AN IMPACT EVALUATION OF THE ENGAGEMENT OF TRADITIONAL AND RELIGIOUS LEADERS IN THE NIGERIAN POLIO ERADICATION INITIATIVE

Draft Report

November 2012

NATIONAL PRIMARY HEALTHCARE DEVELOPMENT AGENCY (NPHCDA). ABUJA. NIGERIA

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Acronyms

FGD	Focus Group Discussion
ICC	Inter-agency Co-coordinating Committee
IPDs	Immunization Plus Days
LGA	Local Government Area
PEI	Polio Eradication Initiative
NiCE	Nigerian Communications and Engagement
TRL	Traditional and Religious Leaders
PRS	Planning, Research and Statistics
RI	Routine Immunization

Executive Summary

Introduction

Since 2009 Nigeria engaged the active support of traditional and religious leaders for the country's Polio Eradication Initiative activities on a larger scale than seen hitherto.

Consequently between then and 2011 the nation recorded progress in terms of reducing the number of endemic polio viruses in the country and also improvement in the routine immunization service delivery.

These progresses were attributed to the engagement of traditional and religious leaders although no proper evidence based on field research was relied on for this conclusion. The objectives of this study were to collect data on key variables of TRL activities, determine the factors that may be associated with performance variations, assess the magnitude of determinants of the roles performed by traditional and religious leaders in the high risk states and explore other possible factors that may account for improvements in PEI delivery services.

Methods

Respondents for the study were drawn from the following states in Nigeria; Kano, Kebbi, Kaduna (North West Zone), Bornu, Bauchi (North East Zone). For the quantitative tool a total of 549 out of a projected 600 caregivers were interviewed by trained enumerators during the duration of the exercise in all the five states combined. A 50% sample i.e. 5 states in terms of number of high risk states was deemed valid. A total of 14 LGA teams conducted the survey in a 50% sample of the 10 high-risk states. Each LGA team had 2 data collectors with one of them designated Team Leader (28) and a supervisor per state (5).

The two sets of data tools were developed and pilot-tested in the field before proceeding to the field after the data collectors were trained for two days followed by a one day practice on data collection and field pilot. For the qualitative data tool there was one FGD per LGA to triangulate data from the quantitative data tools.

Results

91.4% of the respondents were Muslims and nearly all of them (91%) had heard of vaccination services. Christian respondents were in the minority (8.6%) but all of them had heard of vaccination services.

Numerically 89 out of 446(20%) said community heads and heads of religious groups prompted children to be vaccinated in comparism to 161 selections for husband or heads of households. Such prompting was based on persuasion and not coercion (75%). Almost 90% of the respondents believed that traditional leaders were important, definitely important or extremely important in the country's immunization services. This was slightly more than the 80% who believed that religious leaders were slightly important, definitely important or extremely important in the country's immunization services. 87% of the respondents therefore suggested greater involvement of the traditional leaders in vaccination activities.

On the other hand 92% of the respondents suggested greater involvement of the religious leaders in vaccination activities. Both proportions were not significantly different. 71% of the respondents were very satisfied with the sensitization activities by the traditional leaders while 7% were not satisfied. This level of satisfaction was not associated with the use of coercive powers or level of education.

Religious inclination (Christianity and Islam) and completion of vaccination did not bear an association of statistical significance though Christian respondents had fully vaccinated their children. Participants in the FGDs were mostly of the view that the traditional and religious leaders were a major source of information in addition to radio and health workers and suggested greater involvement of the leaders in vaccination activities as they were performing optimally.

Conclusions and Recommendations

The traditional and religious leaders are key stakeholders for vaccination under the Nigerian Communications Engagement model (NiCE). This study has shown a high level of information dissemination from mosques and churches on a fairly consistent basis. The role of these leaders as mobilizers, sensitizers and creators of awareness are consistent with the results of the study and relates to the specific objectives.

A significant proportion of children are not vaccinated without their(TRLs) prompting which is mostly devoid of use of force. Most respondents see the traditional and religious institutions as important in the delivery of vaccination services and expresses full satisfaction with their work.

The caregivers opine that traditional and religious leaders need to be further engaged to continue their present role and they need to be provided with more opportunities for meetings. The issue of lack of felt needs is sighted as one way to further engage and draw the support of these leaders.

Send all correspondences or comments to the Principal Investigator or any of the authors

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Introduction

Since 2009 Nigeria engaged the active support of traditional and religious leaders to support the country's Polio Eradication Initiative activities on a larger scale than seen hitherto.

Consequently between then and 2011 the nation recorded progress in terms of reducing the number of endemic polio viruses in the country and also improvement in the routine immunization service delivery.

These progresses were attributed to the engagement of traditional and religious leaders although no proper evidence based on field research was relied on for this conclusion. It was difficult to draw such conclusions partly because there had been no baseline study before the engagement of the traditional and religious leaders. The engagement of these stakeholders being a demand-side intervention satisfies the requirements for an impact evaluation as an appropriate methodology i.e. targets a critical service with clear and measurable outcomes is subject to scale-up and has been operated for some years and therefore may lose momentum except if re-invigorated. Since there was no such study as a baseline the present one is conceived as a cross sectional study combining both quantitative and qualitative data collection approaches whose outcome can then form a baseline for 2012 upon which feature impact will be gauged if the TRL engagement is continued.

Impact evaluation as a design for this study should be applied in a liberal sense to match the reasons and results of vaccination with the engagement and non-engagement of traditional or religious leaders to assess such an impact. "Impact" again is broadly taken to mean result or outcome measures after vaccinations are carried out.

The study was multicentre and was based on a sample of known high-risk states for vaccination or polio eradication initiative in Nigeria.

The result of this survey will form a basis for governments and stakeholders to decide on continuing the present high level of support to traditional and religious leaders or otherwise. This is a strong justification for this study.

