

PRRINN-MNCH Annual Review Executive Summary

Narrative Report

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1. Key Findings of the Review

This review is a DFID annual review of two projects that have been combined: the DFID-funded Programme for Reviving Routine Immunisation in Northern Nigeria (PRRINN) project (begun in 2006) and the Norwegian-funded Maternal, Neonatal, and Child Health (MNCH) project (begun in 2008). The four programme states in Northern Nigeria have a combined population of approximately 16 million—comparable to the populations of Sierra Leone and Zambia combined. The states were chosen for their exceedingly low health indicators (some of the highest maternal and infant mortality rates in the world) and the challenging environments (both physical and institutional). Still, the programme is making good progress against its outputs, even in this challenging environment.

This is an innovative programme as it combines health systems strengthening with maternal, neonatal, and child health interventions. This programme therefore combines a horizontal and vertical approach simultaneously—and could bring the best of both with proper attention given to strengthening the health system as well as extra attention to approaches demanded by a vertical programme. This is an approach that has not often been used before and may yield good results when outcomes can be measured some years in the future, especially in reducing maternal and child mortality. This programme is one to watch.

The project has made good progress in working with government at both state and federal levels, and in defining both human resource needs and the Minimum Service Package. Operations research has progressed and the stage is set with committees, research questions, protocols and some common OR tools. The HMIS component is showing signs of beginning to build a data culture in the states and the community engagement is showing good progress. The project's maternal health 'clusters' pull together groups of health facilities meant to respond to maternal health emergencies at

the primary, secondary and tertiary levels. All service delivery work in each state will proceed in this cluster format.

The partnerships with stakeholders are strong on all levels and the team was clear that the PRRINN-MNCH team was improving the relationships between the government and the many UN and other donor players. A few partners said that they had never before seen such a good collaborator as PRRINN-MNCH. In addition, PRRINN (begun in 2006) and MNCH (begun in 2008) are truly integrated this year and MNCH is building on what PRRINN has learned. Finally, states are at varying levels of implementation and there is more scope for cross-state learning.

The programme's particular successes this year were:

- The basket fund in Zamfara state demonstrating that funds can be transparently managed there.
- The appreciation expressed by the state governments of Zamfara and Jigawa for capacity building elements of the project, demonstrating their willingness to participate in the process of transparent government.
- Human resource audits with fulltime HR units established within each SMOH, demonstrating real progress in HR planning in all states.
- Costing of the Minimum Service Package (MSP) in each state.
- Posting of 96 midwives per state through the Midwife Service Scheme (MSS).
- Increasing demand for routine immunisation (RI) and a programme survey indicates a doubling of routine immunisation rates for the four states (albeit from a very low base).

An implementer of a USAID-funded health project said rather wistfully that they wished that their project had a governance component—something that is built into the PRRINN-MNCH project already. This governance component allows the project to deal with the political realities and take the time to build government capacity. While it must be remembered that this project is primarily a health project and not a governance one, the integration of health and governance is looking like a more promising prospect for a lasting impact. Pressing for accountability and better performance from Government will continue to be priority. In Jigawa, the project can continue to work with Paths2 and SPARC.

The biggest problems remain:

- Tracking the release and expenditure performance of budgets at every level (federal to state to LGA);
- An overly complex health architecture across Nigeria; and
- A lack of trained health personnel, particularly midwives.

This programme remains High Risk as governance and institutional issues persist. While some indication of real government commitment to the programme is becoming apparent in some states, it cannot be guaranteed that this will continue. The team saw

some improvements in commitment also at the federal level as well but it is too soon to say whether these will endure.

2. Scoring Assessment

The scoring assessment is complicated by the fact that two programmes – PRRINN and MNCH have been interwoven into one logframe with seven outputs. These programmes were launched at different times so the work of the PRRINN programme is more advanced. Results of the PRRINN Annual Review are presented in Annex 1.

