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

PRRINN-MNCH Baseline Studies 2009

Summary Report

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Contents

Introduction

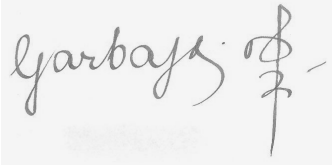
The PRRINN-MNCH programme is working to strengthen maternal, newborn and child health services within Katsina, Yobe, Zamfara and Jigawa states. All four states experience higher than average rates of maternal and child mortality, and high rates of poverty. In 2007 the DfID-funded PRRINN programme was set up to strengthen routine immunisation in these areas. This was joined in 2008 by the complementary Norway-funded MNCH programme which aims to improve maternal, newborn and child health. The jointly-implemented programmes work to facilitate the states in delivering their own health reform agendas in support of the revitalisation of primary health care (PHC) services, with a special focus on improving MNCH outcomes.

PRRINN-MNCH activities are designed and implemented in close collaboration with local communities, state and federal stakeholders. The programme is structured around the following key themes or outputs:

1. Strengthened State and Local Government Authority (LGA) governance of PHC systems geared to MNCH;
2. Improved human resource policies and practices for PHC;
3. Improved delivery of MNCH services via the PHC system;
4. Operational research providing evidence for PHC stewardship, MNCH policy and planning, service delivery, and effective demand;
5. Improved information generation with knowledge being used in policy and practice;
6. Increased demand for MNCH services;
7. Improved capacity of Federal Ministry level to enable States' routine immunization activities.

In early 2009 PRRINN-MNCH carried out a variety of baseline studies relating to these outputs, which provide crucial data about the current status of MNCH services, the major challenges and the opportunities to bring about change. This report contains summaries of the key findings of these studies, along with recommendations. These findings serve as reference points against which the success of the programme will be gauged over time in its efforts to improve the quality and availability of maternal, newborn and child health services in Northern Nigeria.

In June 2009 the PRRINN-MNCH programme held a 2-day baseline studies review meeting in Kano. Overviews were presented on several themes relating to the current status of maternal, newborn and child health in the four states, which then formed the basis for discussions of strategies and plans to address the key issues identified. We were delighted to welcome to this meeting a variety of stakeholders from Katsina, Yobe, Zamfara and Jigawa, who contributed to the many productive discussions with the programme's technical advisors and other experts in the field of maternal, newborn and child health. The strong turn-out demonstrated the depth of commitment to improving maternal and child health within these states, and the meetings proved an inspirational and informative experience for attendees.



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Governance Baseline Studies Summary – Overview

Introduction

Each state has had three baseline governance assessments – policy and strategy assessment, public finance management assessment, and a political economy assessment. The state-specific summaries that follow outline the findings of the assessments as they relate to the eight key 'governance' issues:

- Free MNCH services
- Bringing PHC under one roof
- Strengthening budget and planning cycle
- Public finance management
- Routine immunisation strengthening
- Eminent Persons Group
- Midwifery service scheme and other HR issues
- Memorandum of understanding

A number of general points applicable across the states need to be highlighted:

- Structural changes often do not address the underlying problems. If tackled, structural changes need to be focussed on improving service delivery rather than on creating further fragmentation and thus additional problems.
- For all activities/initiatives clear targets/steps need to be established (and, if possible, communicated in such vehicles as an MOU) and progress needs to be reviewed against these targets/steps and appropriate remedial action taken.
- Within the Nigerian health sector there has been substantial policy development in recent years (especially at Federal level). However, the policies have not always been translated into implementable activities. This needs to be factored into plans at state and LGA levels and the reasons for the lack of implementation understood.
- Currently, budget reform processes are difficult but some opportunities exist and should be supported.
- It is important to consider how the profile of health is raised prior to the 2011 elections.

Findings and Recommendations

Free MNCH services

In all three states this is seen as a high priority. Following the Governors Forum declaration on free MNCH services, PRRINN-MNCH should move swiftly to support this area of work. Free MNCH services need to be linked to the development of a Minimum Service Package approach. In each state this will require substantial work on developing appropriate staffing, equipment, drug supplies at each level of care. This must be linked to the work in outputs 2 (Human Resources) and 3 (MNCH service delivery). The MSP will need to be costed and then options can be presented and discussed at state level. Terms of reference have been approved for this work and work will be initiated in Zamfara in June. The other two states should follow shortly thereafter.