Objectives of the Study

- ✓ To collect data on key variables of TRL activities within the context of the NiCE model
- ✓ To determine the factors or determinants that may be associated with performance variations by TRL in high risk states
- ✓ To assess the magnitude of causes or determinants of the roles performed by traditional and religious leaders in the high risk states
- ✓ To explore other possible factors that may account for improvements in PEI delivery services

Methodology

Selection of the respondents

Respondents for the study were drawn from the following states in Nigeria; Kano, Kebbi, Kaduna (North West Zone), Bornu, Bauchi (North East Zone).

For the quantitative tool a total of 549 out of a projected 600 caregivers were interviewed by trained enumerators during the duration of the exercise in all the five states combined. The validity of the sample size was based on application of the formula $pq/(E/1.96)^2$ or pqZ^2/d^2 where; 90% was level of probability that the engagement of traditional and religious leaders does not yield impact i.e. readiness of type II error and a precision of 10%. P and Q are probabilities of presence or absence of a desirable characteristic which in this case was taken as 60% and 40% respectively.

Applying this formula $pq/(E/1.96)^2$ or pqZ^2/d^2 definite numbers per LGA were determined. An application of this formula yielded close to 700 as optimum sample size to yield valid inferences from the sample to the entire population of 10 high risk states. A 50% sample i.e. 5 states in terms of number of high risk states was deemed valid.

For the qualitative aspect one focus group discussion was held per local government area to give a total of 11 FGDs as some could not hold.

Survey personnel and training

A total of 14 LGA teams conducted the survey in a 50% sample of the 10 high-risk states. Each LGA team had 2 data collectors with one of them designated Team Leader (28) and a supervisor per state (5). The Field Supervisors coordinated with the Team Leaders for problem solving, back-checking of quality of data collected when there were questions, reviewing edited questionnaires, and collection of completed data collection forms, electronic sources etc and sending them to Abuja for collation, entry and analysis. Teams that submitted forms with missing or inconsistent data were asked to return to the site to complete the data collection accurately**.** The process from data collectors training to completion of implementation took up to two (2) weeks. The state Directors of PRS and Health Educators served as facilitators and co-coordinators for the field data collection.

Table 1: States and LGAs sampled for the traditional and religious leaders study

Zones	States	LGAs Covered
NWZ	Kaduna	Zaria Makarfi Igabi
	Kano	Bichi Dawakin-Kudu Nassarawa
	Kebbi	Bagudo
NEZ	Bauchi	Ningi Darazo Katagum
	Bornu	Damboa
Totals	5	11
	Total No Returned	**549**

Data Collection Tools

The two sets of data tools were developed and pilot-tested in the field within Karu LGA of Nassarawa state in September 2012. The actual data collection took place within second week of September 2012. Before proceeding to field the data collectors were trained for two days followed by a one day practice on data collection and field pilot.

Following the training and field practice in Karu LGA the tools were further modified based on feedback and then finalized.

Quantitative Tool for Caregiver Personal Interviews

With the structured quantitative tool data was collected from the caregivers who were heads of various families or the wives or any other person who had custodial role over eligible children.

Qualitative Data Tool

In each LGA one FGD was organized to triangulate data from the quantitative data tool.

Data Entry and Analysis

Survey and abstracted data were entered into SPSS version 16 software by trained data entry officers and analyzed by the Principal Investigator after necessary cleaning. For the caregiver tool data were entered on state by state and LGA basis which had to be merged to create a single dataset so as to extrapolate for the entire high risk states in the north as against individual states or LGAs.

The quantitative data tool which contained mainly nominal data information were subjected to descriptive statistical analysis in form of frequencies, tests of associations by Chi-square analysis. Bar charts were for visual displays. The strength of reproducibility of proportions was defined by standard errors(SE) of means and tests of significance were based on $p=0.05$. $P<0.05$ meant significant association or rejection of null hypothesis (Ho) and vice versa.

Result

Of the 15 randomly selected LGAs it was not possible to collect data from 4 LGAs; 2 in Kebbi state and 1 each from Kaduna and Bornu states. This was due mainly to enumerator drop out from security challenges in those areas.

A total of 549 questionnaires were returned out of a projected 600(91.5% return rate).

Gender Distribution: There were 329(60.3%) males and 217(39.7%) females while 3(0% valid) were not determined from non-response.

Table 2: Age of respondent on last birth day

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	15-24	84	15.3	16.6	16.6
	25-34	135	24.6	26.7	43.3
	35-44	157	28.6	31.0	74.3
	45-54	87	15.8	17.2	91.5
	Over 55	43	7.8	8.5	100.0
	Total	506	92.2	100.0	
Missing	System	43	7.8		
Total		549	100.0		