- (i) For the PRRINN outputs the scoring is as follows, with last year's scores in brackets:
 - Output 1 – Effective harmonisation and alignment of all agencies' support for routine immunisation at State and LGA levels: *Score – 1 (2 in 2009)*
 - Output 2 – Improved capacity at State and LGA levels for strategic analysis, policy development, planning and budgeting of routine immunisation: *Score – 2 (2 in 2009)*
 - Output 3 – Primary health care systems strengthened to support routine immunisation: *Score – 2 (3 in 2009)*
 - Output 4 – Increased demand for routine immunisation: *Score – 1 (2 in 2009)*
 - Output 5 – Improved capacity of Federal level to enable States' routine immunisation activities: *Score – 2 (3 in 2009).*

- (ii) Overall Outputs Score for PRRINN remains '2'.

- (iii) For the PRRINN-MNCH outputs, the scoring is as follows:
 - Output 1 – Strengthened state and LGA governance of PHC systems geared to RI and MNCH: *Score – 2 (no scoring in 2009)*
 - Output 2 – Improved human resource policies and practices for PHC: *Score – 2 (no scoring in 2009)*
 - Output 3 – Improved delivery of MNCH services (including RI) via the PHC system: *Score – 3 (no scoring in 2009)*
 - Output 4 – Operations research providing evidence for PHC stewardship, RI and MNCH policy and planning, service delivery, and effective demand creation: *Score – 2 (noscore in 2009)*
 - Output 5 – Improved information generation with knowledge being used in policy and practice: *Score 2 – (no scoring in 2009).*
 - Output 6 – Increased demand for MNCH (including RI) services: *Score 2 – (no scoring in 2009)*
 - Output 7 – Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities: *Score 2 – (no scoring in 2009)*

- (iv) Overall Outputs Score is '2'.

- (v) Almost all PRRINN scores advanced by one mark as good progress has been made, especially in harmonisation and demand creation. PRRINN-MNCH scored

lower as many outputs that are progressing well have not yet accomplished their objectives. Output 3 scored 3 again as service delivery is not yet fully functioning.

3. Risk Assessment

- (i) The risks originally identified and discussed in the 2009 Annual Review are still valid. The successful management of mitigation strategies is helping to reduce risks. See Annex 10 for an assessment of the risks.
- (ii) Overall rating of PRRINN-MNCH remains: High Risk.

4. Summary of Recommendations

General

For the programme

G.1. Continue stellar work with partners (UN and other health development projects as well as government stakeholders; the review team did not speak with local partners).

G.2. Increase collaboration with Paths2 (both in Jigawa and beyond)

- o Clarify workplans and responsibilities, especially at federal level
- o Serve on each others' review teams.

G.3 As procurement is slowing progress, the process should be examined more closely to see if there can't be improvements made by both Crown Agents and the PRRINN-MNCH programme.

For DFID

G. 4. A project complication is that the PRRINN funding will end before the MNCH funding does. This complicates matters as the projects cross-subsidise each other—particularly with the staffing. Extend DFID PRRINN funding for a sixth year, if possible, to coincide with the end of the MNCH funding as this would allow the project to consolidate all progress and complete its full range of activities by project's end.

G.5. DFID must continue to work with other donors by influencing them. DFID can use information fed from PRRINN-MNCH on potential opportunities, objectives and desired outcomes.

Output 1: State Governance: Strengthened state and LGA governance of PHC systems geared to RI and MNCH

For the programme

- 1.1 Maintain the momentum to gain the state political will, as in Zamfara.
- 1.2 Maintain emphasis on simplifying architecture for the health system (keep an eye on the drugs as an indicator of a functioning system).