Bringing PHC under one roof

This is also seen as a high priority but with a different focus in Katsina. This work is partly driven by the proposed Health Bill which requires the formation of a SPHC Agency/Board through which the PHC Fund will be administered. Work has already progressed a substantial way in Yobe and has started in Zamfara. Concern was expressed on two key issues: the need to protect the Bill's passage through the state legislative process to guard against last minute

changes; and the work that is required to reposition the Ministries (especially the SMOH) in the light of the changes proposed in the Bill. As with the free MNCH work, the work is budgeted for. In terms of Katsina where the SPHCDA already exists, the focus is on reviewing progress made and supporting strengthening initiatives to bring PHC under one roof. This will require delicate diplomatic and advocacy skills.

Midwifery service scheme and other HR issues

It is seen as important for PRRINN-MNCH to support the implementation of the midwifery service scheme. Support needs to be provided at both Federal and state levels. At state level, although problems were identified with ghost workers and the maldistribution of staff, the baseline studies clearly identified that these were issues that PRRINN-MNCH should avoid. A key issue was the need to employ unemployed skilled health workers (particularly SBAs) but this would be hampered by the 'blocking' of posts by the excess unskilled workers. This particular problem would need creative thinking to address and the use of the HR audits for advocacy purposes might help. Much of this work will occur under output 2 (Human Resources), although a ToR needs to be developed to support the midwifery service scheme work.

Public Finance Management

This is another priority area for PRRINN-MNCH to support. The ongoing work on strengthening the planning and budgeting cycle at state and LGA levels should continue. Other key areas include strengthening key MDAs (e.g. SMoH and SHMB) to budget programmatically – where possible using a modified chart of accounts; introducing basic bookkeeping at all levels; working with the SMoLG to develop a budget framework for LGAs; initiating tracking release of funds; and ensuring that the quarterly review process includes plans, budget and expenditure. More specific ToRs need to be drawn up and the budget allocation needs to be reviewed.

Eminent Persons' Group

This issue should proceed slowly and with caution. It would be best to keep this as an informal group. It was proposed that Drs Sule and Garba do some further thinking on the purpose and role of this group in each state and circulate their thoughts for discussion.

Routine Immunisation strengthening

The work in this area should continue. Key issues include ensuring that states acquire, utilise effectively and retire GAVI funds; tracking the release of budgeted monies; and comparing money spent on RI and SIAs. It is also important to document outputs (e.g. coverage) so as to inform policy makers how the money has been utilised.

Memorandum of Understanding

This is seen as a tricky but necessary task. Other DfID programmes are exploring the use of a change matrix. This will be a more specific form of the MOU (to be signed between DfID and the state government) for use between the programme and the relevant MDA at state level. It is important to craft win-win situations at least initially. Although the MOU work is in the 2009 plan, there is no budget for this. Thus a ToR needs to be developed and budget sourced for the work. Suggestions for what to include in the MOU need to be cross output.

Governance Baseline Studies Summary – Katsina

Introduction

Each state has had three baseline governance assessments – policy and strategy assessment, public finance management assessment and a political economy assessment. The summary below outlines the findings of the assessments in Katsina as they relate to the eight key 'governance' issues:

- Free MNCH services
- Bringing PHC under one roof
- Strengthening budget and planning cycle
- Public finance management[1]
- Routine immunisation strengthening
- Eminent Persons Group
- Midwifery service scheme and other HR issues
- Memorandum of understanding

Findings and Recommendations

Free MNCH services

Free MNCH is seen to be feasible and politically attractive if there is further work on the scope, affordability and practical details of implementation. As with the other states there have been several political announcements re free MNCH services (e.g. Northern Governor's Forum, 2003 EXCO decision, 2006 Economic Summit decision). Issues to be considered include:

- As the provision of Free MNCH has not been fully costed or planned and budgeted (although some work has been done on this (e.g. for drugs)), assistance to define options and the longer term implications of Free MNCH services would be crucial.
- Support for more institutionalised drugs procurement (SDSS) could also be valuable.
- Free MNCH is an excellent issue for strengthening a coalition amongst interest groups – e.g. SHA, Special Adviser's Office on Girls' Education and Child Development, MWA, Wife of the Governor.

Due to the current economic climate the whole package would be unlikely, thus the focus on phased options is likely to be more attractive.

Bringing PHC under one roof

Katsina already has an SPHCDA. However, PHC services still remain fragmented with different aspects of management at state and LGA levels. Thus, the focus in Katsina should be on reviewing the current relationships with a view to making recommendations on how matters can be improved.