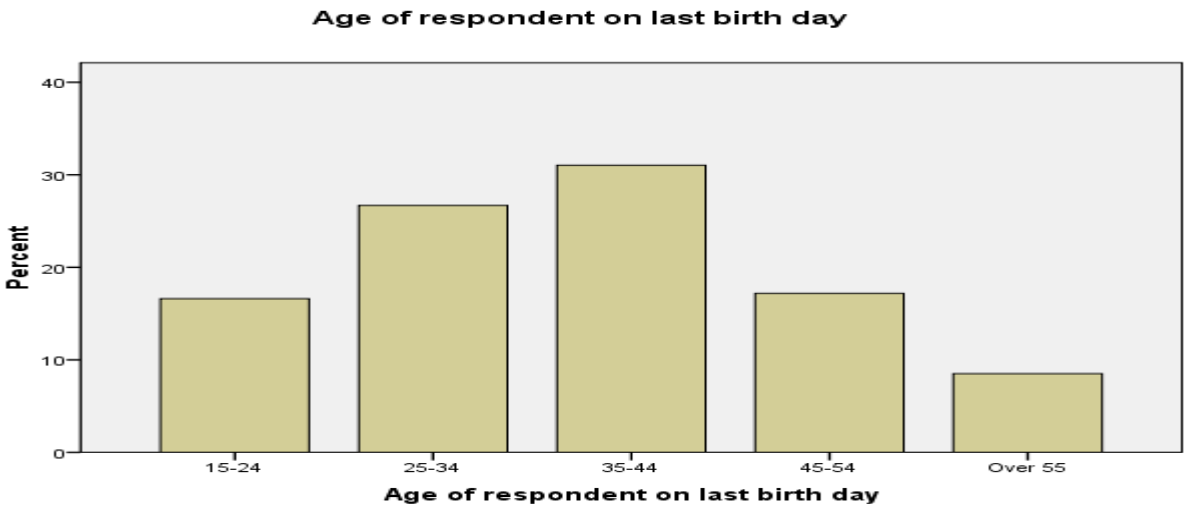

Fig 1: Histogram of age distribution as in table 2

Table 3: Table showing age distribution of respondents

Level of education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No formal schooling	95	17.3	18.0	18.0
	Some primary	59	10.7	11.2	29.1
	Finished primary	71	12.9	13.4	42.5
	Some secondary	40	7.3	7.6	50.1
	Finished secondary	80	14.6	15.1	65.2
	Some university	21	3.8	4.0	69.2
	Finished university	25	4.6	4.7	73.9
	Vocational training	28	5.1	5.3	79.2
	Other	110	20.0	20.8	100.0
	Total	529	96.4	100.0	
Missing	System	20	3.6		
Total		549	100.0		

Religion and Hearing of Immunization

There were 371(91.4%) out of 406 respondents for this question who belong to Islamic faith and 91% of the 371 have heard of immunization services. Also all the 35(8.6%) Christian caregivers interviewed out of 406 said they have heard of immunization.

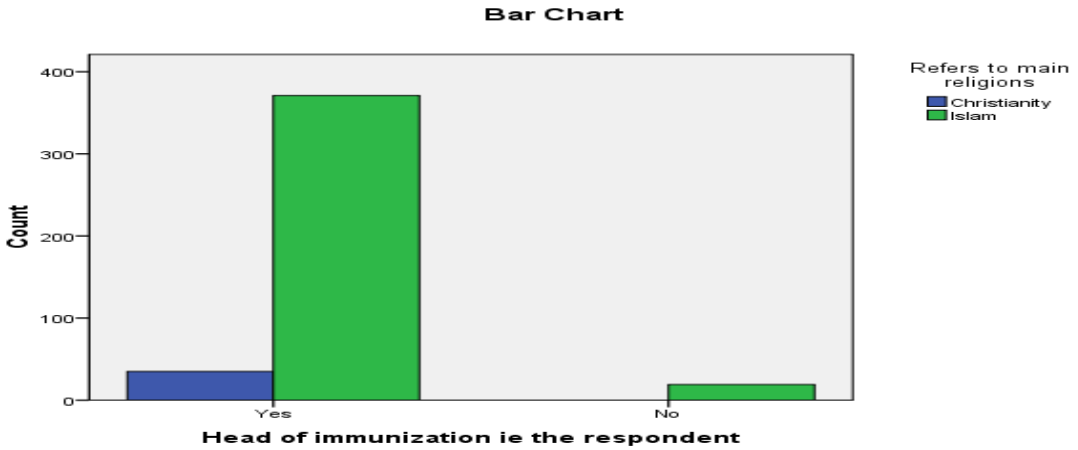

Fig 2

Bar chart showing that more Muslims had not heard of immunization services while there was no Christian that had not.

Table 4: Person prompting immunization i.e. traditional leader, religious leader

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Husband	161	29.3	39.8	39.8
	Wife	16	2.9	4.0	43.7
	Community head	58	10.6	14.3	58.0
	Head of religion	5	.9	1.2	59.3
	Television	7	1.3	1.7	61.0
	Friend	6	1.1	1.5	62.5
	Relative	9	1.6	2.2	64.7
	Health worker	66	12.0	16.3	81.0
	Personal initiative	67	12.2	16.5	97.5
	Others	10	1.8	2.5	100.0
	Total	405	73.8	100.0	
Missing	System	144	26.2		
Total		549	100.0		

Table 4 shows that in decreasing order of magnitude the vaccination of children was prompted by the following persons or groups: Husband(39.8% validity),personal initiative(16.5%),health worker(16.3%),Community head(14.3%).

Numerically a combined 89 out of 446 selections were for community head and head of religious groups prompted children to be vaccinated in comparism to 161 selections for husband. This question is multiple entries implying that each respondent could select more than one entry or selection.

Prompting Immunization Services

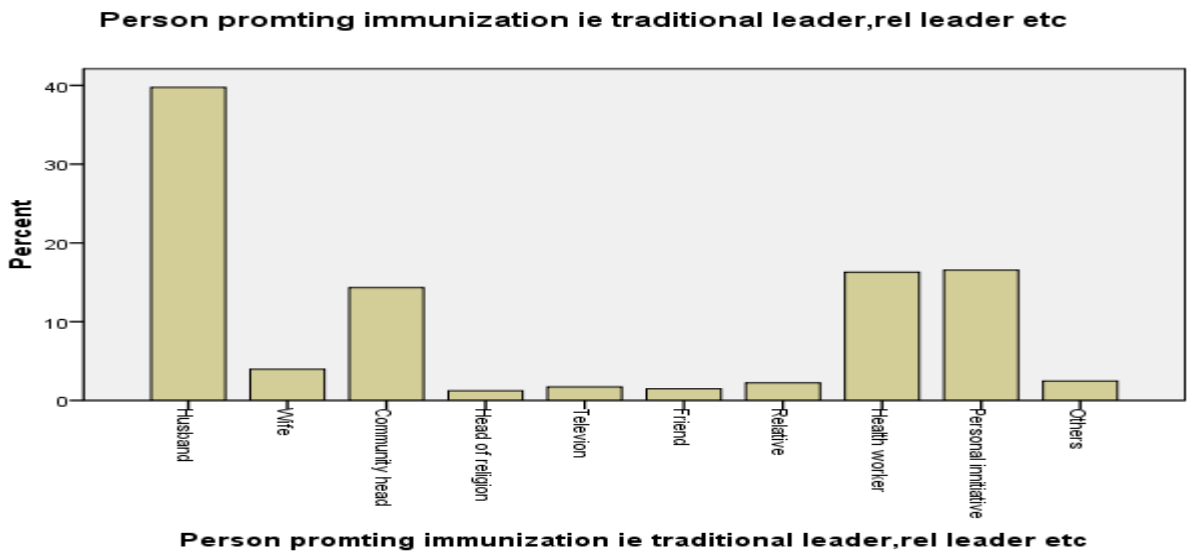

Fig 3

Did Prompting to Vaccinate involve the use of force?

