



PRRINN - MNCH

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# 2008 ANNUAL REPORT



Partnership for Reviving Routine Immunisation in Northern Nigeria;  
Maternal Newborn and Child Health Initiative



An infant entertains herself while her mother participates in a community forum about childhood immunization

## Forward

Immunisation coverage data for Northern Nigeria has declined over the last 15 years in parallel with the deterioration of PHC services. Recognising this, the Department for International Development partnered four states in Northern Nigeria – Jigawa, Katsina, Yobe and Zamfara. The focus was on strengthening routine immunisation services.

Early on, it was recognised by all stake holders that strengthening routine immunisation services could only occur within the ambit of improved PHC services. In September 2008 the Norwegian Government linked up with the immunisation project and the combined PRRINN-MNCH programme was borne.

The 2008 annual report reflects the achievements and the challenges experienced by the PRRINN team during 2008 and also describes the broadening of the programme with the additional resources from the Norwegian Government.

Early results suggest that there have been some improvements in PHC services in the four states. More importantly, the project has generated enthusiasm and energy around PHC services which if harnessed appropriately by state and local governments should lead to substantial improvements in immunisation coverage and mother and child health indices in the coming years.

The report highlights some of the key areas where the programme has concentrated its activities and is a testimony to the work of the PRRINN-MNCH team and the numerous stakeholders at state, federal and Kano levels.

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This report would not have been compiled but for the extremely hard work of the state and national teams of PRRINN (now PRRINN-MNCH) and the multitude of stakeholders involved in activities to strengthen RI and PHC in the four targeted states – Jigawa, Katsina, Yobe and Zamfara.

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## Acronyms

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women’s Health Services
AHPSR	Alliance for Health Policy and Systems Research
ANC	Antenatal Care
CBO	Community Based Organisation
CCO	Cold Chain Officer
CE	Community Engagement
CHEW	Community Health Extension Worker
CHO	Community Health Officer
COMPASS	Community Participation for Action in the Social Sector
DFID	Department for International Development
DHIS	District Health Information System
DPRS	Director Planning Research and Statistics
DPT	Diphtheria, Pertussis and Tetanus
DSN	Disease Surveillance
DSS	Demographic Surveillance Site
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunisation
EUPRIME	European Partnership to Reinforce Immunisation Efficiency
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to combat AIDS, TB and Malaria
HDCC	Health Data Co-ordinating Committee
HERFON	Health Reform Foundation of Nigeria
HF	Health Facility
HMIS	Health Management Information System
HP	Health Partnership
HR	Human Resource
HSS	Health Systems Strengthening
ICC/IACC	Interagency Coordinating Committee
IMC	Integrated Measles Campaign
IMCI	Integrated Management of Childhood Illnesses
IMNCH	Integrated Maternal, Neonatal and Child Health
IPDs	Immunisation Plus Days
ISS	Integrated Supportive Supervision
JCHEW	Junior CHEW
LB	Live Births
LEC/O	Local Engagement Consultant/Officer
LGA	Local Government Authority
LGSC	Local Government Service Commission
LIPD	Local IPD
LLGA	Learning LGA
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MDG	Millennium Development Goal
MLM	Mid Level Management

MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MSP	Minimum Service Package
MTSS	Medium Term Sector Strategies
NDHS	National Demographic and Health Survey
NHMIS	National HMIS
NICS	National Immunisation Cluster Survey
NIDs	National Immunisation Days
NIPD	National IPD
NORAD	Norwegian Agency for Cooperation and Development
NPHCDA	National PHC Development Agency
NPI	National Programme on Immunisation
OIC	Officer in-Charge
OPD	Outpatients Department
OR	Operational Research
OVI	Objectively Verifiable Indicators
PATHS	Partnership for Transforming Health Systems
PEI	Polio Eradication Initiative
PHC	Primary Health Care
PPRHAA	Peer and Participatory Rapid Health Appraisal for Action
PRRINN	Partnership for Reviving Routine Immunisation in Northern Nigeria
PS	Permanent Secretary
RI	Routine Immunisation
RTHC	Road to Health Card
SBA	Skilled Birth Attendant
SCH	State Council of Health
SCHEW	Senior CHEW
SHMB	State Hospital Management Board
SIA	Supplemental Immunisation Activity
SIACC	State Inter Agency Coordinating Committee
SIPD	State IPD
SMoH	State Ministry of Health
SMoLG	State Ministry of Local Government
SPHCB	State PHC Board
SPHCDA	State PHC Development Agency
U5MR	Under Five Mortality Rate
UNICEF	United Nations Children's Fund
VHC	Village Health Committee
VPDs	Vaccine Preventable Diseases
WDC	Ward Development Committee
WHO	World Health Organisation
WMHCP	Ward Minimum Health Care Package

## Summary

Following the fall in immunisation coverage figures in Nigeria (with the lowest coverage figures in Northern Nigeria), DfID (UK Department for International Development) initiated a programme in Northern Nigeria to strengthen routine immunisation (RI). This became PRRINN (Programme for Reviving Routine Immunisation in Northern Nigeria). The programme was based in four states (Jigawa, Katsina, Yobe and Zamfara) from late 2006.

The importance of strengthening the PHC system was realised early on. Thus in September 2008 the Norwegian Government added the MNCH (Maternal, Newborn and Child Health) component. This broadened the focus to include governance and systems issues at PHC level and the full MCH package.

Baseline studies revealed a highly dysfunctional PHC system. Thus, initiatives have been broad-based and have included;

- A focus on strengthening planning and budgeting at state and LGA levels
- Support at the national level for strengthening both IPDs (Immunisation Plus Days) and RI
- Strengthening RI services including work on the cold chain, microplanning and transport
- Broad systems work on human resources (HR), HMIS (Health Management Information Systems), and finance
- Community engagement activities to increase demand for services and boost voice and accountability
- Key policy and governance initiatives such as the State PHC Board work in Yobe, continuing the PATHS (Partnership for Transforming Health Systems) work in Jigawa in building the Gunduma system, supporting the merger of NPI (National Programme on Immunisation) and NPHCDA (National PHC Development Agency) and the holding of the State Council for Health in Yobe.

This 2008 annual report describes the activities of the combined PRRINN-MNCH programme. In addition, some early results are presented from the sentinel site system, the two years of PPRHAA (Peer and Participatory Rapid Health Appraisal for Action) data, the HR audits and the community engagement strategy. The results suggest that the programme is starting to have an impact on immunisation and on PHC systems and services.

## 2. General Overview

### 2.1 Nigerian context 2008

While the Federal Government elected in 2007 has settled into its role, the Federal Department of Health has witnessed significant changes in 2008. The Minister of Health (Professor Grange) was replaced early in 2008. The acting Minister (Dr Lawan) was superseded by the new Minister (Professor Osotimehin) in December. Similarly the acting Permanent Secretary (Dr Sule) retired towards the middle of 2008 and the Executive Director of the National PHC Development Agency was replaced towards the end of 2008 by Dr Pate. All these changes have created an unsettled environment but bode well for 2009.

The most significant piece of Federal health legislation (the new Health Bill) was passed by the two houses in May 2008, but has yet to be signed by the President. Two critical weaknesses of the current health system are addressed by the Bill:

- Resolving the current fragmentation within the health sector through clarifying the roles of the three tiers of government
- Strengthening PHC through the creation of a PHC fund which will be administered through a State PHC Board.

In anticipation of the passage of the Bill, several states are moving to strengthen PHC services. For several years Jigawa has been building a Gunduma system that incorporates many of the features proposed by the new Bill (addressing fragmentation and strengthening PHC services). The Gunduma Act was passed in 2007 and throughout 2008, work has been occurring on implementation of the Act through strengthening the Gunduma Board and Gundumas and repositioning the different State Ministries responsible for Health (largely the SMoH and SMoLG<sup>1</sup>). In late 2008, work started in Yobe. The focus there has been on creating a State PHC Board which will co-ordinate all PHC services. Katsina has had a SPHCDA (State PHC Development Agency) for several years. While there are some challenges in terms of integration of PHC services (see box) the SPHCDA has played a key role in strengthening PHC services.

### **Katsina – Role of the SPHCDA**

Although the assumption is that the Katsina SPHCDA controls all PHC activities in Katsina, this is not really the case.

The LGAs control the facilities within their LGA. For example, Batsari Local Government Authority (LGA) has 64 PHC facilities (Basic PHC facilities and health posts). In addition, there are 4 model PHC facilities which were built by the SPHCDA. SPHCDA provided seed money for drugs and equipment and then handed over the running to the LGA. Staff are managed in the usual way: level 6 and below are appointed and managed by the LGA and level 7 and above by the Local Government Service Commission (LGSC - a state body). The finances for LGAs are managed by the Local Government Inspectorate – which is part of a parastatal (including chieftaincy affairs) under the Deputy Governor's office.