Public finance management

While there has been some progress in linking planning and budgeting, the baseline assessments suggested that a high priority in the state is for the SMOH to link up with SMOLG and Ministry of Budget and Planning to link plans and budgets and ensure timely release. An issue highlighted was the absence of an overall state planning process despite there being a costed health strategic plan. Other issues to consider include:

- Support for co-ordinated state operational health sector planning, linking the plan to the budget and increasing releases, should continue.

[1] Note that while the two issues (strengthening planning and budgeting cycle and public finance management) were discussed separately in the meeting they will be combined in the report

- Emphasis should shift to tracking LGA cash releases against budget (as release of LGA funds is often based on state directives rather than budgets).
- Inadequate staffing of the Directorate of Planning, Research and Statistics in SMOH has resulted in serious capacity constraints across the Ministry.
- Support is needed to introduce a modified chart of accounts to do programme budgeting in the SMOH.
- Basic financial management skills and systems should be strengthened at State Level, LGAs, and in facilities.

Routine immunisation strengthening

Progress has been made on strengthening RI systems:

- Funding for the recurrent costs of RI has improved significantly.
- State directive for monthly LGA funding of immunisation running expenses.
- Mobile clinics also offer immunisation.
- Strategic health plan encourages increasing emphasis on providing routine immunisation.
- Establishment of an Immunisation Task Force by the Governor.

These efforts need to continue with a particular emphasis on institutionalising the release of resources for RI.

Eminent persons group

As with the other states, informal methods of communication with interested citizens should be pursued.

Midwifery service scheme and other HR issues

There is a well established need to increase the number of skilled health workers (particularly SBAs). This should be supported through assisting the state with the rollout of the midwifery service scheme, strengthening the training colleges and employing unemployed health professionals. Issues re the maldistribution of skilled health workers (e.g. SBAs) are significant and ways of addressing this maldistribution need to be explored. Katsina has a strong educational focus and this needs ongoing support.

Memorandum of understanding

This is seen as a good idea and could be considered more as a change matrix. It should include a stepped approach with a built in review process. Initial steps should be easy for both parties to meet.

Governance Baseline Studies Summary – Yobe

Introduction

Each state has had three baseline governance assessments – policy and strategy assessment, public finance management assessment and a political economy assessment. The summary below outlines the findings of the assessments in Yobe as they relate to the eight key 'governance' issues:

- Free MNCH services
- Bringing PHC under one roof
- Strengthening budget and planning cycle
- Public finance management[2]
- Routine immunisation strengthening
- Eminent Persons Group
- Midwifery service scheme and other HR issues
- Memorandum of understanding

Findings and Recommendations

Free MNCH services

This is seen as a priority and there have been political commitments made. Issues that need consideration include:

- As government is unlikely to be able to support a full package of free MNCH services (at least initially), consideration needs to be given to a phased rollout.
- Assistance will be needed in defining and costing packages
- Other stakeholders and government ministries (e.g. MOWA) need to be involved in the process and this initiative should be seen as an opportunity to build a broad coalition to address women's and children's health issues.

Bringing PHC under one roof

Already considerable work has been done on this initiative and it seems a high priority within the state. Key issues that need consideration include:

- The need to ensure that all constituencies have bought into the concept – this includes unions and professional associations.
- An effective communication system that Identifies and addresses all concerns raised by individuals/groups.
- The need to clearly identify funding sources for the Board and where they will be lodged, and to establish the accounting and financial management systems required by the Board.
- Establishing effective mechanisms for the release of the funds for the Board.
- Define and strengthen the SMOH role within the new arrangements.

As with the other states work on repositioning the key MDAs affected by the new legislation should start immediately and the state committee driving the legislative process needs to ensure that the key tenets of the legislation are understood and maintained throughout the legislative process.

Public Finance Management

[2] Note that while the two issues (strengthening planning and budgeting cycle and public finance management) were discussed separately in the meeting they will be combined in the report

There are opportunities to generally strengthen the planning and budgeting process and PFM. In sum, many of the budgeting and financial systems and processes are weak and in need of improvement. Specific activities recommended include:

- To improve programme budgeting use an interim template for Chart of Accounts until BC and CoA formally changed.
- Focus on budget efficiency and review allocations for capital and recurrent budgets (one issue is the building of new facilities as against upgrading existing facilities).
- Link with other programmes (e.g. SRIP) in strengthening the budget review process and in promoting transparency.
- Focus on tracking releases, especially at LGA level.
- Assist the MoLG and LGAs to prepare simple budgets.
- Work closely with key officials who are prioritising the budget allocation.