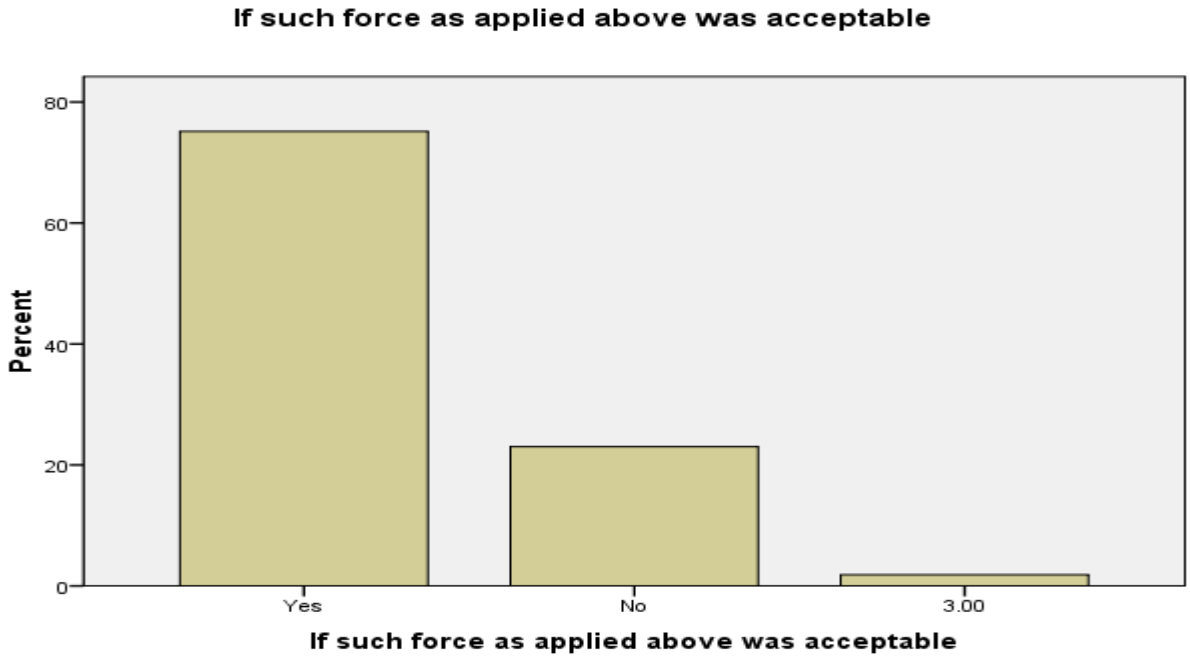

Fig 4

Close to 75% of respondents said prompting them to vaccinate their children did not involve the use of force while 23% indicated that some force was applied before immunization could be accepted. The remaining 2% of respondents did not answer this question.

Importance of Traditional Leaders

Table 5: Importance of the traditional leaders

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all	19	3.5	3.6	3.6
	Only slightly	40	7.3	7.6	11.2
	Somewhat Slightly	13	2.4	2.5	13.7
	Important	199	36.2	37.8	51.4
	Definitely Important	139	25.3	26.4	77.8
	Extremely important	117	21.3	22.2	100.0
	Total	527	96.0	100.0	
Missing	System	22	4.0		
Total		549	100.0		

Almost 90% of the 527 respondents for this question believed that traditional leaders were important, definitely important or extremely important in the country's immunization services. Only about 10% spoke in the contrary i.e. that the traditional leaders were not important or only slightly.

Importance of Religious Leaders

Table 6: Importance of the religious leaders

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all important	17	3.1	3.2	3.2
	Only slightly important	35	6.4	6.5	9.7
	Somewhat important	29	5.3	5.4	15.1
	slightly important	233	42.4	43.5	58.6
	Definitely important	115	20.9	21.5	80.0
	Extremely important	107	19.5	20.0	100.0
	Total	536	97.6	100.0	
Missing	System	13	2.4		
Total		549	100.0		

Similarly almost 80% of 536 respondents for this question believed that religious leaders were slightly important, definitely important or extremely important in the country's immunization services. Only about 20% spoke in the contrary i.e. that the traditional leaders were not at all important, only slightly so or somewhat important.

Involvement of Traditional leaders in mobilization for vaccination activities

Table 7: Traditional leaders involvement in mobilization for vaccination

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	463	84.3	87.0	87.0
	No	37	6.7	7.0	94.0
	Do not know	32	5.8	6.0	100.0
	Total	532	96.9	100.0	
Missing	System	17	3.1		
		549	100.0		

87% of the respondents suggested greater involvement of the traditional leaders in vaccination activities; the remaining proportion (13%) either did not know or gave a contrary opinion.

Table 8: Religious leaders involvement in mobilization for vaccination

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	412	75.0	77.6	77.6
	No	79	14.4	14.9	92.5
	Do not know	40	7.3	7.5	100.0
	Total	531	96.7	100.0	
Missing	System	18	3.3		
Total		549	100.0		

92% of the respondents suggested greater involvement of the religious leaders in vaccination activities; the remaining proportion (8%) either did not know or gave a contrary opinion.

A test for significant for difference in the two proportions i.e. involvement of traditional and of religious leaders was significant at P =0.05 showing that it was necessary to engage both groups and not one of them. There was a 3.1% and 3.3% non-response rate for the two questions on traditional and religious leaders respectively.

