documents	No	Yes
<b>Conduct of sessions</b>	Fixed session days with the application of the Reach Every Ward (REW) micro plan	No	Yes

Source: Team analysis  
<sup>1</sup>Optimised integrated routine immunization sessions

Figure 19: SCIDaR-led HF selection criteria

## Did the SCIDaR-led facility adoption and mentoring model work?

In total, 56 facilities were visited at least three times within each cycle. Over the 15 months of implementation, the team recorded notable improvements in the performance of health facilities where the strategy had been adopted (see the average performance of some health facilities between the baseline and the final visit in Figure 20).

While Borno and Sokoto recorded average improvement across all thematic areas, which could be attributed to the sustained monthly follow-up to those facilities, Kaduna State recorded an average decline in vaccine and supply chain logistics due to increased wastage rates in one of the sample facilities. In addition, there was an average stagnation in financial management, service delivery, and community engagement across Kano State and Yobe State.

The performance ratings for health facilities that were visited three times improved from an average of 62% to 84% at the end of the three-month period with some variations across the states and thematic areas (see Figure 21).

### Average performance in sample HFs visited by thematic areas between baseline and final visit

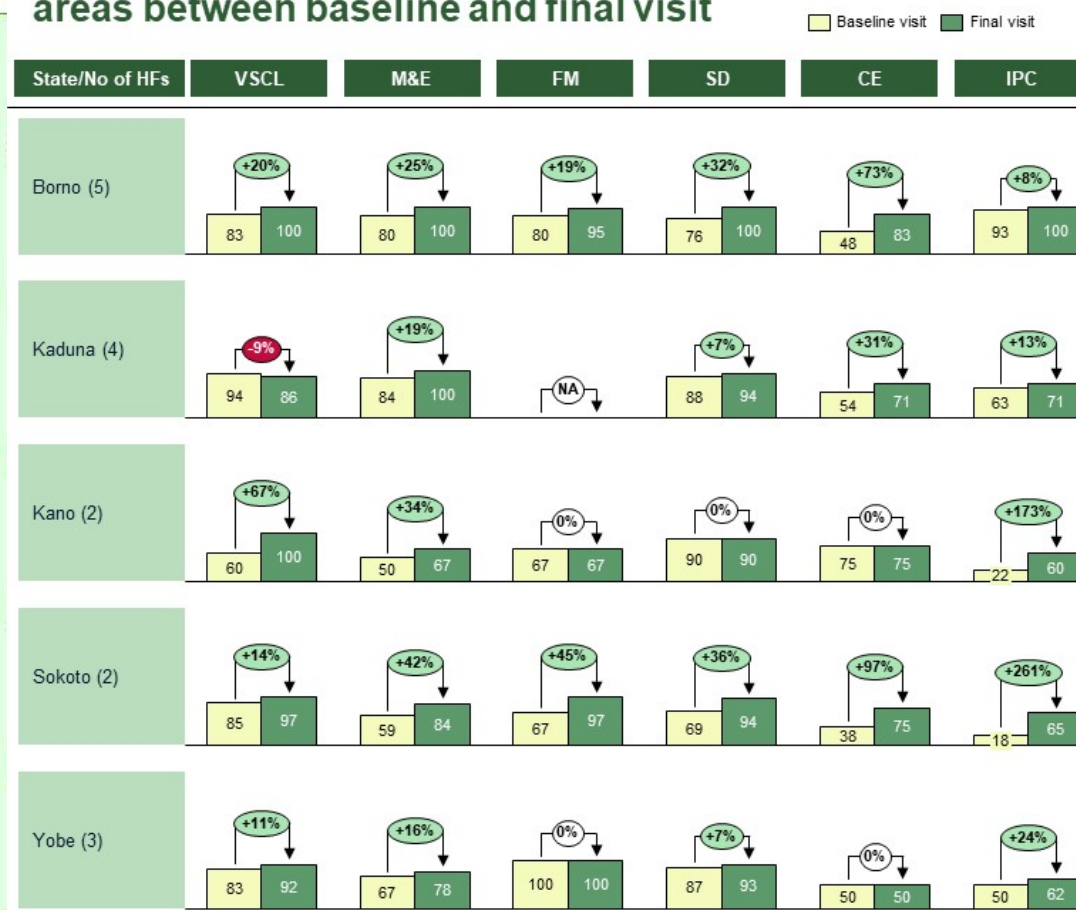


Figure 20: An overview of the improvement in the average performance of sample health facilities visited by thematic areas between the baseline and the final visit in Q2 of 2021.



The successes identified due to the SCIDaR facility mentoring model provide additional **proof of concept for targeted supportive supervision focused on facilitating facility-based problem solving and capacity transfer** rather than facility performance assessments at poor-performing health facilities.