Routine immunisation strengthening

Work on continuing to strengthen routine immunisation systems is important. Issues to consider in improving RI systems include:

- Documenting and understanding the resource allocations between RI and SIAs so as to inform better decision-making.
- Tracking release of LGA imprest accounts for RI (e.g. for cold chain maintenance).
- Strengthen the use of the GAVI funds.

Eminent Persons Group

This is seen as an important grouping, however given the political changes work in establishing the group should proceed cautiously. It was seen as important to package some of the baseline results to share with this group.

Midwifery service scheme and other HR issues

As with the other states, the focus should be on supporting the rollout of the midwifery scheme (e.g. assisting states in meeting their requirements of allowances and accommodation) and on employing current unemployed skilled health workers (especially SBAs). Work would include developing a database of unemployed workers, working with LGAs to facilitate employment and supporting training institutions in upskilling existing workers. Other HR work (e.g. addressing the maldistribution of health workers) should be addressed later.

Memorandum of understanding

This was seen as valuable as it would encourage capability, accountability and responsiveness of stakeholders and would help civil servants and project team members to promote changes and state action. There is a need to define key issues and milestones and then negotiate these with the state government.

Governance Baseline Studies Summary – Zamfara

Introduction

Each state has had three baseline governance assessments – policy and strategy assessment, public finance management assessment and a political economy assessment. The summary below outlines the findings of the assessments in Zamfara as they relate to the eight key 'governance' issues:

- Free MNCH services
- Bringing PHC under one roof
- Strengthening budget and planning cycle
- Public finance management
- Routine immunisation strengthening
- Eminent Persons Group
- Midwifery service scheme and other HR issues
- Memorandum of understanding

Findings and Recommendations

Free MNCH services

This is seen as a high priority as it emerged from the State Council for Health and there have been several political pronouncements on this issue. Key issues to consider include:

- The composition of the committee should include all role-players (including other government departments such as MWA and MOLG).
- The committee will need assistance identifying policy choices and costing/packaging the different options.
- There is a possibility to link free MNCH services with the service delivery fund.

Given the poor health indices, efforts to improve MCH are key political issues. Thus, it is important to partner with key politicians (and their wives) to drive this initiative forward.

Bringing PHC under one roof

While this is seen as a priority a number of factors need to be taken into account as this issue is taken forward:

- While creating opportunities for dialogue on a PHC Agency is straightforward, attention needs to be paid to LGA Chairs, SMOLG, Emirs and other elites to ensure broad ownership and buy-in.
- It is important to ensure the Governor's commitment to the initiative, and potential advocates in the State Health Assembly need to be identified.
- Policy development is usually easier than implementation.
- The implementation team needs to be realistic about targets for the Agency.
- Funding sources for the Agency and where they will be lodged must be clearly identified
- The implementation team should design and establish effective accounting and financial management systems required by the Agency and establish mechanisms for the reliable and timely release of funds for the Agency.

As with any new initiative, attention needs to focus on packaging the proposals and changes so that all stakeholders understand the issues and can contribute to the outcomes. Special care needs to be undertaken to ensure that the legislation is not distorted in the process and that work on repositioning the relevant MDAs is initiated early as a result of the proposed changes.

Public finance management

Given the specific interest and support of the Ministry of Budget and Planning, there are several opportunities that exist in Zamfara at the moment. Thus, it is important to continue to support the Ministry of Budget and Planning in institutionalising the planning and budgeting process, including budget tracking. Equally important are initiatives to improve reporting and performance reviews. Some concerns were expressed on the timely release of committed funds and weak documentation at all levels. Specific activities would include:

- Strengthening the accounting and financial management system.
- Supporting the MOBP to review and develop a robust budget classification system and Chart of Accounts.
- As the 2009 budget reflects the operational plan, the focus needs to shift to track release (especially at LGA level).
- Monitoring service outputs (numbers, infrastructure), also because the operational plan is reflected in the budget.
- Reviewing the balance between the capital and recurrent components of the budget.
- Strengthening the SMOH DPRS to ensure that the SMOH and the SMOBP continue to work closely together.