The SPHCDA oversees PHC activities in the state, has a technical officer in each of the seven zones and has significant influence over the funding by the Local Government Inspectorate. But, this is more an institutional arrangement than a formal structural arrangement. In addition, the SPHCDA has money for capital projects (e.g. model PHC facilities) and manages the drugs for the mobile/ambulance services (the actual ambulance/mobile services are managed by the LGAs). The SPHCDA is responsible for staff allocation (grade level 7 and above). But, the PHC co-ordinators at LGA level report to the LGA chairmen.

The Inspectorate (Ministry of Local Government and Chieftaincy Affairs) prepares the budget from submissions by the LGAs, hears the budget defence and submits the final budget to the Governor/State Executive Council. Then the Inspectorate releases the full recurrent budget directly to LGA accounts. LGAs are meant to send monthly reports to the Inspectorate and the Special Advisor and team also visits LGAs regularly. The Inspectorate has zonal inspectors.

Thus PHC services are managed by both the SPHCDA and the LGAs; while the LGSC and the LG Inspectorate control staff above level 6 and finance respectively.

1 SMoH – State Ministry of Health, SMoLG – State Ministry of Local Government

Nigeria has some of the worst health indices in the world – both the maternal mortality rate (MMR) and the Under Five Mortality Rate (U5MR) are excessively high. With the emphasis on implementing the Millennium Development Goals (MDGs), in the health sector there has been a strong focus on MDGs 4 and 5 – related to mother and child health (MCH). Thus, to strengthen MCH services, 2008 saw two strategies been implemented:

- The Integrated Maternal Neonatal and Child Health (IMNCH) strategy which is been driven by the FMoH
- The Ward Minimum Health Care Package (WMHCP) strategy from the NPHCDA.

Both strategies have similar broad-based approaches to addressing largely MNCH and PHC issues with significant overlap between the two strategies.

To support the implementation of these strategies, significant resources have been sourced. For example, NPHCDA manages the current GAVI<sup>2</sup> money and will allocate the proposed Health Bill money (the PHC Fund) and manage the GFATM money for health systems strengthening; while the GAVI HSS money will be managed by the FMoH Directorate of Planning Research and Statistics (DPRS) and the MTSS document money is controlled by the FMoH, Department of Family Health.

What is clear is that at Federal level the issues concerning fragmentation are still far from resolved.

At State level there has been increased commitment to offer free MCH (Maternal and Child Health) services. This was articulated at the Northern Governor's forum in 2008. Extra resources have already been allocated for this purpose in several states (e.g. for establishing the mobile services in Katsina).

## 2.2 Introduction to the PRRINN programme

The Partnership for Reviving Routine Immunisation in Northern Nigeria (PRRINN) programme started in November 2006. Four states in Nigeria (Jigawa, Katsina, Yobe and Zamfara) were identified and programme staff started operations in early 2007. The consortium managing the programme consists of three partners (Health Partners International, GRID Consulting Ltd and Save the Children, UK) and several associates (Partnership for Appropriate Technology in Health, Health Reform Foundation of Nigeria and Johns Hopkins University, Centre for Communications Programme).

From high immunisation coverage in the early 1990s, coverage has declined dramatically over the following decade and Nigeria is one of the four countries still hosting the wild polio virus, with northern Nigeria being the epicentre. Because of this the government's response was to attempt to eradicate polio through a focus on supplemental immunisation activities (Immunisation Plus Days – IPDs). However, there is a growing realisation that this strategy is inadequate and Routine Immunisation (RI) also needs to be strengthened.

Thus was the PRRINN programme borne. At the start of PRRINN it was recognised by all stakeholders (including DFID and the programme implementers) that RI required an effective PHC system, but that there were serious constraints in the management and delivery of all PHC services, particularly at LGA and facility level. Thus, while the focus is on reviving routine immunisation, this needs to be in the context of strengthening the PHC system. Immunisation is primarily the function of the PHC services. While PHC service components fall under Local Government Authorities (LGAs), much of the control of finance and of certain aspects of human resource management remains with the State and Federal governments.

<sup>2</sup> GAVI – Global Alliance for Vaccines and Immunisation, GFATM – Global Fund to combat AIDS, TB and Malaria, HSS – Health Systems Strengthening, MTSS – Medium Term Sector Strategies

In addition, purchase and the delivery of vaccines and supplies is primarily a function of the federal level of government – initially through the National Programme on Immunisation (NPI) and following the merger in 2007 through the National PHC Development Agency (NPHCDA).

PRRINN's mandate is to strengthen the RI system. Thus work in 2008 focussed on:

- building the cold chain through repair of solar fridges
- strengthening the capacity of facilities to deliver RI services through training of midlevel managers
- developing and implementing micro-plans
- supporting the development of transport policies and so on.

This culminated in the development of state plans for RI (see example from Jigawa).

**Table 1: Revised Logical Frame Work for Strengthening Routine Immunization in Jigawa State**

Narrative	Key Performance Verification indicators	Data Collection Strategy/ Report: Means of verification	Assumption/Risk
<p><b>Goal</b> Better health outcomes for Jigawa children through the reduction of vaccine preventable diseases by the Year 2011 achieved</p>	<p>Reduction of infant mortality from the current 98/1000 Live Births (LB) to &lt;50/1000 LB by 2011</p>	<p>DSN reports  NDHS</p>	
<p><b>Purpose</b> The capacity of Jigawa immunization system to deliver quality services by 2011 strengthened</p>	<p>Routine immunization coverage rates for the fully immunized Jigawa child under 1 year increased from the current level of 35% to 50% by 2011</p>	<p>NHMIS (Routine immunization administrative data)  National Immunization Coverage Survey (NICS)</p>	<p>Adequate political support sustained  Adequate stable political and economic environment exists  Performance in non-health sectors [non-health sector determinates such as education, poverty reduction, women empowerment, etc.] provides sufficient support to health sector</p>
<p><b>Outputs</b></p>			
<p>Vaccine Delivery and Cold Chain performance improved</p>	<p>All selected 270 PHC facilities providing routine immunization services weekly by 2011</p>	<p>Integrated Supervision support reports  PPRHAA</p>	<p>Supply of adequate quantities of bundled vaccines from NPHCDA is adequate and regular  Staffing and resource levels are maintained at adequate levels</p>

<p>The capacity of Jigawa Immunization System strengthened</p>	<p>50% improvement in drop out rates, and card retention by 2011</p> <p>80% of Managers and Service Providers trained on MLM module by 2011</p> <p>80% of funds budgeted for routine immunization released every year till 2011</p> <p>Number of VPDs outbreaks anticipated yearly</p> <p>100% of planned support supervisory visits achieved by 2011</p>	<p>NHMIS (Routine immunization administrative data)</p> <p>Integrated Supervision Support (ISS) quarterly reports</p> <p>PPRHAA</p> <p>National Immunization Coverage Survey</p> <p>Jigawa State annual audited accounts</p> <p>DSN reports</p> <p>Integrated Supervision Support (ISS) quarterly reports</p>	<p>Partnerships to plan and coordinate activities and mobilize resources for immunization are built</p> <p>Adequate financial resources mobilized and applied</p> <p>Financial tracking &amp; management system in place</p>
<p>The demand for immunization services increased</p>	<p>New functional outreach/ mobile sites increased yearly by 25% yearly till 2011</p> <p>270 Wards with a development committee and/or a health partnership implementing an action plan to increase RI demand by 2011</p>	<p>NHMIS (Routine immunization administrative data)</p> <p>ISS quarterly reports</p> <p>PPRHAA</p> <p>DSN reports</p> <p>Minutes of monthly meetings of WDCs</p> <p>Survey of active WDCs and VHCs</p>	<p>Adequate support , responsiveness and commitment is maintained in communities</p>
<p>Activities</p>	<p>Details in operational plan</p>		<p>Adequate financial resources for implementing activities mobilized and sustained</p>

However, the management consortium ensured that the focus was broader than RI and key PHC systems, strengthening work in 2008 included building up the planning and supervisory systems at state and LGA levels, reinforcing the routine HMIS and work on human resource and financial management systems.

At Federal level the PRRINN programme supported initiatives to eradicate polio through the IPD approach while at the same time focussed on strengthening the RI system.

Work on the demand side focused on supporting the states to develop community engagement approaches that were locally appropriate to the implementation context. Community engagement activities have focused not only on creating demand for routine immunisation and ANC, but also on building

capacity at community level to claim improvements in poorly functioning PHC services. Other activities have focused on building state, local government and national consultant capacity to address issues on the 'demand-side'.