Table 9: Extent of satisfaction for sensitization activities by traditional/rel leaders

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not satisfied	38	6.9	8.9	8.9
	Very satisfied	388	70.7	91.1	100.0
	Total	426	77.6	100.0	
Missing	System	123	22.4		
Total		549	100.0		

71% of the respondents for this question (426) were very satisfied with the sensitization activities by the traditional leaders while 7% were not satisfied. The remaining 22% non-response was however statistically significant meaning that more respondents were needed for a valid conclusion.

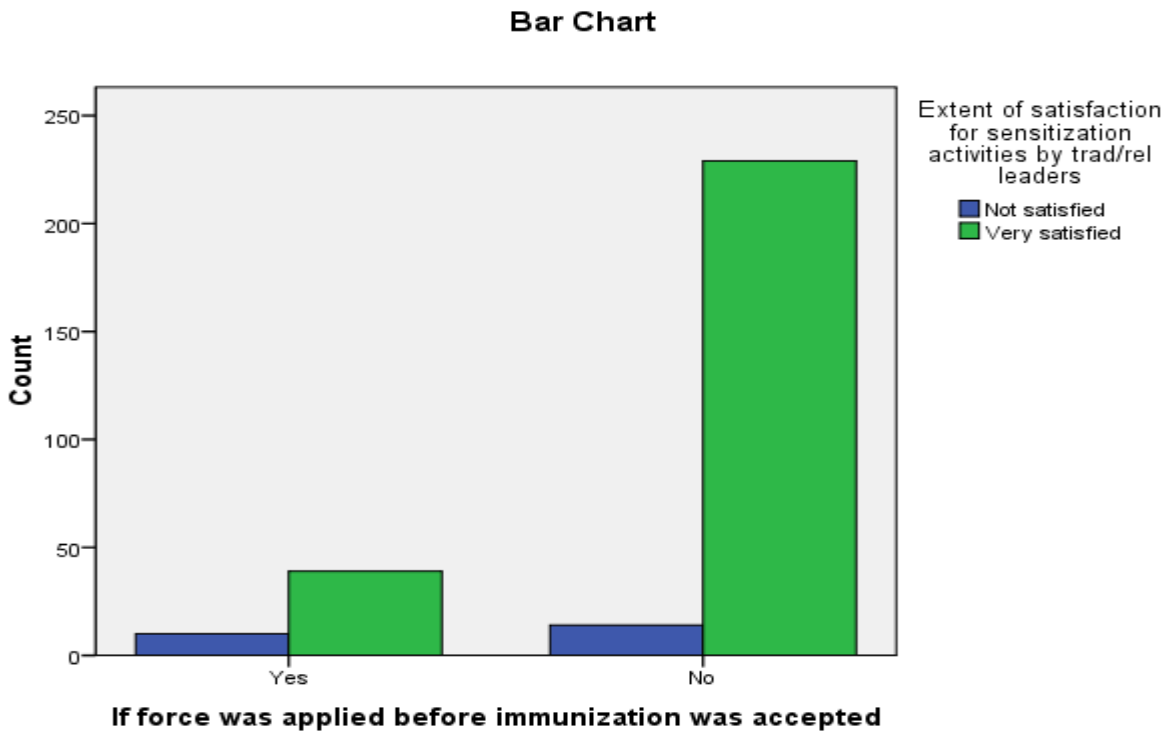

Fig 5

Above shows the output when this variable was cross-tabulated against the impression among respondents when force was applied for their children to be vaccinated. At P=0.05 there was no statistical difference. Thus level of satisfaction was not associated by application of force.

Table 10; Level of Education and Expression of Satisfaction on Role of Traditional and Religious Leaders

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.221[a]	8	.104
Likelihood Ratio	14.773	8	.064
Linear-by-Linear Association	2.132	1	.144
N of Valid Cases	411		

a. 5 cells (27.8%) have expected count less than 5. The minimum expected count is 1.11.

A Pearson Chi Square value of 13.2 at 8 df was not significance at P = 0.05 i.e. P>0.05.

Thus there was no association between level of education and expression of satisfaction by respondents.

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Table 11: Occupation and expression of satisfaction.

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	47.756[a]	33	.047
Likelihood Ratio	44.283	33	.091
Linear-by-Linear Association	.075	1	.785
N of Valid Cases	463		

a. 32 cells (66.7%) have expected count less than 5. The minimum expected count is .00.

Level of Education and Expression of Satisfaction on Role of Traditional and Religious Leaders

Also there was no significance at P = 0.05 i.e. P>0.05 between expression of satisfaction and occupation. Thus there was no association between occupation and expression of satisfaction on the role of these leaders by respondents.