Routine immunisation strengthening

There has been considerable progress around strengthening the technical aspects of routine immunisation services (e.g. cold chain management, health worker training). With the imminent start up of the service delivery fund, an opportunity exists to enhance routine immunisation services. Support is needed to implement the service delivery fund, track releases and communicate all this to benefitting communities.

Eminent Persons Group

This needs to be seen as an informal grouping of interested citizens.

Midwifery service scheme and other HR issues

The initial focus needs to be on assisting the state in implementing the midwifery service scheme and employing unemployed skilled health workers. Activities would include:

- Establishing a database of unemployed skilled cadres.
- Developing a plan with LGAs to hire skilled cadres.
- Follow up state-level preparations to ensure that the midwifery service scheme is a success (e.g. allowances and accommodation is in place).

Other HR activities (e.g. addressing the maldistribution of health workers) are not seen as a high priority but where opportunities arise, these opportunities should be supported.

Memorandum of Understanding

This is seen as a high priority as it would assist in defining key issues and milestones. This would allow all partners to pursue a change plan that outlines what both the programme and the state wish to achieve with a focus on institutional performance (not just individual capacity), mutual responsibilities and inputs, a timetable and agreed targets, processes for assessing progress, etc. Thus, the MOU will strengthen policy and strategy development and create adequate links to the budgeting and planning process.

Governance Summary - Jigawa

Introduction

In Jigawa, the lead DfID health programme is PATHS2. However, for the purposes of this review relevant information was accessed via presentation of the PE analysis and the policy and strategy assessment carried out by the DfID-supported SPARC programme. The Governance group's discussion also drew on the PRRINN-MNCH 2009 Governance plans for Jigawa and the PFM team's knowledge of PFM issues in Jigawa.

Findings and recommendations

The group discussions led to the following conclusions:

- Within their PRRINN mandate the team can continue with the planning and harmonisation work.
- Similarly, the team will continue with strengthening Routine Immunization systems and tracking releases for RI.
- The focus of PRRINN-MNCH's work is at Gunduma council and lower levels.
- Some concern was expressed over higher level work; this being the mandate of lead state programmes.
- For example, the repositioning SMoH work has ground to a halt which has led to the creation of some tensions.
- Thus there is a need to re-approach DfID regarding continuing the repositioning work and financial management work – both these are seen as critical to maintaining the development of the Gunduma system and for ongoing PRRINN-MNCH supported work.
- One possibility that exists is for PRRINN-MNCH to review the Gunduma system as a learning process for PRRINN-MNCH.

Human Resources Baseline Studies Summary

Introduction

Accurate and up-to-date information is required for Human Resources for Health (HRH) policy formulation, strategic planning and for decision making on human resource management (e.g. recruitment, deployment, retention) and human resource development (e.g. education, training and continuing professional development). Identifying and understanding key HR issues and challenges will help inform the development of appropriate strategies and interventions to address them. In order to improve the quality and availability of HRH data, to provide a reliable and up to date analysis of the HRH situation within and across the states and provide a basis for judging subsequent programme progress towards its targeted goal and purpose, a number of baseline studies and survey were conducted in the three states. Those that provided HRH relevant data included:

- Policy and Strategy Making Baseline Study;
- Health Facility Survey administered in all government hospitals and 239 PHC facilities in Katsina, Yobe and Zamfara;
- Assessment of Health Training Institutions in the three states including a review of the training curricula for nurses, midwives and CHEWs;
- HR Audit conducted in Jigawa, Katsina, Yobe and Zamfara.

Information was collected through various instruments and methodologies including key informant interviews; questionnaires & rapid assessment tool (RAT); focus group discussions; site visits to collect data and administer tools; and technical & developmental stakeholder workshops.

Findings

Policy and Strategy Making Baseline Study

The Policy and Strategy Making Baseline Study provides information on HRH stakeholder, functions, structures and the HR policy environment. It found that in many cases policy formulation is delinked from research, information and the realities on the ground. There is some understanding of HRH issues and challenges but the strategies developed to address them are too broad; more detailed plans and activities are required to ensure that the plans are implemented. The Study indicated that the involvement and participation of key HR stakeholders in policy formulation, planning and implementation also need to be improved. For example in the Katsina report it was noted that the some of the key institutions involved in human resource development such as the Joint Human Resource Management Committee responsible for recruitment, discipline and promotion of staff and the College of Health Sciences were not involved in the formulation of training plans for the State. A key recommendation of the review report was that '*all the States definitely and urgently need support to package a strategy for scaling up the recruitment, placement, retention & development of health human resources'.*

HR Audit and Health Facility Survey

The key findings of the HR Audit and the Health Facility Survey were that there was an inequitable distribution of facilities in relation to population across each state and that there was low workload and provision of MNCH services at hospital and PHC facility levels. For example in Dapchi MCH the two midwives there reported that there had been were 24 deliveries conducted in 3 months. Hospitals in all three states reported that they were conducting less than 10% of the expected deliveries annually.