- 1.3 Look at the political opportunities to ensure that budget and planning is transparent at all levels. (Follow the resources to ensure they are reaching the LGA level.) The programme needs to continue to provoke debate and encourage realistic health allocations that are implemented effectively.
- 1.4 Consider using the Zamfara basket fund approach in Yobe and Katsina as a temporary mechanism to demonstrate that funds can flow transparently.
- 1.5 The state governments need to be thinking for themselves and talking about change—PRRINN-MNCH should be aiding in this dialogue and eventually easing themselves out.
- 1.6 In Zamfara, with good performance, consider additional funds to build capacity in the area of budget, planning and implementation monitoring; also in expenditure tracking.
- 1.7 In Jigawa, the programme should continue to work closely with Paths2 and SPARC to feed RI into wider state planning and budgeting processes.
- 1.8 All state programmes should raise concerns, opportunities and options for DFID to advocate to the State Government to support the development. Use DFID as a tool.

For DFID

- 1.9 DFID should be supporting the momentum to gain the state political will and signing MOUs with states directly (especially in Yobe).

For the Government

- 1.10 As above, the state governments need to be thinking for themselves and talking about change
- 1.11 Maintain emphasis on simplifying architecture of the health system
- 1.12 Look at the political opportunities to ensure that budget and planning is transparent at all levels. (Follow the resources to ensure they are reaching the LGA level.)

Output 2: Human Resources: Improved human resource policies and practices for PHC

For the programme

- 2.1 Re-orienting managers to better post matching, qualification and performance based HR systems will be difficult, as well as maintaining an accurate HRIS, but it should remain a PRRINN-MNCH priority.
- 2.2 It would be a very positive step to publish HR data and periodic reports among the agencies and donors, disaggregated by gender to facilitate awareness of shortages, equity, and deployment issues.
- 2.3 PRRINN-MNCH may want to also look at innovative models for addressing chronic shortage of CHEWs and midwives:
 - o Explore alternative models for deploying and supporting CHEWS
 - Rotating female CHEWS for outreach services (Yobe)
 - Mobile services (Katsina)
 - CHEWS posted to hard-to-reach areas (Jigawa, Zamfara)

- o Integrate village health volunteers (TBAs, CBDs, etc), CHEWS and midwives to support MNCH services
 - o Extend support around incentives to keep staff in place
 - o Support PHC management training for health personnel within the training institutions and as part of supportive supervision and in-service training.
- 2.4 There is an opportunity to think outside the box and address equity/social inclusion of women and girls within the context of the more socially acceptable need for health services such as:
- o Determine reasons why so few women graduate from midwifery school and remedy; also look at CHEW curriculum.
 - o A health care worker 'feeder programme' focused on getting girls from primary through secondary using a basic life skills/health care track; or
 - o Increasing the acceptability of male CHEWs.

Output 3: Service Delivery: Improved delivery of MNCH services (including RI) via the primary health care system

For the programme

- 3.1 Coordinate timelines for MNCH to offer the full package with all M, N, and CH elements
- 3.2 Promote complete delivery of the MH package
 - o Accelerate work in family planning and communicate this to state teams
 - o Ensure that family planning is included in the Minimum Service Package (MSP) as well as that contraceptives are on all state Essential Drug Lists (EDL) and coordinating with MCHIP.
- 3.3 Harmonise MNCH services with RI as quickly as possible so that they are both available in all facilities
 - o Concentrate on the CEOC clusters in each state and coordinate timelines for MNCH to offer the full package.
 - o Ensure that the MSP can be delivered, particularly at the primary level—and move to integrated services as quickly as possible.
 - o Cooperating with WHO on IPDs is worth the good relationship (but phase out as soon as is politic).
- 3.4 Facilitate Sustainable Drug Supply Systems (SDSS) in each state as soon as possible as the current Drug Revolving Funds (DRFs) are being decapitalised.
- 3.5 Support the states to monitor and support the facilities within the CEOC clusters.

Output 4: Operations Research: Operational research providing evidence for PHC stewardship, RI and MNCH policy and planning, service delivery, and effective demand creation

For the programme

- 4.1 Build state capacity and ensure a variety of research questions across the four states, but also seek and support studies that allow comparison and learning across states.