Relationship between vaccination status and religious faith

Refers to main religions * If all the children are vaccinated Cross tabulation

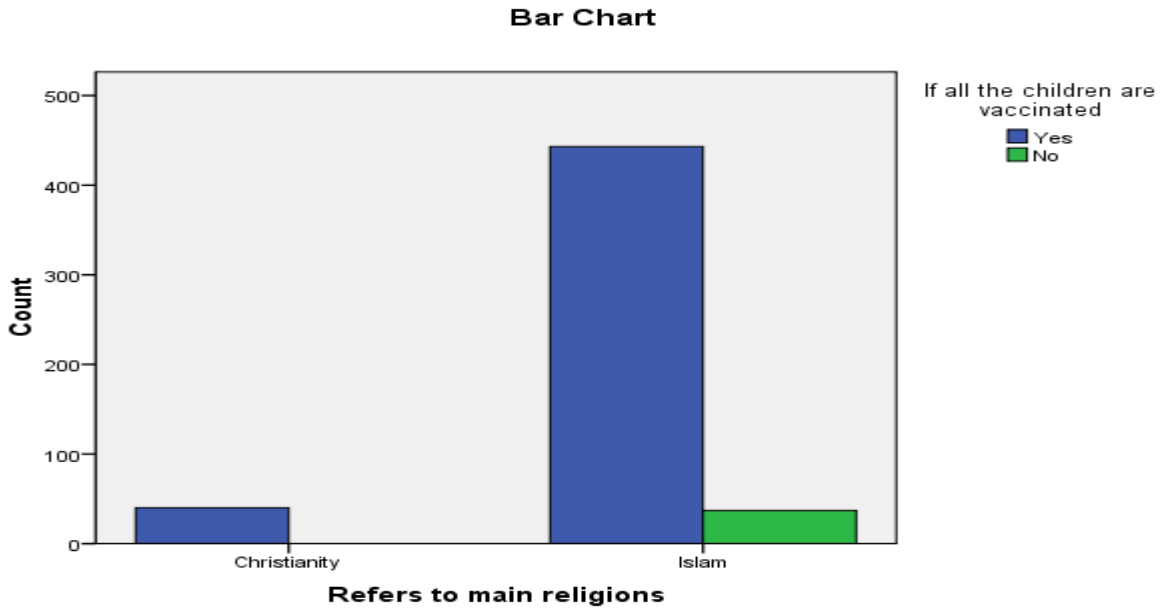

Fig 6

Table 12: Association between religion (Islam, Christianity and others) and completion of vaccination

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.320[a]	1	.068		
Continuity Correction	2.256	1	.133		
Likelihood Ratio	6.154	1	.013		
Fisher's Exact Test				.101	.046
Linear-by-Linear Association	3.313	1	.069		
N of Valid Cases	520				

a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.85.

b. Computed only for a 2x2 table

A Pearson chi square of 3.3was more than P at 0.05 i.e. 0.068 suggesting no statistical association between religion (Islam, Christianity and others) and completion of vaccination. However all Christian respondents fully vaccinated their children.

Result Summary: Rating the Result of FGD

Table 13: Summary Result of Pooled Focus Group Analysis

		Majority	Many	Few
Source of information about IPDs	Radio		+++	
	TRLs			+
	Town announcer			+
	Health workers	+++++		
	Tv			+
TRLs as Source of Information	Yes	+++++		
	No		+++	
	Others			+
Frequency of Information from TRLs	Always		+++	
	Many times(frequently)	+++++		+
	Occasionally			
Greater engagement of TRLs	Yes	+++++		
	No		-	
	Others			+
TRLs performing optimally	Yes	+++++		
	No		+	
	Others			+
TRLs tend to apply coercion	Yes		+++	
	No	+++++		
	Others			+

Conclusions and Recommendations.

- A majority of the respondents for this question belong to Islamic faith and nearly all have heard of immunization services. All the Christian caregivers interviewed said they have heard of immunization.
- Close to a fifth of eligible children could only be vaccinated on the prompting of either a traditional or religious leader. About three quarter said the prompting was not based on the use of coercion.
- A cumulative ninety percent of respondents said the traditional rulers were important in supporting vaccination services while a slightly lesser proportion said the religious leaders were similarly important.
- More than three quarters of respondents said the traditional and religious leaders are involved in mobilizing caregivers for vaccination.
- Almost 90% of the respondents are satisfied with the role traditional and religious leaders play in supporting vaccination services.
- There was no association between level of education and expression of satisfaction by respondents or the use of coercion.
- There was no statistical association between religion (Islam, Christianity and others) and completion of vaccination. However all Christian respondents fully vaccinated their children.
- The main sources of information related to IPDs are the health workers followed by the radio. However generally TRLs provide health information on a consistent basis.
- The respondents suggest greater engagement of the TRLs and they also need to be encouraged by providing them with greater funding, logistics, and meetings. Meeting their felt needs was also identified as a way to improve on their performance.

Recommendations

This survey forms a strong evidence to fully exploit the opportunities available while engaging the traditional and religious leaders in Nigeria's polio high risk states. NPHCDA and partners will now engage with these stakeholders in a systematic way. Part of such re-engagement would require that they be part of all planning and co-coordinating processes to deliver vaccination services. TRLs should on recommendation be nominated into all working groups, Core Group, RI clusters and ultimately the ICC. Such new roles are without prejudice to existing task forces at various levels.

TRLs should receive invitations for trainings and receive stipends. In specific terms ward and village heads must be held accountable for successes or failure of PEI efforts within their domain.

This suggests that such leaders should be empowered to drive all trainings, monitoring and supervision, social mobilization and coordination of logistics and other supplies.

This or similar study should be repeated after two years to assess changes after implementing these recommendations.

ANNEXURE

INSTRUMENT NO: 1

SURVEY QUESTIONNAIRE

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY (NPHCDA) ABUJA NIGERIA

Date

Dear Chief/Prof. /Dr. /Mr. /Mrs. /Ms.: _____

You are being invited to answer the attached questionnaire about impact of Traditional and Religious Leaders in mobilizing for the improved uptake of Polio Eradication services especially as experienced in 2010. There are no risks or penalties for your participation in this research study. However, there is some potential benefit. The information you provide will help us analyze the key factors and your perspectives of ensuring better polio eradication. Should the data be published, your identity will not be disclosed.

Your participation is voluntary, that is, by participating in the discussion, you are to take part in the study. You are also indicating that all your present questions have been answered in the language you can understand. You are free to decline to answer any of the questions that you do not wish to answer or that make you feel uncomfortable. Your oral consent is acceptable.

If you have any questions about this study, please feel free to call either Dr. Eric Nwaze Head, Operations Research Division. National Primary Healthcare Development Agency (NPHCDA), 681/682 Port Harcourt Crescent Area 11 Garki Abuja. Phone: +2347039266431/+2348053336758 or Dr Emmanuel Odu Director, Planning, Research and Statistics. Phone +2347067213832

We look forward to your participation.