The surveys found that many of the PHC facilities are overstaffed but these surpluses comprised mainly untrained staff. For example in Bursari LGA (Yobe) there was 1 midwife and 178 health assistants. In other facilities it was noted that there are shortages of trained health professionals. In the hospitals in particular there is a critical shortage of nurse-midwives for the provision of MNCH services and only 35% of hospitals have the staff required to provide 24/7 EOC services

A key challenge across all the states is the maldistribution of health workers including geographical distribution (urban/rural disparities), distribution by level of care (tertiary, secondary, and primary levels) and distribution by skills mix (skilled and non-skilled birth attendants and health workers). Many dispensaries and health clinics serving rural populations are not functional, inaccessible and many have been abandoned. Many of the trained health professional available are based in the hospitals, for example 79% of the total number of midwives (430) in Katsina are working in the 3 hospitals. The majority of the dispensaries and health clinics surveyed are staffed by unqualified and untrained staff, few facilities provide skilled attendance at birth and many of the SBAs and CHEWs deployed to the PHC facilities are male. For example of the 459 staff found in the PHC facilities surveyed in Yobe, 10 (2%) were midwives, 60 (13%) were CHEWS and 389 (84%) were Health Assistants.

Assessment of the Health Training Institutions

The Assessment of the Health Training Institutions found that the number and type of students produced are not meeting health sector requirements; in particular there are too few nurses and midwives produced. The resources and infrastructure available in the institutions cannot support the number of enrolled students and the quality of the teaching and learning is being compromised as a result. There is a severe shortage of tutors and of tutors with appropriate skills; current student:staff ratios range between 1:50 and 1:120 much higher than universal standard of 1:10 to 1:15. Institutional policies to attract recruit and retain teaching staff are weak and there is limited professional development for teaching staff. There is a high attrition rate from pre-service training. Student hostels are overcrowded and dilapidated, and water and sanitation services are inadequate. Furthermore the health professionals that are being produced are not being recruited and deployed within the health sector.

Opportunities for in-service training and/or continuing professional development for staff in post are limited. Some staff have been trained in immunisation but few have received training in MNCH related areas, For example many of the midwives and doctors in the hospitals require training in Life Saving Skills (LSS) for EOC and newborn care.

Across all three states human resource management and development (HRM/D) capacity is limited and HR is not perceived as a core strategic function within the states. Those responsible for the HR function tend to be ex-nurses and community health officers who have not received any specific HR-related training. HR Administration systems and procedures are highly centralised and HR information systems are not fully functional, and are poorly maintained and poorly utilised for HR decisions.

Recommendations

As a result of the findings of the survey several key issues and challenges were identified. Improved strategic coordination, organisation and oversight of the HR function are required, which will involve the formulation and development of appropriate HR policies, structures, strategies and plans to ensure that the challenges are addressed in a holistic, cost effective and comprehensive manner. HR capacity, systems and procedures, including information systems, need to be strengthened at all levels to be more effective for strategic and operational HR planning, management & development.

Key policies and strategies will be required as follows:

- On recruitment to ensure that health workers shortages are addressed;
- On deployment and redeployment to address inequitable distribution;
- On retention to address shortages & attrition of health professionals and teaching staff and to improve distribution by level of care and skills mix.

Key recommendations:

- States should utilise the Midwifery Corps scheme and one year compulsory rural service scheme to improve distribution of trained midwives and skills mix in understaffed areas/facilities.
- Performance management systems are needed to improve productivity and the provision of quality MNCH services.
- The pre-service training institutions need to be strengthened and accredited, with particular attention to improving infrastructure & utility services, student:tutor ratios, curricula and training materials.
- Existing SBAs and CHEWs require on-the-job competency based training programmes to improve the quality and provision of MNCH services.
- Retraining of 'surplus' staff could be considered so that these staff can be redeployed to understaffed facilities and underserved areas.