### 2.3 Introduction to the MNCH programme

In September 2008, the same consortium with some additional partners (Liverpool Associates in Tropical Health, Mailman School of Public Health - Columbia University and Ahmadu Bello University) was awarded an additional contract to extend the PRRINN programme to a MNCH programme. Three of the four states (Katsina, Yobe and Zamfara) were covered by this programme. The funding for this extension was via NORAD (Norwegian Agency for Development Cooperation). The programme would be run as a joint programme (PRRINN-MNCH) with DfID as the co-ordinating development partner. The PATHS2<sup>3</sup> programme will lead on MNCH activities in Jigawa.

While the focus was on MNCH, there was in addition a much broader mandate. The key shifts included a substantial emphasis on governance issues and the interlinkages between these and systems issues. In addition, a further component focussed on operations research (OR). In PRRINN there were limited resources for selected OR studies, while with MNCH there are resources to develop a Demographic Surveillance Site (DSS) in one state and a learning LGA (LLGA) in the other states. It is expected that the DSS and the LLGAs will pilot interventions and implement successful components across the states.



Delivering vaccines

As there was considerable overlap between the two programmes, the MNCH component mainly deepened and broadened the original PRRINN programme and its existing components, with some new emphasis on maternal-newborn care, addressing governance issues and significant additional resources for operations research. This has necessitated revision of the programme logframe, some additional baseline assessments and review of some of the initiatives started under PRRINN.

In October 2008 programme staff and external technical advisers met to discuss the new direction of the combined programme under

each output. Key ideas were presented and discussed at a stakeholder forum in Kano. Following this visits to each state fleshed out the details. This has been captured both in the combined PRRINN-MNCH 2009 plan but also within state and LGA plans in each state.

### 2.4 Aims of the Programme – An Overview of the 7 outputs

The combined PRRINN-MNCH programme aims to achieve seven main outputs by the time it is completed:

- Strengthened State and LGA governance of PHC systems geared to MNCH
- Improved human resource policies and practices for PHC

3 PATHS2 – Partnership for Transforming Health Systems – is another DfID supported programme.

- Improved delivery of MNCH services via the PHC system
- Operational research providing evidence for PHC stewardship, MNCH policy and planning, service delivery, and effective demand
- Improved information generation with knowledge being used in policy and practice
- Increased demand for MNCH services
- Improved capacity of Federal Ministry level to enable States' routine immunisation activities

While each output has its own objectively verifiable indicators (OVIs), the following output/ outcome indicators will be utilised to measure the overall effectiveness of the programme:

- Outpatient attendance increased by 50% by 2013
- Utilisation of emergency obstetric care is at least 75% of estimated need by 2013
- % births attended by a skilled birth attendant to increase<sup>4</sup>
- % women receiving antenatal care increased by 50% by 2011
- 60% of infants fully immunized before first birthday by 2011
- 70% of women aged 15-49 have appropriate TT doses by 2011
- Measles incidence reduced by 80%

#### *Output 1 - Governance*

Following baseline assessments, the programme will focus on supporting states and LGAs to harmonise PHC services under the banner of **'bringing PHC services under one roof'**. Linked to this will be the need to finalise the Minimum Service package (MSP) and to operationalise the Northern Governors Forum's decision to provide free MCH services. The work started by PRRINN on strengthening the planning and budgeting cycle at state and LGA levels will continue. In addition, work will be initiated on strengthening public finance management systems and on mobilising and effectively utilising extra resources. A key initiative will be on exploring options for performance based resourcing. The current advocacy strategy will be reviewed and aligned to the broader governance initiative.



Visit of National Programme Manager and Norwegian Ambassador to Katsina State

#### *Output 2 – Human Resources*

In 2008 PRRINN supported a human resources (HR) audit in Jigawa and Zamfara. This work will expand in 2009 to include Katsina and Yobe. Further work will be on strengthening HR policies and plans; addressing shortages and maldistribution of health workers; and increasing the numbers and quality of Skilled Birth

<sup>4</sup> PATHS2 – Partnership for Transforming Health Systems – is another DfID supported programme.

Attendants (SBAs). To this end, PRRINN-MNCH will support the Midwifery Corps Scheme. Pre-service and in-service institutions will be assessed and supported to deliver higher quality programmes.

#### *Output 3 – Service Delivery*

This output covers both systems and services and continues work initiated under PRRINN. It focuses on the basic and essential requirements to deliver PHC, especially MNCH and RI. Systems strengthening work includes transport management; vaccine distribution and storage; developing sustainable drug supplies; supportive supervision; and enabling equipment management and maintenance. Service aspects will concentrate on maternal, newborn and child health care. Initially to reduce the high maternal mortality rate, the emphasis will be on increasing the numbers and quality of skilled birth attendants (SBAs), of revitalising emergency obstetric care (EOC) services in line with accepted norms and improving the quality of care (especially antenatal and postnatal care services). The quality of neonatal care will be assessed and improved while child health services support will include strengthening IMCI services. A particular focus will be on identifying and reaching the hard-to-reach in terms of immunisation services.

#### *Output 4 – Operational Research*

This component is based on experience gleaned from the In-Depth network and particularly the Navrongo operational research initiative in Ghana. The team will establish a Demographic Surveillance Site (DSS) in one LGA (most likely in Zamfara State) and a learning LGA in the other states. Various initiatives will be piloted in the DSS and then implemented across the PRRINN-MNCH supported states.

#### *Output 5 – Information Generation and Knowledge Management*

In PRRINN the emphasis has been on establishing a sentinel site system that would track the progress of the programme. Integration of the sentinel site system with the routine HMIS (as occurred in Jigawa in 2008) will lead to rebuilding the routine HMIS as is planned in the combined PRRINN-MNCH programme. In rebuilding the initial emphasis will be on the collection, collation and analysis of quality data. Following this, there will be a shift to utilisation of data by managers, service providers and communities. The knowledge management strategy developed under PRRINN will kick off in 2009 with formalisation of an implementation plan, development of a website and the training of local writers.

#### *Output 6 – Demand for Services*

Continuing the implementation of a community engagement (CE) strategy will create healthy partnerships between communities and service providers. Communication activities, started under PRRINN, will strengthen advocacy initiatives, inform communities and facilitate demand for quality health services. Strengthening health-related community structures (e.g. facility health committees) will deepen the voice of communities in health matters and promote accountability of the health services to their communities. Across the programme issues of gender and social inclusion will be mainstreamed.

#### *Output 7- Strengthening Federal Capacity*

The mandate of PRRINN-MNCH does not extend much to the federal level except in the area of immunisation. PRRINN-MNCH will work closely with structures at Federal level (especially the NPHCDA) to strengthen both RI and PHC services. Avenues to leverage extra resources will be explored.

The PRRINN-MNCH programme will continue to work closely with all partners in each state and support the harmonisation of plans, budgets and activities that has started under PRRINN. Rather than establish new structures, existing structures have been and will be revitalised (e.g. State Interagency Co-ordinating Committee or SIACC for immunisation and PHC matters, the Health Data Co-ordinating Committee or HDCC for HMIS matters).

While the MNCH mandate covers three of the existing PRRINN supported states, Jigawa is covered by the PATHS2 programme. Already the PRRINN team in Jigawa has built a strong relationship with the PATHS1 programme and it is expected that this will translate seamlessly to the incoming PATHS2 team.

### 2.5 Approaches adopted and methods used

The PRRINN-MNCH programme is characterised by a strong emphasis on stakeholder engagement and involvement, using a flexible, responsive and inclusive approach. National and State teams have a mandate to respond to the needs of stakeholders, have the capacity to be flexible in what they can and cannot support. As far as possible, all initiatives should link in with Federal, State and LGA plans and initiatives. Some methods utilised to achieve this have included:



Community meeting in Jigawa State

#### a) Local Engagement Consultants/Officers (LECs/LEOs)

The LEOs or LECs are playing a significant role in ensuring that PRRINN-related activities are happening with LGAs, health facilities and communities. LEO/LECs have been employed in each state and work at either health zone level, Gunduma level or serve a group of LGAs. The purpose of these workers is to ensure that policy and plans are implemented, supported and monitored on the ground. Each state has a different number depending on the size of the state.

**Table 2: LEC/LEO Numbers**

State	No. of LEC/Os
Jigawa	9
Katsina	9
Yobe	5
Zamfara	5

LEOs/LECs started work in September 2008 and have played slightly different roles in each state.

In Zamfara, LECS have been used to:

- Support LGA officers in their tasks
- Verify status of RI at health facility level
- Compare data at health facility level with data available at state level and discuss differences

In Yobe LECs:

- Support LGAs in the LGA planning exercise
- Verify the status of health facilities (e.g. functioning, services offered)
- Strengthen meetings within each LGA
- Assist in costing immunisation services

In Katsina the LECs:

- Use a modified ISS checklist to collect baseline data on the facilities in their areas
- Visit all the facilities in their areas over a 4 month period (over 100 each)
- Provide support to the LGAs
- Support the PPRHAA exercise
- Serve as independent monitors during IPDs

In Jigawa, LEOs have assisted with:

- Collecting the sentinel site data
- Supporting and strengthening management at Gunduma and LGA levels
- Documenting the implementation and effect of policies and strategies
- Implementing the Community Engagement strategy

In each state checklists have been developed to assist the LECs.