Sincerely,

Dr. Eric Nwaze

Principal Investigator

I. REFERENCE IDENTIFICATION

1. State……..
2. LGA……..
3. Town/Community…….
4. Name of Interviewer…….
5. Date & Duration of Interview……..

6. Gender:

    1. Female

    2. Male

II. RESPONDENTS BACKGROUND

7. Your relationship to head of the household

    1. Head

    2. Wife……..

    3. Other (specify)……

8. What is your present marital status?

    1. Never married

    2. Married monogamy

    3. Married polygyny

    4. Divorced

    5. Widowed

    6. Separated

    7. Co-habiting

9. If husband, how many wives do you have?
    a. None
    b. One
    c. Two
    d. Three
    e. Four
    f. More than four

10. If wife, how many co-wives do you have?

    1. None

    2. One

    3. Two

    4. Three

    5. Four

6. More than four.

11. How old were you on your last birthday?
    Or estimated year…….

12. What is your religion?
    1. Christianity
    2. Islam
    3. Traditional
    4. Other……

13. What is the highest level of formal education you have obtained?
    1. No formal schooling
    2. Some primary
    3. Finished primary
    4. Some secondary
    5. Finished secondary
    6. Some University
    7. Finished University
    8. Vocational training
    9. Other……..

14. What is the main kind of work you do most to earn money?
    1. Government Official
    2. Business owner
    3. Farmer
    4. Uniform Personnel
    5. Artisan /craftsman
    6. Transport worker
    7. Teaching in secondary school
    8. Schooling
    9. Unemployed
    10. Pensioner
    12. Housewife
    13. Other Professional……..

15. About how much do you earn/ make in a month?
16. How many children do you have?
17. Have immunized all your children?
    i. Yes……..
    ii. No……..
18. If “No” to question 17, why?

III ATTITUDE AND PRACTICE OF POLIO ERADICATION PROGRAMME

19. Have you heard about Polio? Yes/ No

20. Name Three ways that Polio can be contracted
First mention…….

Second mention…….

Third mention…….

21. List three ways that Polio can be prevented
First mention…….

Second mention……..

Third mention…….

22. Have you heard about immunization?
Yes…….

No……..

23. If "yes "to question 13; where did you first hear of immunization
1. Community Head
2. Radio
3. Television
4. Friend
5. Relative
6. Posters
7. Church
8. Mosque
9. Others (Specify)……..

24. Have your child/Children been ever immunized? 1. Yes 2. No

25. If "yes" to question 24; when did you have the first immunization? …… (In months or years)

26. If "yes" to question 24; where did you have the first immunization? ……..

27. Have you ever used it? 1. Yes 2. No

28. If "no" to question 24; why? ……..

29. If "yes" to question 24; who prompted you to present your child/children for immunization?

1. Husband
2. Wife
3. Community Head
4. Head of your Religion
5. Television
6. Friend
7. Relative
8. Health worker
9. Personal initiative
10. Others (Specify)…….

30. If "yes" to question 24; where you forced?

    1. Yes…….

    2. No.....

31. If "yes" to question 24; would you like such promptings in future?

    1. Yes……. Give reasons……..

    2. No..... give reasons.....

32. Do you know of other people within your neighborhood that followed the promptings of any of the following people?

    1. Community Head
    2. Head of your Religion

33. Do you agree that Traditional Leaders are important in mobilizing for the improved uptake of Polio Eradication services?

    1. Not at all
    2. Only slightly
    3. Somewhat Slightly
    4. Important
    5. Definitely Important
    6. Extremely Important

34. Do you agree that Religious Leaders are important in mobilizing for the improved uptake of Polio Eradication services?

    1. Not at all
    2. Only slightly
    3. Somewhat Slightly
    4. Important
    5. Definitely Important
    6. Extremely Important

35. Do you agree that they should be involved more in Public health mobilization campaign?

1. Yes…….Give reason(s)……
2. No……. Give reason(s)……

36. Has your Traditional Leader been involved in Public health mobilization campaign?

1. Yes…….
2. No……..
3. Do not know……..

37. Has your Religious Leader been involved in Public health mobilization campaign?

1. Yes…….
2. No……..
3. Do not know……..

38. How high do you rate the opinion of your Traditional Leader in managing your family health issues?

1. Not at all Important
2. Only slightly Important
3. Somewhat Important
4. Slightly Important
5. Definitely Important
6. Extremely Important

39. How high do you rate the opinion of your religious Leader in managing your family health issues?

1. Not at all Important
2. Only slightly Important
3. Somewhat Important
4. Slightly Important
5. Definitely Important
6. Extremely Important

40. Government claims to be using the Traditional and Religious Leaders extremely well in mobilizing for the improved uptake of Polio Eradication services. Do you agree?

1. Strongly Disagree
2. Slightly Disagree
3. Disagree
4. Agree
5. Definitely Agree
6. Extremely Agree

41. How would you like to be involved in mobilizing for the improved uptake of Polio Eradication services?

1. Personally Involved. Please explain-…….
2. Involved as a group. Please explain-…….
3. Don't want to be involved. Please give reasons…….

42. How satisfied are you with the amount of sensitization efforts of Traditional and Religious Leaders in Public health mobilization campaign?

1. Not satisfied

2. Very satisfied

43. What do you think are the reason(s) for the relatively low uptake of Polio Eradication Services?

First mention……..

Second mention…….

Third mention …….

Fourth mention ……

Fifth mention ……..

Remember to Thank the Respondents please

INSTRUMENT NO. 2

FOCUS GROUP DISCUSSION GUIDE

A. PRELIMINARIES

1. **Date----------**
2. **Venue----------**
3. **Group Type----------**
4. **Introduction / Establishment of Rapport:** ***(Moderator welcomes the Participants)***

I. Good day, I am …….. and my Colleagues are …… we thank you for agreeing to come and participate in this discussion.

II. We are from …….. and we are here to learn from you and share with your knowledge, opinion and suggestions about the National immunization programme.

III. We have invited you because of your wealth of experience in this community and confidence we have in you.

IV. Please, in this discussion, there is no right or wrong answer. Every one's opinion is important and should be freely expressed.

V. What we will learn from you today will be useful in the future for planning how to improved uptake of Polio Eradication services in this locality

VI. We crave you indulgence to allow us to use a tape recorder to record the proceedings of these discussions. This is to ensure we do not forget all the useful opinions you will share with us. We however, assure you that whatever you disclose to us will not be used against you in anyway.