MNCH Service Provision Baseline Survey Summary

Introduction

Provision of Skilled Birth Attendance (SBA) and availability of Essential (or Emergency) Obstetric Care (EOC) coupled with Newborn Care (NC) are key strategies that if implemented will reduce maternal and neonatal mortality and morbidity. Providing Skilled Attendants able to prevent, detect and manage the major obstetric complications, together with an enabling environment, which includes the equipment, drugs and other supplies essential for their effective management as well as a back-up referral system, is probably the single most important factor in preventing maternal deaths.

Most obstetric complications cannot be predicted and occur suddenly and unexpectedly – prompt access to good quality EOC is essential. For an estimated 15% of all women, such a complication will be life threatening unless she has access to EOC. Having the skills to recognise and then respond effectively to such unexpected events is a key part of a skilled attendant's role.

The PHC and BEOC Health Facility survey was carried out in the three state CEOC (Comprehensive Essential Obstretic Care) clusters. The clusters each comprise 2-3 LGAs around a selected CEOC hospital, constituting a population of around 500,000 per cluster. The survey used quantitative and qualitative approaches including an adapted tool for baseline assessment of health facilities; extracting data on utilisation of health facilities from registers; and key informant interviews with PHC co-ordinators and MNCH co-ordinators in each cluster LGA.

Findings

A total of 238 health facilities (HF) were surveyed, of which 126 were dispensaries (53%), 58 were health clinics (24%), 27 were MCH centres (11%), 21 primary health centres (PHC) (9%) and 4 comprehensive PHCs (2%). 83 HFs were surveyed in Katsina state (Daura cluster), 64 in Yobe state (Geidam cluster) and 91 in Zamfara state (Bungudu cluster). The estimated number of pregnant women for the 3 month period for the Katsina, Yobe and Zamfara clusters was 6,508, 4,279 and 6,345 respectively.

Provision of Maternal, Newborn and Child Health services

Results of this survey indicate that only a small proportion of HFs provide MNCH services. Most dispensaries only provide curative care and some also childhood immunisation, which is offered weekly or once or twice a month. Not all CHC, PHC and MCH clinics offer MNCH services.

Only 26% of HFs surveyed in the 3 CEOC clusters across the 3 states offered ante-natal care (ANC) services, while none of the HFs offered all components of ANC (iron supplements; syphilis testing; haemoglobin estimation; urine testing; tetanus vaccination; intermittent preventive therapy; insecticide treated nets; and prevention of mother to child transmission of HIV). Only about 36.2%, 1.1%, and 6.6% of all expected annual births occur in HFs below hospital level in CEOC clusters in Katsina, Yobe and Zamfara states respectively. Based on the total population (1,631,556) of the CEOC clusters, a minimum of 3 CEOCs and 13 BEOCs will be required. Only 1 out of the 238 HFs surveyed provided all six BEOC signal functions. Post natal care (PNC) was only available in about 20% (17/83) of HFs in Katsina state, in about 8% (7/91) in Zamfara state and in about 12% (8/65) of HFs in Yobe state.

Neonatal care was also not available in almost all HFs surveyed. Child welfare services (under five clinics) are usually restricted to childhood immunisation and vitamin A distribution. Growth monitoring and nutrition activities are rarely done and Integrated Management of Childhood Illness is not practised. Very few HFs offer Family Planning (FP) services and if they do the range of contraceptives on offer is limited to three methods: oral contraceptives, injectable contraceptives and condoms.

Accessibility, emergencies and facility conditions

In general utilisation rates of existing MNCH are very low, even in urban areas where accessibility is not an issue for the urban population. In rural areas distances to health facilities for remote populations, the difficult terrain, lack of roads and means of transport and costs of transport (particularly for emergency cases) make MNCH services poorly accessible; moreover rural dispensaries and health clinics usually do not provide MNCH services.

No systems are in place for referral of emergency (obstetric and paediatric) cases. Ambulance services are not available for most HFs and where ambulances are available at PHC offices or HFs there are no resources for fuel, maintenance and repair. No means of communication are available at HFs to call for emergency transport. Hiring a local vehicle in case of emergency is prohibitively expensive.

No arrangements for maintenance and repair of HFs and inventory are in place. Most buildings of HFs show signs of wear and tear and vary in state of disrepair and decay. HFs which receive support from development partners such as the MDG project, IFAD or the World Bank are in much better condition. Lack of water supply, water storage and hand washing facilities is a problem in almost all HFs. Even many newly constructed HFs have no water supply or storage facilities. Waste disposal is inadequate in most HFs and dispensaries and HCs have no toilet facilities. There is a lack of staff quarters at HFs and existing staff houses need refurbishment and lack toilets, water supply and water storage facilities.