Although improvements cannot solely be attributed to SCIDaR-led facility mentoring as multiple supervisory efforts were routinely implemented, definite facility-specific improvements can be attributed to this facility-based problem solving. For instance, in Zannari MCH in Borno State, a disparity existed between the Child Immunization Register (CIR) and tally sheet for Bacille Calmette-Guérin (BCG) at the baseline assessment; however, by the third month, data congruence was achieved. More importantly, the Q2 REW micro plan that was missing during the baseline visits was already available and updated accordingly (see Figure 22).

Another facility-specific improvement case study is found in the Bangi Dabaga Clinic in Sokoto State, where the thematic area of compliance with COVID-19 IPC guidelines increased from 0% to 43% with an evident adherence to the practice of face mask usage by health workers and social distancing practice in Q2 of 2021 (see Figure 23).

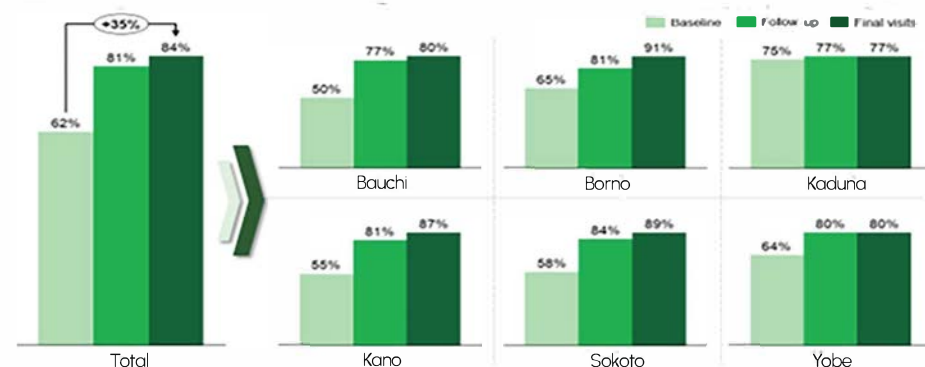


Figure 21: An overview of the average facility performance for the six MoU states in 2021

Progress made since the baseline visit in Zannari MCH, Borno State					
<span style="color:red">■</span> 0-49% <span style="color:orange">■</span> 50-69% <span style="color:green">■</span> 70-100%					
HF	Thematic area	Major issue at Baseline	Findings based on follow-up	Baseline	Final visit
Zannari MCH	Service delivery	No evidence of REW micro plan available	Q2 REW micro plan seen and updated accordingly	33	100
	Data Management	Disparity between CIR and tally sheet for BCG Improper management of data tools	Congruence between data on the tally sheet and CIR for BCG checked Data tools are properly stored and well arranged	25	100
	Community Engagement	Improper use of tickler box for tracking defaulters No evidence of reconciliation meetings	Tickler box was properly arranged and was used to track defaulters for June 2 of 4 reconciliation meetings planned was conducted in June	20	100
	Financial management	No evidence of January, February and March retirement report	April and May retirement was available	50	100

Figure 22: An overview of a facility report in Q2 of 2021 in Borno State

Progress made since the baseline visit in Bangi Dabaga Clinic, Sokoto State					
<span style="color:red">■</span> 0-49% <span style="color:orange">■</span> 50-69% <span style="color:green">■</span> 70-100%					
Health facility	Thematic areas	Key findings at baseline visit	Findings on follow-up	Baseline	Final
Bangi Dabaga Clinic	VSCL	Vaccine stock ledger not available for use	Vaccine ledger is available and in use	75	94
	COVID-19 IPC guidelines	Non-practice of IPC guidelines: face masks not used and social distancing not practiced	Face mask used by H/W and social distancing practiced	0	43
	Data management	Data tools were littered and not in good shape, Disparity between the monthly summary and CIR for checked antigens	Data tools are adequately kept There is no data congruence	67	67
	Service delivery	Fixed sessions do not hold as planned due to a lack of session plan	Fixed sessions still do not hold as planned	50	88
	Community engagement	Health worker does not use tickler bags to track defaulters for immunization	Health worker still has poor knowledge of the use of tickler bags	0	50
	Financial management	UC is not a signatory to the facility's RI account even though HF receives disbursement	UC is now a signatory to the facility's RI account	67	94

Figure 23: An overview of a facility report in Q2 of 2021 in Sokoto State

**SCIDaR**  
SOLINA CENTRE FOR INTERNATIONAL  
DEVELOPMENT AND RESEARCH



©2022

[www.scidar.org](http://www.scidar.org)