VII. We therefore appeal to you to participate fully and honestly in the discussion. Once again, thank you for coming***. (Allow each participant introduce or say one or two things about himself or herself)***

5. **Participants' information /Profile:** Participants are expected to introduce themselves by giving the following information:
   - Name (optional)
   - Organisation being represented and position occupied
   - Sex, age
   - Highest level of education
   - Number of years with the organisation /ministry and in the current position

B. GENERAL DISCUSSIONS

1. What have been your experiences with the Polio Eradication programme?
2. Is polio eradication and immunization necessary?
3. What childhood diseases does immunization seek to prevent?
4. Who do you think is responsible for carrying out immunization?
5. How well has the service providers satisfied the needs of the community?
6. What are the major problems you experience during immunization exercise?
7. Why do you think some people withhold their children and wards from immunization?

8. Is it right to deny a child immunization services?
9. How can we ensure that no child is denied immunization services?
10. Who should ensure that a child is immunized? Is the father or mother?

Take time to note the answers and correct any misinformation

C. MAIN SESSION

1. Information, Education and communications.

1. How do you get information about immunizations days?
2. Are the information detailed and timely
3. Is there any room for improvement?
4. Have you ever received information from your Traditional and Religious leaders?

2. Role of Traditional and Religious leaders

1. How often have you received immunization information from your Traditional and Religious leaders?
2. Do you think the Traditional and Religious leaders should be more involved in mobilizing the community?
3. Do you think that the Traditional and Religious leaders are doing enough or they should do more?
4. Heading to the call for immunization by Traditional and Religious leaders is like coercion or voluntary?
5. What are your expectations in Government relationship with Traditional and Religious leaders for the mobilization of the citizenry for uptake of public health services?

D. CLOSING SESSION WITH SUGGESTIONS AND FINAL THOUGHT.

1. What specific action(s) would you suggest or recommend towards improving the uptake of immunization services in this community**?** ***(Make sure every participant has an opportunity to answer)?***

End the focus group session by doing the following:

- ***Debrief the participants***
- ***Thank them for their cooperation***
  Entertain them with snacks

- ***Give each participant his or her gift of appreciation***
- ***Extend a warm wish to drive home carefully.***

Detailed Result of Qualitative Tool (FGD):

Core Thematic Areas and Focus	LGA	FGD
1.IEC • Source of information about IPDs	1,2.Bichi 3.Ningi 4.Zaria 5,6.Dawakin-kudu 7. Igabi 8.Bagudo 9.Bagudo 10.Nasarawa 11, 12.Dambua.	1.Radio, Tv, Town crier 2.Radio,Town announcer, health worker 3.Health worker(LGA HE) 4. Radio, Town announcer, health worker 5.Radio,Jingles,traditional leaders 6. Campaigns, TRLs 7. Town announcer, Health worker 8. TRLs 9.District head 10.Radio, Television, health worker 11. Health worker, media 12. Radio, Traditional leader, health worker 13.LGA health officials 14.Maigi film
• Ever received information from TRL?	13.Katagum 14.Darazo	1. Yes. 2.Yes 3.yes 4.Yes 5.yes 6.yes 7.Yes 8.Yes 9.Yes 10.Yes 11.Yes 12.Yes 13.Yes 14.Yes
• Detailed and timely information?		1.Yes 2.Yes 3.Yes 4.Yes 5.Yes 6.Yes 7.Yes 8.Yes but not always 9.Not always 10.Yes 11.Yes 12.Yes 13.Yes

		14. Yes often.
2.Role of TRL o Frequency of information from TRLs		1.Frequently 2.Many times 3.Daily during campaigns 4.Frequently 5.Only during SIAs(many times) 6. Only during SIAs(many times) 7.Regular intervals 8.Always 9.Regularly 10.Occasionally 11.Frequentlyy 12. So many times 13.Regularly 14.Non-response
o Should TRLs be more involved?		1.Yes 2.Yes 3.yes 4.Yes 5.Yes 6.Yes 7.Yes 8.Yes 9.Yes 10. Yes. 11.Yes 12.Yes 13.Yes 14.Non-response
o Are TRLs doing enough?		1.Yes 2.Yes 3.Improvement needed 4.Should be more involved 5.Yes,improvement needed 6.Yes 7.Should do more 8. Yes, improvement needed 9.Yes but needs encouragement 10.Not enough 11.Should do more 12. Not enough 13.Yes 14.Non-response
o Do TRLs apply force?		1.Yes but needs encouragement 2.Yes, if persuasion fails 3.No 4.No 5.Yes 6.Yes

o Expectations on TRLs to mobilize citizenry for PEI		7.No 8.No 9. No 10.No valid response 11.No 12.No 13.Yes 14. Non-response 1.logistics and allowances 2.Put greater effort 3.Moral and financial support from govt 4.TRLs should receive more funding and logistics, be more involved in planning and have more meetings or workshops 5.Supply more drugs and essential commodities 6. Improve RI and provide adequate drugs 7.Cordial relationship and total involvement of the TRLs 8.Government needs more commitment and transparency 9. Traditional leaders should mobilize citizenry to improve uptake of immunization services. 10.Govt should pay more attention and improve their work 11. Traditional leaders should mobilize citizenry to improve uptake of immunization services. 12.Greater involvement of the TLs 13.Govt should step down information to TRLs an d pay them allowances for meetings attended 14. Needs support and encouragement.
3.Open-ended Suggestions improve on the role of TRLs.		1. TRL should create more awareness. Organize cinema show in local communities 2.Educate people Create awareness 3.People's felt needs are not being met 4. Non-response 5.Improve RI and supply of drugs 6.Improve RI and supply of drugs 7.Full participation of TRLs Ward heads should be attached to each H-H teams 8. Govt should give TRLs free hand to operate. 9.TLs cannot do without govt. collaboration is needed 10.Govt should address felt needs(provide equipments and drugs, roads, maintain facilities and mobilize communities) 11. Provide equipment and drugs, allowances, security and payments should be prompt. 12. Involve wards/village leaders and pay them token. Logistics, funding and supplies should come in early.

		13.Continuoslyy involve TRLs in PEI(gave examples already mentioned) 14.Non-response