#### **b) Advocacy**

State stakeholders, the Health Reform Foundation of Nigeria (HERFON) and other contributors are driving advocacy initiatives with the combined PRRINN-MNCH team. An advocacy strategy has been developed under PRRINN that will be finalised after the MNCH baseline assessments (especially the governance assessments) in May 2009. Advocacy initiatives have included working with a range of leaders and influencers within government and the community and have led to increased interest in and commitment to PHC and RI. Recent advocacy work in Yobe for instance has led to a major government initiative to establish a State PHC Development Agency. It is clear that substantive improvement in PHC service delivery will depend on major changes in how health services are managed, organised and used, which can only be achieved with the active engagement of key stakeholders at every level.

#### **c) Governance/Systems**

A central feature of the combined PRRINN-MNCH programme is the focus on governance issues and the interlinkages between governance issues and systems. Health services generally are not functioning properly not because of inadequate capacity or poor systems (although these contribute). Rather the dysfunction in these organisations has more to do with a broader range of "governance" issues, including corruption, lack of accountability, patronage in human resource systems, poor transparency in funding, and a failure to respond to the needs of poor people. An explicit aim of the combined PRRINN-MNCH programme is to engage with the structures and institutional 'rules' that define how things happen. In this way systems can be enabled and capacity unleashed to improve PHC services.

#### **d) Planning/budgeting**

One of the key systems to strengthen are planning/budgeting systems. As already noted these are fragmented with multiple bodies having responsibility. The key is to ensure that plans are costed, that these are incorporated into State and LGA budgets, that budget release is enabled and that implementation is tracked and reported on. Governors and LGA chairmen need to be confident that money is utilised correctly and effectively. PRRINN started this work right from the very beginning and this will be expanded under the combined PRRINN-MNCH programme.

### 3. Implementation

#### 3.1 Key Areas

##### a) Immunisation strategy/GAVI

Over the last few years, government has concentrated on Supplemental Immunisation Activities (SIAs) to eliminate polio in particular. This has contributed substantively to the breakdown in the functioning of the RI system. Finances have flowed into SIAs but not into RI. PRRINN has assisted states in developing an overall immunisation strategy (see Table 1). In addition, in several states PRRINN assisted the government in understanding what resources were available for SIAs and RI services respectively (see Table 3 for Jigawa). This has been used as an advocacy tool to lobby for increased funding for RI. Jigawa successfully managed to leverage additional funding for RI using this tool in 2008 (see State Report section).

**Table 3: Comparison of RI and SIA expenditure in Jigawa – 2008**  
**Supplemental Immunisation Activities (budget released 2008)**

Level of support	Month	Naira in millions
State Support	January NIPD <sup>1</sup>	5.2
	February NIPD	5.3
	March LIPD	3.8
	April SIPD	5.4
	June SIPD	6.8
	July SIPD	7.3
	August SIPD	11.7
	November IMC	11.2
	Total	56.7
LGA support	January NIPD	45
	February NIPD	43
	April SIPD	44
	June SIPD	55
	July SIPD	58
	August SIPD	51.4
	November IMC	44.3
	Total	340.7

#### Routine Immunisation Activities – State Budget Request 2008

Recurrent Costs	For 2008	N28.9 million (both state and LGAs)
		Naira in millions
Capital Costs	54 motor cycles	8.1
	2 vehicles	10.4
	27 deep freezers	2.6
	35 refrigerators	2.3
	17 generators (15KVA)	29.7
	Total Capital	53.1

Total requested for RI for state and LGA = N82 million

Total spent on SIAs in 2008 = N397.4million

GAVI has substantial resources for immunisation activities. The resources are managed by the NPHCDA. One of the problems (especially in Northern Nigeria) is that second tranches of money never materialise as the first tranche has not been properly retired and accounted for. Starting in Yobe, PRRINN assisted states to retire and account for the first tranche and so access the second tranche.

#### b) Cold chain – solar fridges

Key to maintaining the cold chain in 2008 was the repair of solar units and development of maintenance capacity within each state.



CCO doing minor repairs on a solar panel

In Zamfara, the plan is to have one solar fridge in one facility per ward (147 wards). To date 63 existing solar fridges have been repaired and a contract has been awarded for an additional 70 solar units. This will mean that around 75% of the 147 wards will soon be covered. PRRINN has supported the training of an assistant Cold Chain Officer (CCO) to install, manage and do minor repairs on cold chain equipment. In addition, 45 Officers in-charge (OICs) of PHC health facilities have been trained in routine solar panel maintenance.

In Yobe, 21 solar panels and 81 batteries were purchased and installed. PRRINN supported UNICEF who was tasked with maintaining the solar system. The inventory was updated.

In Katsina, all LGAs now have adequate cold chain storage capacity.

In Jigawa, 81 solar units were available, of which 29 were functional. PRRINN assisted in getting 25 more units functional, and has budgeted in 2009 for the remaining ones.

#### c) Planning and Budgeting

An early focus of the PRRINN programme was on strengthening planning and budgeting capacity at all levels. Initially, PPRHAA<sup>5</sup> was used to appraise and plan at PHC facility and LGA level. Following the initial PPRHAA in 2007, the four PRRINN baseline studies were used to inform the development of a three-year state strategic health plan and a one year operational plan. In 2008, the strategic and operational plans were reviewed, 2009 state strategic plans were developed and for the first time LGA operational plans emerged. All these were costed and included in budgets for 2009. The emphasis has shifted to defending budgets, tracking release of resources and monitoring the effectiveness of the plans. This has been a major initiative of the PRRINN programme. The combined PRRINN-MNCH programme will deepen and broaden this initiative.

#### d) Policy work

As described earlier, governance issues (both structural and institutional) are important in addressing the problems facing the health sector. Key initiatives have included:

- In Yobe, supporting the development of a State PHC Board that will fast track the approach of **'bringing PHC under one roof'**.
- In Zamfara, assisting the state to hold the first ever State Council for Health that led to the incorporation of the resolutions in the State Operational Plan for 2009.
- In Jigawa, continued support to the development of the Gunduma system, including the repositioning of the SMoH.

### e) Support at Federal level

The National Programme Manager and the National Policy Advisor have continued to work with structures at national level. This has included state structures (particularly NPHCDA and the FMoH), development partners, national Nigerian bodies (e.g. HERFON) and bodies such as the Interagency Co-ordinating Committee (ICC) and substructures. For the last mentioned body PRRINN produced a discussion document in June on the Polio Eradication Initiative (PEI) and RI.

### f) OR Studies

Two studies were commissioned in 2008:

- An Analysis of High and Low Performing Local Government Areas and Primary Health Care Facilities<sup>6</sup>
- Mapping the supply and logistics for immunisation

Anecdotal evidence and feedback from the PRRINN baseline studies had indicated large differences in functionality between different PHC facilities and LGAs. The analysis of the high and low performing facilities was very interesting and showed wide variance in functioning. For example higher performing LGAs and facilities were associated with:

- The availability of annual plans and supervision
- The involvement of facilities in setting and reviewing RI targets
- Staff who could calculate and review coverage rates
- Staff using their own transport to collect vaccines
- Staff ability to calculate vaccine needs

However, the sample size was not sufficient and thus a more in-depth study is planned for 2009. The mapping exercise occurred late in 2008.

In addition, a proposal was submitted to the AHPSR (Alliance for Health Policy and Systems Research) on 'Evaluating a peer and participatory research methodology within an aid-funded, five year programme in Northern Nigeria'. This was approved in the middle of 2008 and the final negotiations are currently being concluded.

### A tale of two health centres<sup>7</sup>

#### Health Centre

This is a well run, clean and effective health centre providing good quality care and weekly RI to the nearby village, in spite of minimal support from the LGA. The midwife in charge has 5 staff and does weekly immunisation sessions with a monthly average of 120 participants, nearly all under one year. RI data is well recorded on the tally sheets and the immunisation register is meticulously completed by date for every individual child, each with a number allocated from the Road to Health Card (RTHC). She had 60 new children <1 year for 2008 so far, giving her a coverage of almost 70%; and a drop out rate of only 15%, mainly amongst the migrant Fulani herdsmen. Very few children come over 12 months as they are all immunised before then. They used to have a solar powered fridge but this has not worked for 5 months, since a storm destroyed the solar panels. The LGA "always promises they will repair it tomorrow" but have not repaired it yet. There is a hand drawn map on the wall showing all the habitations in the catchment area and their population. However, most of the children come from the nearby village as she has no transport to do outreach for the outlying villages and migrant cattle herders.