- 4.2 OR agenda in each state tests alternative service delivery models. Need to work closely with Outputs 3 and 6 to insure coordination of initiatives and learning across outputs.
- 4.3 Promotion of cross-state learning and OR “division of labour” can help all states launch studies, accelerate learning within and between states and allow cost-sharing for OR costs
 - o OR training workshops with all states to develop common methodologies where possible
 - o Quarterly cross-state OR meetings
- 4.4. Need to integrate PBF into the OR protocols
 - o Demonstrate if Free MNCH is possible in Jigawa
 - o Zamfara experimenting with women’s savings groups as form of PBF
- 4.5 OR outcomes measured include the logframe indicators, but many other intermediate outcomes needed to facilitate learning about what works.
- 4.6 Continue to ensure that the whole programme staff maintains a good understanding of the operations research component of the programme.

Output 5: HMIS/Information: Improved information generation with knowledge being used in policy and practice

For the programme

- 5.1 Update and streamline national HMIS forms with state and national stakeholders
 - o Need to cover MNCH services more completely (e.g. add FP, c-sections, more details on M,N, C services)
 - o Ensure all partners can use and feed into the same system
 - o Include way for register to be used to develop facility or community reports.
- 5.2 Analyse data at all levels and use it to genuinely inform decisions.
- 5.3 HMS 001 forms need to be in place and training given in their use, especially at facility level.
- 5.4 Use data to ensure that communities can eventually understand that conditions are improving (or worsening) in their areas (important for V&A)
- 5.5 Explore greater use of visual material for HMIS staff to both support them and the importance of their work and to remind them of their responsibilities.
- 5.6 Learn from other states: Feature best practice.
- 5.7 The programme needs to think through its strategy for the use of success stories and more visual information, including (perhaps) a website.

For the Government

- 5.8 MLG must provide more and adequate personnel to do the data management job at all levels.

Output 6: Demand Generation: Increased demand for MNCH (including RI) services

For the programme

- 6.1 The team strongly recommends jointly developed demand generation, V&A, and any equity and social inclusion workplans across participating donor/agencies with clear roles and deliverables. V&A has a yet untapped potential to drive political change.
- 6.2 With demand generation and community engagement ahead of the supply of primary care, it is important to be careful to keep this work balanced in a stepped fashion.
- 6.3 The project may want to increase support of existing village/ward development committees as critical elements in creating demand and supply of services.
- 6.4 The demand generation should begin to supplement general awareness messaging with messaging around access – what services, where, and when.
- 6.5 Need for community health volunteers to be more mobile and recognized for contributions.
- 6.6 Include family planning. Child spacing and family planning conversations are going on within the communities. The FMOH/Reproductive Health Unit, project staff and health workers seem to think demand is there and communities are receptive. Begin to work on some family planning tools and messages.
- 6.7 There is a real V&A opportunity to focus on engaging State Ministry of Health and Ministry of Local Government on resource allocation and utilization and performance of health care delivery system using strong professional groups such as the Nigerian Medical Association and HERFON.

For DFID

- 6.8 Ensure demand creation coherence across Nigerian programmes

Output 7: Federal Governance: Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities

For the programme

- 7.1 PRRINN-MNCH must continue its strategic approach at federal level and continue to work with other key players.
- 7.2 Assist the FMOH and the FPHCDA to continue to clarify their roles.
- 7.3 The PRRINN-MNCH programme can help NPHCDA by demonstrating that it is at the state level where the most difference will be made.
- 7.4 Look at incentives to obtain more and retain midwives.
- 7.5 Continue to look at solutions for the lack of midwives at the federal level. Are midwife standards too high? What are the intermediate cadre options?

For the Government

- 7.6 As above, the FMOH and the FPHCDA must continue to clarify their roles to avoid overlap and ensure coherent coordination.
- 7.7 The federal government must act decisively in considering alternative solutions to the shortage of midwives in the north.