<sup>6</sup> See report 'An Analysis of High and Low Performing Local Government Areas & Primary Health Care Facilities by Dr Sudeep Chand, Dr David McCoy, Dr Muhammed Ibrahim and Dr Kabir Sabitu, November 2008

<sup>7</sup> Extracted from the 'Report to National Epidemiologist, State Team managers by Arthur Heywood, November 2008'

The health centre does no deliveries, though the in-Charge is a midwife, as there is no delivery equipment, in spite of repeated requests to the LGA. She does not have an OPD register and uses an exercise book to record attendances. The health centre sends HMIS data monthly to the LGA, but data is not available at the health centre as she does not keep copies.

At the LGA headquarters, 30 km away, the issue of the solar panel, outreach, deliveries and the OPD were raised with the LGA PHC coordinator and his team, who make effusive promises that everything will be rectified by the next visit. As we leave we are told that he makes these promises every month, but nothing has ever been done to implement them.

**Table 4: Immunisation Comparison**

	Health Centre 1		Health Centre 2	
	RI visits <1 yr	RI visits 12-23 months	RI visits <1 yr	RI visits 12-23 months
June	134	0	1	7
July	138	18	1	0
August	115	0	3	3
Sept	117	18	0	0

#### **Health centre 2**

This PHC facility has 22 staff, of which only one, a young CHEW, is trained. The walls are plastered with immunisation posters saying (in English) that “parents who love their children will have them immunised”, a picture of children saying “Immunise us ... we want to live” and “Immunised children are healthy children”. An up-to-date EPI cumulative coverage graph on the wall shows 80% DPT1 and 70% coverage for DPT3 .... However closer investigation shows that all children (even over 5s and those done on NIDs) are recorded and not just the RI target of 210 children under one year. Closer inspection of the registers show that, in the past four months, a total of five under one and 10 12-23 month olds have been immunised ... not even one child per staff member in four months! The children that do come for RI (61 in 2008) are 3-7 years of age.

The OPD register shows that since 16<sup>th</sup> September, four weeks ago, not one patient has attended the clinic, as everyone is busy harvesting. From January to May there were no records of OPD and from March to June, there were no immunisations performed. There are no records of vaccines collected

Discussion with the in-Charge shows that people do not come for RI, but “like to be vaccinated when we go to their houses”. HMIS data is not collected and there are no forms, as “the LGA never asks us for it”

The LGA PHC coordinator, called from his house, at first insisted that the PHC facility was “doing very well”. When asked for data to prove this, he started shouting at his record officer and the rest of his team to produce the data. When they could not, he grudgingly accepted that there was no data for that or any other health facility and that the HMIS was not functioning. He claimed to have visited every health facility in the LGA in the year since he took office and that

this PHC facility “was a bad choice”. He promised to use an upcoming training session to make sure that data was properly collected and that by my next visit “everything would be in order”.

### **Conclusions and recommendations**

These two facilities, 30 km from each other, show starkly different RI coverage data based on the quality of the officer in charge. They need completely different approaches to improving the situation by LGA management, which in both cases was extremely weak. The role of the LEO is crucial in strengthening the LGAs to identify core problems, ensure adequate provision of RI equipment and supplies, data collection tools and to ensure that RI is appropriately strengthened throughout both LGAs with the active supportive supervision and in-service training.

### **g) Human Resource (HR) audit work**

PRRINN assisted Jigawa and Zamfara to do an HR audit in late 2008. In 2009, this work will be extended to Katsina and Yobe. One of the problems bedeviling PHC service delivery is the lack of skilled staff, the excessive numbers of unskilled staff and the maldistribution of staff. The audit created a baseline database of staff for the first time. Staffing norms were established that would allow managers to compare existing staff with the norms. Thus, health service managers could plan, allocate and distribute staff more rationally.

### **h) Community engagement**

Health Partnerships that will evolve into Village Health Committees of experienced and engaged “doers” constitute the core of the demand creation activities supported by PRRINN. This community engagement approach addresses:

- the widespread mistrust of the Government health system
- minimal awareness of routine immunization (RI)
- delayed seeking of RI services
- polio eradication fatigue and
- underutilisation of antenatal care (ANC).

Health Partnerships are composed of thirty community members who volunteer to partner with their health workers to increase RI and ANC utilisation by promoting demand and increasing access. State Health Educators lead a step-down training process that train and coach these volunteers to *facilitate health discussions with their peers*. Some volunteers assist health workers during RI sessions and others follow up when babies miss their RI visits. Volunteers in one third of the Health Partnerships carried out advocacy to the LGA PHC officials to ensure regular vaccine services. After about six months when early volunteer dropouts have left and the Health Partnerships are solidly established and recognized for their success in increasing RI/ANC utilisation, they will be supported to constitute a Village Health Committee.

PRRINN piloted 40 Health Partnerships linked to the main PHC facilities in 5 wards per LGA - located in two LGAs per partner state. Post-training implementation began in mid-July 2008 for Jigawa and Yobe and mid-August for Katsina and Zamfara.

### **Voice and Accountability through Health Partnerships**

Twelve out of forty Health Partnerships faced RI service barriers and successfully held their LGA officials to account. For example, the Bukarti Ward Health Partnership set up a four-person committee to advocate to the health facility to set specific dates for RI services and invited the PHC Coordinator to attend a community meeting. Government responded to their organised community voices; monthly RI sessions and monthly outreach sessions are now taking place. In Jigawa State one Health Partnership gained Government permission for a member to collect the vaccines from the state capital on his way back from work.

## Participatory Communication through Health Partnerships

Participatory communication activities empower the Health Partnerships and community members with awareness and social approval to adopt healthier behaviours. Health Partnerships have organised volunteer-led peer discussions with women in large compounds and in Islamia schools and with men in *majalissas* (daily meetings among male friends) and community-based organisations (CBOs). These group discussions provide community members with health information and the opportunity to reflect on the information together. Participants are encouraged to share the information with family and friends generating social approval and making it easier for spouses to discuss and arrange to take their infants to the health facility.



Community meeting in Katsina State

Easy to recall, no-cost “whole-body tools” and mimes empower community volunteers to promote RI and ANC even if they and/or their community audiences are non-literate. The whole-body tools use the positioning of parts of one’s own body to represent a key element of a message while calling out the message. Thus the *Benefits Poses*<sup>8</sup> communication tool enables volunteers and the participants in their peer discussions to remember the lifelong harms that are avoided by immunization. The *Vaccination*

*Hand* is a positioning of the fingers on ones own hand that links the vaccination schedule to memorable life events, thereby assisting everyone to recall the vaccination schedule.



The Vaccination Hand - 4 visits within 4 months; the measles vaccination visit at 9 months.

### Mother in Maska Ward, Katsina State describing the effects of peer-led health discussions

My house is an extended family house. We are more than 20 women. *Mallama* Mariam (a lead Community Volunteer) comes to our house and gathers us to have the discussions. She taught us the Vaccination Hand (the speaker demonstrated correctly). *Mallama* told us the importance of immunization that if our children are not immunized they could be deaf, blind or lame (the speaker correctly demonstrated using the whole-body tools). All the women in our house now bring their children to the health facility for immunization. Some of us are pregnant women and they visit for ANC. Now our husbands are ready to make us visit the health facility. *Mallama* Mariam has told me she will bring me to the health facility for my second immunization visit for my child coming Tuesday”.

8 To carry out the Benefits Poses, participants call out the lifelong harms that are avoided by immunization while illustrating them with their bodies: blindness (cover your eyes with your hands, deafness (cover your ears), etc. Other mimes include the *Vaccine Bodyguard Mime*, the *Measles Transmission Mime* and three *Polio Transmission Mimes*

**i) HMIS and Sentinel Sites**

During 2008, the emphasis was on establishing a sentinel site system that would allow both the programme to track progress but also allow state and LGA managers to monitor key indicators. A small set of indicators was developed and a sample of health facilities chosen as sentinel sites. Progress was more rapid in Jigawa where PATHS1 had been strengthening the routine HMIS for several years.

**3.2 State reports**

Each state report highlights the activities and achievements of 2008. The report does not claim to be exhaustive rather describes certain areas of work. Much of the state work has been described already in the preceding sections.

**a) Zamfara**

*Increasing vaccine storage capacity at LGA and facility level*

When PRRINN started no LGA could store enough vaccines to last for a minimum of a month. Now all LGAs have this capacity. Further, in the 147 wards in the state, the plan is to have one solar fridge in one facility per ward. To date 63 existing solar fridges have been repaired and a contract has been awarded for an additional 70 solar units (5 per LGA). All new fridges will be WHO approved brands. This will mean that shortly around 75% of the 147 wards will be covered. PRRINN has supported the training of an assistant Cold Chain Officer (CCO)



The Governor of Zamfara State being welcomed to the SCH

to install, manage and do minor repairs on cold chain equipment. In addition, 45 Officers in-charge (OICs) of PHC health facilities have been trained in routine maintenance. Having readily available vaccines at LGA and health facility level should impact positively on routine immunisation activities and coverage rates.

*Strengthening Planning*

A key PRRINN activity in 2008 was assisting all levels of government to develop policies and costed plans. Zamfara was no exception. For the first time ever, the State held a State Council of Health (SCH).<sup>9</sup> The event was opened by the Governor and attended by many LGA chairmen. The government provided N1.8million for the successful holding of this event. A committee was established to follow up on the resolutions adopted. Following the visit of the Permanent Secretary (PS) to an African immunisation meeting in Mauritius later in 2008, the PS has insisted that the Interagency Consultative Committee (IACC) should meet monthly and that the resolutions adopted at the SCH need to be implemented.

After the SCH the SMOH held a planning retreat in Katsina. All directors and above from the SMOH and the SHMB attended. The resolutions adopted at the SCH were converted into a costed plan. At this stage the team is awaiting the outcome from the budget defence. At LGA level, all 14 LGAs developed a 2009 plan.

<sup>9</sup> This is a mandatory annual activity

The planning workshop was co-ordinated by the DPRS from the MoLG and the planning and budgeting officers in the MoLG assisted the consultants at the workshop. These plans have been incorporated into MoLG plans for 2009.

#### *Partners Forum*

PRRINN introduced the Partners Forum which comprises WHO, UNICEF, ACCESS, EUPRIME, COMPASS and PRRINN. This group now meets regularly. This has led to far better co-ordinated activities and avoided clashes.

#### **b) Yobe**

##### *State PHC Board (SPHCB)*

Following a directive from the Governor, a seven person committee was formed to create a State PHC Board (SPHCB) in order **'to bring PHC under one roof'**. Following visits to Katsina and Jigawa to explore the SPHCDA and Gunduma approaches respectively, the committee drafted a proposal that was extensively discussed within the state. By the end of 2008, legislation was being drafted to realise the plan of a SPHCB. PRRINN provided technical support (including legislative technical assistance) to assist this process.



Meeting with an Emir

##### *Strengthening Planning*

As in the other states, support for the strengthening of planning capacity was a core component of PRRINN's work in 2008. In 2008 the state strategic plan (2008-2010) and the current 2008 operational plan were reviewed. Both of these had been developed with PRRINN's assistance in 2007. Following the review a 2009 costed state operational plan was developed. At LGA level, all 17 LGAs developed a costed operational plan for 2009. This followed the annual PPRHAA<sup>10</sup> exercise and utilised the information collected during the appraisal. At the same time, the PRRINN consultant team developed a LGA planning manual that will be finalised during 2009.

In terms of RI, the state and LGAs were assisted with micro-planning. Health staff and communities were assisted in this process. Although plans were developed the funds to support this were not released. However, in late 2008, the MoLG released N50,000 per LGA as a pilot. The MoLG requested monthly reports and on the basis of these reports would decide whether to continue funding.

##### *Deepening community engagement (CE)*

Utilising the PRRINN community engagement approach, two pilot LGAs (Karasuwa and Fune) were targeted. In one ward in Karasuwa the emerging partnership with the ward head ensured that N30,000 per

month (from ward funds) was given to strengthen RI. In addition, regular meetings between the community and health facility staff explored ways to support RI. In Fune a similar partnership led to regular meetings between staff and communities.

**c) Katsina**

The ambulance/mobile clinic service was launched in the first half of 2008 as a response to PPRHAA findings that services were not reaching all communities and that there was no transport for outreach services. Thirty-four



Men attending a community meeting



Launch of the mobile services

vehicles (one per LGA) were purchased and drugs supplied. The LGAs manage the service within their LGAs and have fixed routes. All the support for this initiative has come from the government and the SPHCA coordinates the programme. By October 2008, the ambulances were serving 856 remote villages on a regular basis, had seen 177,800 patients and handled 225,341 ANC visits. In addition, 898,886 immunisation doses had been given.

**d) Jigawa**

*Strengthening RI systems and services*

In Jigawa, 81 solar units were available, of which 29 were functional. PRRINN assisted in repairing a further 25 and has budgeted in 2009 for the remaining ones. As in the other states, microplanning was supported. Late in 2008 a multiyear immunisation strategy was developed based on the national and state strategic plan. This should assist in leveraging resources from GAVI. SIACC became more functional and focussed on strengthening RI services. Three hundred and thirty-three motorbikes (one per ward focal person) were purchased by state government, thus demonstrating their commitment. As in the other states the community engagement strategy was piloted in 2 LGAs.



Community dialogue at Makera Funtua LGA

*Increasing Budget commitment*

Besides the motorbikes mentioned above, the Governor in 2008 released N45 million for RI to the SMOH and LGAs increased their budgetary allocation. The state was assisted to undertake an analysis of the funding for IPDs and RI. In the 2009 budget there is a budget line for RI and also for PPRHAA/ISS. The state was assisted to account for the previous GAVI monies. This had been holding up subsequent releases from GAVI.



Women discussing RI

*Strengthening PHC systems*

As in the other states, the focus on planning has led to 2009 operational plans for both the state and the 9 Gundumas. A HR audit has been completed in Jigawa and HR norms are now available. A transport policy and guidelines have been developed and adopted. The ISS system was implemented. In support of the Gunduma system, further work on repositioning the SMOH has occurred. In terms of the HMIS, data review meetings now occur at Gunduma level.

## 4. Results, Impact, Challenges, Sustainability

### 4.1 Key results

#### a) Sentinel Site data

The sentinel site has been established in Jigawa where the data for the indicators has been collected using the DHIS. In the other states, the sentinel site system was still in the process of being established and as yet no data is available.

Analysis of the data in Jigawa has revealed that all the indicators show an increase as indicated in the table below.

**Table 5: sentinel site data Jigawa<sup>11</sup>**

	Jul-08	Aug-08	Sep-08	Oct-08	%increase
Number of children (under 1) immunisation visits at facility	2716	2820	3138	3495	28.7
Number of children (under 1) with RTHC	1425	1606	1528	1882	32.0
Attendance - children under 1 year	4568	4546	11436	12313	169.5
Antenatal total attendance - HF	10667	11216	11268	12467	16.8
Routine Immunization provided at facility	30	31	35	32	6.6
Does your facility provide all antigens weekly (Y/N)	14	18	23	24	71.4

What is interesting is that the biggest increase is in attendance figures for children under 1 (170%). However, the number of children coming with Road to Health Cards (RTHCs) has not increased as much; in

<sup>11</sup> 36 health facilities were included in the sentinel site monitoring system in Jigawa. The data was captured using the DHIS. By early December (the time of the visit), four months data from July was available.

October only 15% of the under 1 attendance came with a RTHC; and only 54% of the children under 1 attending specifically for immunisation came with a RTHC. Only 28% of the total child attendance (under 1) in December was for immunisation.

What this represents is both missed opportunities (for immunisation and issuing RTHCs) and because of the poor percentage coming with RTHCs, the possibility of under-recording immunisation coverage in surveys.

Most facilities in Jigawa provide routine immunisation and by December two thirds of these were providing immunisation on at least a weekly basis. Antenatal attendance showed a 17% increase over the four month period.

Because the DHIS data is aggregated data (i.e. the data is entered at facility level) performance at facility and at Gunduma level can be tracked.

**Table 6: Selected sentinel site data by Gunduma**

		Jul-08	Aug-08	Sep-08	Oct-08	% change (Jul-Oct)	% attendance with RTHC (Jul - Oct)
Number of children (under 1) with RTHC	Birnin Kudu	66	84	47	8	-87.9	13.2
	Birniwa	85	54	76	68	-20.0	19.0
	Dutse	410	400	241	452	10.2	32.8
	Gumel	204	306	167	457	124.0	28.8
	Hadeja	31	73	242	304	880.6	6.2
	Jahun	140	113	210	40	-71.4	26.0
	Kafin Hausa	17	18	51	81	376.5	12.9
	Kazaure	264	335	197	179	-32.2	23.3
	Ringim	208	223	297	293	40.9	30.4
Attendance - children under 1 year	Birnin Kudu	360	320	388	481	33.6	
	Birniwa	415	377	436	263	-36.6	
	Dutse	724	763	1185	1909	163.7	
	Gumel	357	138	709	2727	663.9	
	Hadeja	692	675	4539	4644	571.1	
	Jahun	534	565	621	211	-60.5	
	Kafin Hausa	223	248	378	446	100.0	
	Kazaure	641	728	2176	632	-1.4	
	Ringim	622	732	1004	1000	60.8	

What we see with this analysis are enormous differences between the different Gundumas. Because only four months data is available for analysis, caution needs to be exercised in reading too much into the data. However, trends do need to be monitored.

**b) PPRHAA data**

Analysis of the PPRHAA data for M&E purposes is presented in table 7.

**Table 7: PPRHAA comparison 2007 and 2008**

Indicator	Data									
	All		Jigawa		Katsina		Yobe		Zamfara	
	07	08	07	08	07	08	07	08	07	08
% of LGAs/Gundumas with operational plans (quarterly, six monthly or annual)	0	85	0	100	0	41	0	100	0	100
% of LGAs/Gundumas reaching performance ranking tool (PRT) scores over 75% (composite indicator)	7	18	0	11	18	41	0	18	0	0
% of tracer drugs available (PHC facility)	41	50	50	57	41	48	36	42	26	53
% of tracer medical supplies available (PHC facility)	47	58	58	69	48	57	42	47	42	58
% of tracer medical equipment available (PHC facility)	38	31	32	23	47	37	37	28	36	36
Average number of drugs per prescription	3.7	3.8	3.3	3.3	3.9	3.7	3.6	3.3	4.3	4.7
% of drugs prescribed generically	54	37	60	29 <sup>12</sup>	40	48	58	54	51	18
% of prescriptions with antibiotics	60	64	64	59	61	67	58	54	55	75
% of prescriptions with injections	51	47	35	28	63	56	45	42	67	63

Of the nine indicators from PPRHAA that data is available for in 2007 and 2008, the following can be stated:

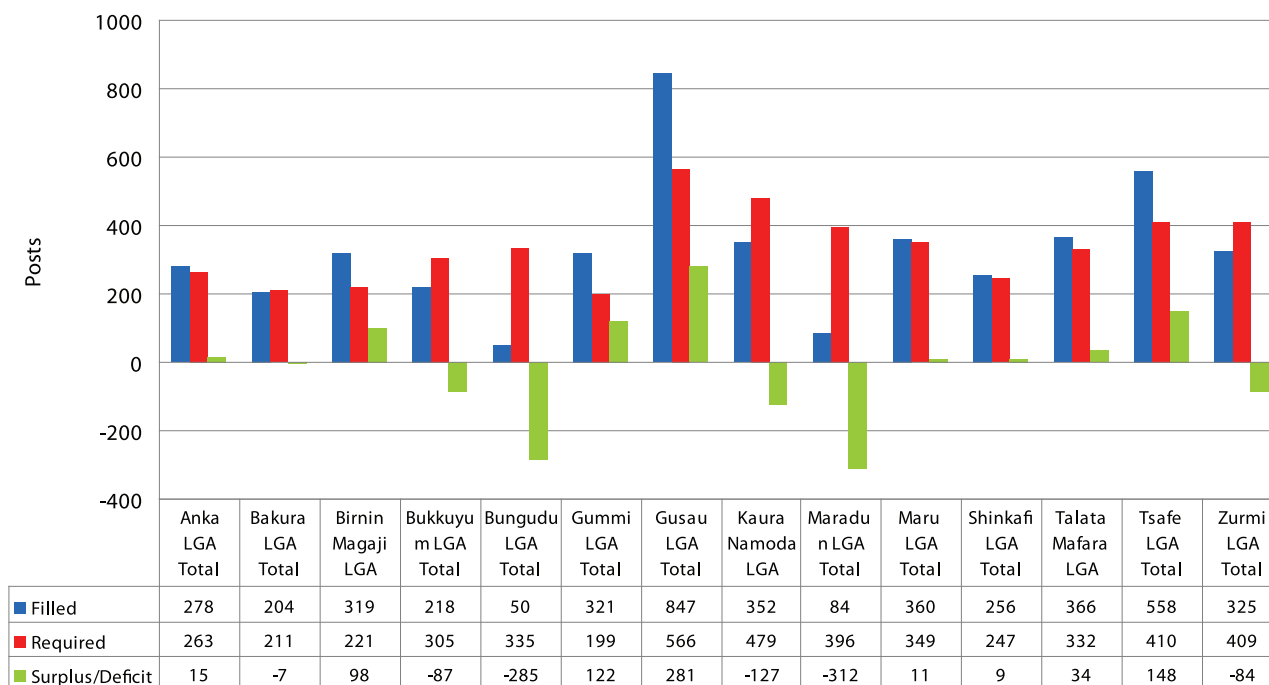
- The emphasis on planning at LGA/Gunduma level is reflected in the significant improvement in the indicator on availability of plans at LGA/Gunduma levels.
- There has been progress in terms of LGAs/Gundumas reaching PRT scores over 75%.
- Availability of drugs, supplies and equipment has not changed much. If anything, tracer equipment appears to be less available. This might be real or might reflect the collection method since the definition used is functional available equipment.
- In most states Rational Drug Use patterns have also not changed much over the year.

<sup>12</sup> In 2008, both Jigawa and Yobe data was the number of scripts that used generic drugs rather than the number of drugs that were prescribed generically – this has been a common problem throughout PPRHAA.

**c) HR Audit data**

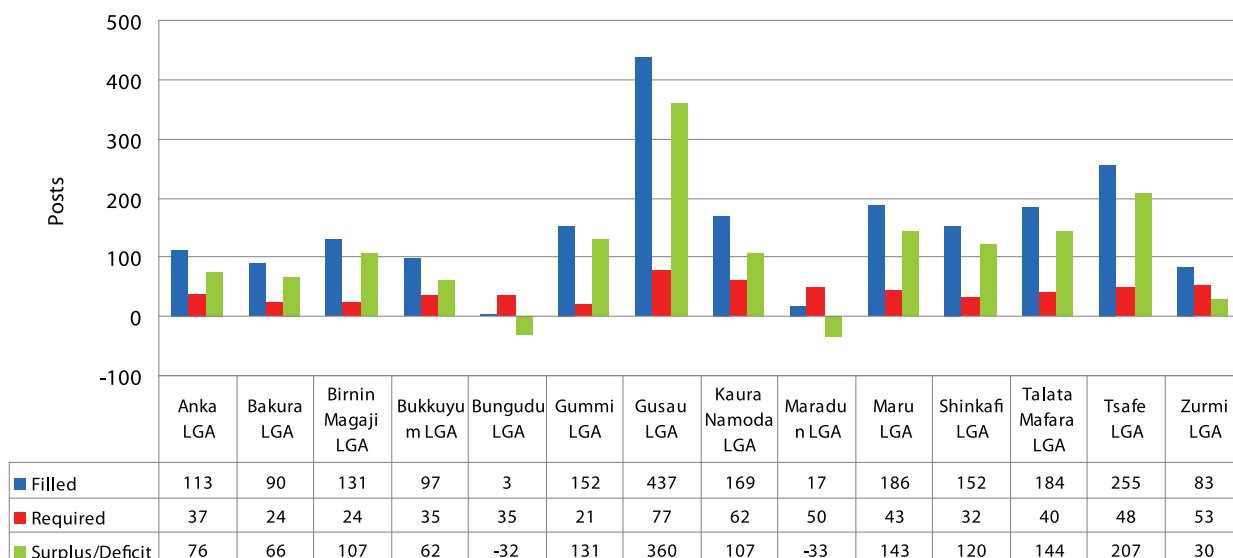
Examples of the HR data collected in the audit are illustrated in the graphs and text below. These focus on Jigawa and Zamfara states.

**Graph 5: Zamfara State LGA PHC Staffing Overview**



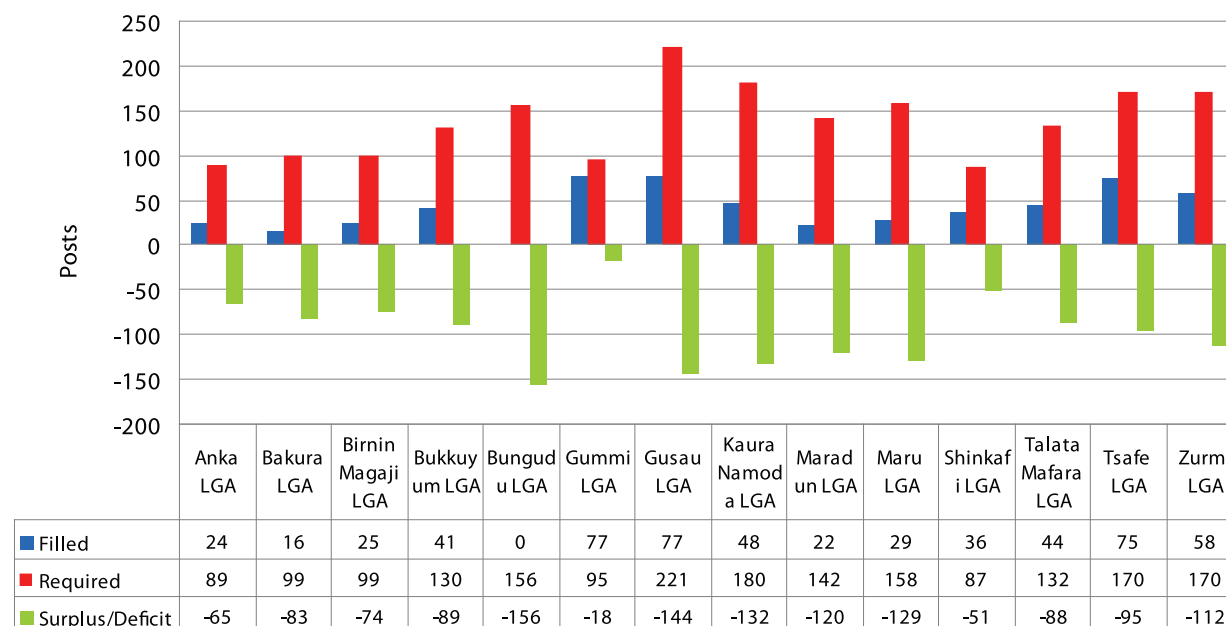
This illustrates the wide differences in staffing at PHC level – in terms of total staff, some LGAs have too many staff while others have too few.

**Graph 7: Zamfara PHC Non-clinical Support Workers by LGA e.g. Health Assistants, Health Attendants etc.**



However, when the data is broken down by type of staff a different picture emerges.

**GRAPH 8: ZAMFARA PHC JCHEW BY LGA**



Generally there is a surplus of unskilled health workers, while more skilled workers are in short supply. To back this up, other data from the HR audit showed that Zamfara had 6 nurse midwives at PHC level while Jigawa had none.

**Table 8: Comparison of skilled clinical workers**

Zamfara			
Category	Actual No.	Target	Difference
JCHEW	572	1928	-1356
SCHEW	430	480	-50
CHO	64	30	34
Nurse midwife	6	510	-504
Nursing sister	65	0	65
Corper doctor	21	0	21
Medical officer	23	0	23
Jigawa			
JCHEW	1264	2855	-1591
SCHEW	334	293	41
CHO	82	20	62
Nurse midwife	0	49	-49
Nursing sister	47	0	47
Corper doctor	1	0	1

The figures in table 8 highlight the general deficit of skilled PHC workers. What is also interesting is that the two states have opted for different norms and also have classified their PHC facilities differently. Zamfara has more PHC clinics and wants a nurse midwife in each clinic, while Jigawa has opted for more health posts and only nurse midwives in certain PHC facilities. This indicates the absence of Nigerian norms for deciding types of facilities, the services provided therein and thus staffing. PRRINN-MNCH will be supporting work on development of a Minimum Service Package (MSP) in 2009 which will explore these issues.

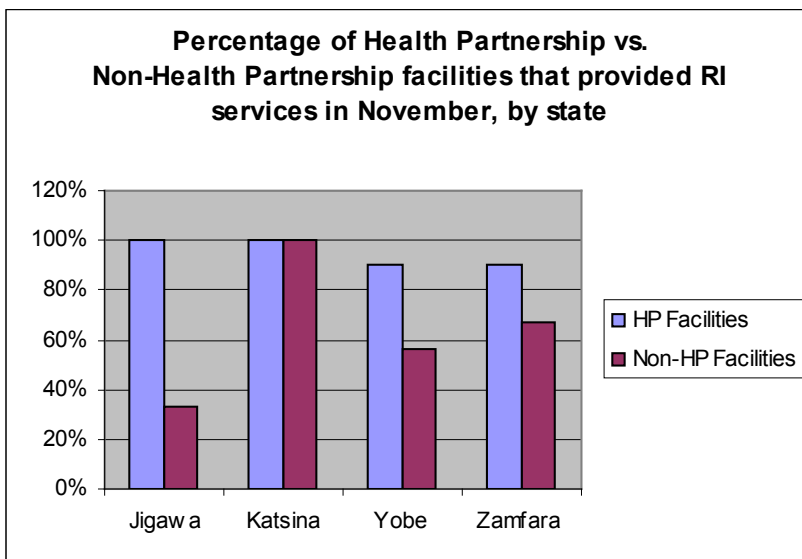


Women meeting in Yobe

**d) Health Partnerships**

Flexible implementation during the pilot period resulted in the development of community engagement approaches that appear to be effective and locally appropriate in the different intervention sites. Not only have hundreds of implementers acquired new skills and the thousands of community members acquired new knowledge, they have also created new approaches across the four states. In Jigawa State an approach based on Health Partnerships (partnership between community members and health providers) utilised *majalisas* (men’s informal meeting groups) as discussion groups; in Katsina State the Makera Village Head promoted Islamia School teachers as community volunteers.

PRRINN has initiated a facility coverage monitoring form that provides a rapid glimpse of coverage progress and problems. An excel spreadsheet utilises the under-1 data in the *Health Facility RI Monthly (Summary)* and the catchment population to calculate the percentage of doses to be administered per month to attain fully immunized children (FIC). In the eight pilot LGAs, data was collected from all the Health Partnership facilities and from the main facility in each ward without a Health Partnership.



**Table 9: Differences in RI services available**

With the exception of the Katsina State facilities, Health Partnership facilities provided significantly more access to RI services than Non Health Partnership facilities (See Table 9). In the pilot LGAs, only 5% of the wards with Health Partnership facilities failed to provide immunization services versus more than one quarter of the wards without Health Partnerships. Taking administration of the required doses to achieve FIC as the benchmark for this short pilot

period, almost one third of the Health Partnership facilities delivered at least 60% of the doses required to attain FIC (See Table 10).

**Table 10: Number of Health Partnership facilities delivering 30-60% and more than 60% of their RI target doses by state (N = 40)<sup>13</sup>**

State	30-60%	Over 60%
Jigawa	5	4
Katsina	3	4
Yobe	5	2
Zamfara	4	2
Total	17	12

## 4.2 Challenges

- **Governance:** The management of the PHC system is characterised by fragmentation and corresponding splits in responsibilities and accountability. Resolution of these governance issues will aid delivery of services at PHC level.
- **Systems:** PHC delivery systems have been neglected for some time and reconstruction of these systems is not an easy or quick task.
- **SIAs and RI:** The enormous resources and efforts that are going into SIAs (particularly the eradication of polio) have had a detrimental effect on efforts to strengthen RI and PHC services.
- **Community Engagement:** Transfer of implementation responsibility to the LGAs, adequate technical support to the community volunteers, and the often expressed desire for incentives remain significant challenges.

## 4.3 Lessons Learned

- **Political will:** There is political will to strengthen PHC and RI services as illustrated through the continuing Gunduma work in Jigawa, the SPHCA in Katsina and the emerging work in Yobe and Zamfara. But, politicians need support all the way and the creation of new systems needs to demonstrate effect for the political will to be sustained.
- **Planning and budgeting:** The importance of strengthening the planning and budgeting systems is being realised through an increased focus on achievable results, the use of plans to leverage resources (e.g. from GAVI) and the ability of workers at LGA and PHC facility levels to describe and monitor the work they are doing.
- **HMIS:** High quality data is difficult to get except in Jigawa (following several years of PATHS support). Yet as shown through the sentinel site system, the HR audit and PPRHAA data is necessary for advocacy purposes, to plan and to track progress.
- **Community Engagement:** Health Partnerships have demonstrated their capacity to generate widespread demand and raise community voices to obtain regular vaccine services if necessary. However, the RI demand generated by the Health Partnerships remains fragile. The Health Partnerships have been most successful around facilities benefiting from a committed Ward Focal Person, a committed Officer in-Charge and/or a committed traditional leader. Regular incentives for volunteers will be difficult to manage and sustain.

<sup>13</sup> Total of 40 facilities

#### 4.4 Way forward

- **Combined PRRINN-MNCH programme:** The additionality of the MNCH programme has allowed the team to focus on the key governance issues, to broaden their ability to address PHC systems issues and through the OR component pilot and then rollout effective interventions. This combination should allow the team to address the deep structural and institutional issues that face PHC services.
- **Community Engagement:** Mass media promotion of RI should commence to reinforce and generate knowledge and demand for RI while utilising reality radio to help communities learn how they can both promote demand and where necessary advocate for supply. Non-monetary forms of recognition need to be tested along with better volunteer identification processes and better local utilisation of the coverage monitoring data to help volunteers recognize their achievements and their challenges.