Emerging issues

- Critical shortage of professional staff, particularly (nurse-) midwives and female staff for provision of maternal care.
- Inadequate planning and management of human resources.
- Lack of in-service training of professional staff in post.
- Lack of supportive supervision.
- Absence of MNCH services in rural areas.
- Poor quality of care.
- Lack of equipment and furniture in rural HFs.
- Non-availability of drugs and medical supplies (health care providers sell their own supply of drugs to patients)
- Lack of maintenance of buildings and poor condition of rural dispensaries and HCs, unless the HF received support from a development partner.
- No water supply and lack of water storage or hand washing facilities at HFs.
- Most HFs are dirty.
- Lack of staff houses and poor condition of existing staff quarters in rural areas, which have no water supply or storage facilties, toilets or power supply.
- No referral system (means of transport, means of communication to call for emergency transport) for emergency (obstetric and paediatric) cases.

- No community participation in health care and no involvement of communities in management of HFs.
- Poor record keeping.

Recommendations and next steps

The identified problems in MNCH service delivery are complex and not simple to resolve. Interventions are needed at different levels and besides improving service provision involve strengthening of governance and health systems in support of MNCH, with special attention to planning and management of human resources. The following points are proposed next steps for the PRRINN-MNCH programme to address the problems identified in MNCH service provision:

- Organise meetings at state level for the dissemination and discussion of the findings of the baseline surveys and for consultation and discussion of the way forward with stakeholders in each state, including the SMOH, SMOLG, LGA administration and PHC offices, political and community leaders and other development partners.
- In consultation with stakeholders from the SMOH and SMOLG, select and agree on model LGAs in each state for PRRINN-MNCH support.
- In consultation with stakeholders in the three states, select and agree on how many and which HFs to be supported by the PRRINN-MNCH programme for upgrading to BEOC facilities or 24/7 maternity units (suggest 4 + 4 in each target CEOC cluster).
- Order and supply essential equipment and furniture to the selected 4 BEOC and 4 24/7 PHC facilities in each CEOC cluster.
- Support the establishment of Drug Revolving Funds (DRFs), giving priority to PRRINN-supported BEOC facilities and 24/7 HFs.
- Agree with other development partners who will support the refurbishment of selected BEOC and 24/7 HFs, including provision of water supply and storage facilities, toilets and solar powered electricity.
- In collaboration with the SMOH, initiate advocacy for increasing the allocation of financial resources to LGAs for MNCH service provision; posting of preferably female nurse-midwives as MCH coordinators in each target LGA; and recruitment of more skilled birth attendants and other professional staff to ensure minimum acceptable staffing levels in target HFs (this has also budget implications).
- Support training of staff in MNCH, such as LSS, MLSS, IMCI, newborn care, and support capacity building by training a pool of master trainers at state level and strengthening existing health training institutions to play a greater role in in-service training for MNCH.
- Governance and health systems at LGA level need urgent attention and support.
- Human resource challenges need immediate short and long term solutions, which will determine overall programme success.

Operations Research Baseline Survey Summary

Introduction

One of the primary goals of the MNCH Programme is to enable a data-based approach by providing population-based data which is used both to inform implementation plans and to gauge progress towards meeting key indicators over the course of the project. The Operations Research baseline survey provides an initial assessment of the health status and health seeking behaviors for women in Katsina, Yobe and Zamfara states. The same questions will be repeated after the programme has been implemented to assess how Health Systems Development activities conducted by the PRRINN-MNCH programme in the target states have affected the following:

- Maternal and child health outcomes (using indicators such as infant and under-5 mortality).
- Use of health care services by children and mothers (using indicators such as immunization coverage and antenatal clinic attendance).

The survey is comprehensive yet designed to be comparable to both clinical and other national indicators, including data on reproductive history, maternal and child health and child health-seeking behavior. It is population based, which means that it is representative of all women of reproductive age (15-49 years) and children in the three state areas participating in the project, not just those who seek health care services. Questionnaires were composed of two sections:

- A background section eliciting information on household characteristics such as economic status and composition.
- A detailed reproductive history, including dates of pregnancies, births and deaths of children, use of health care during pregnancy, delivery and postnatal periods, immunization, *etc*.

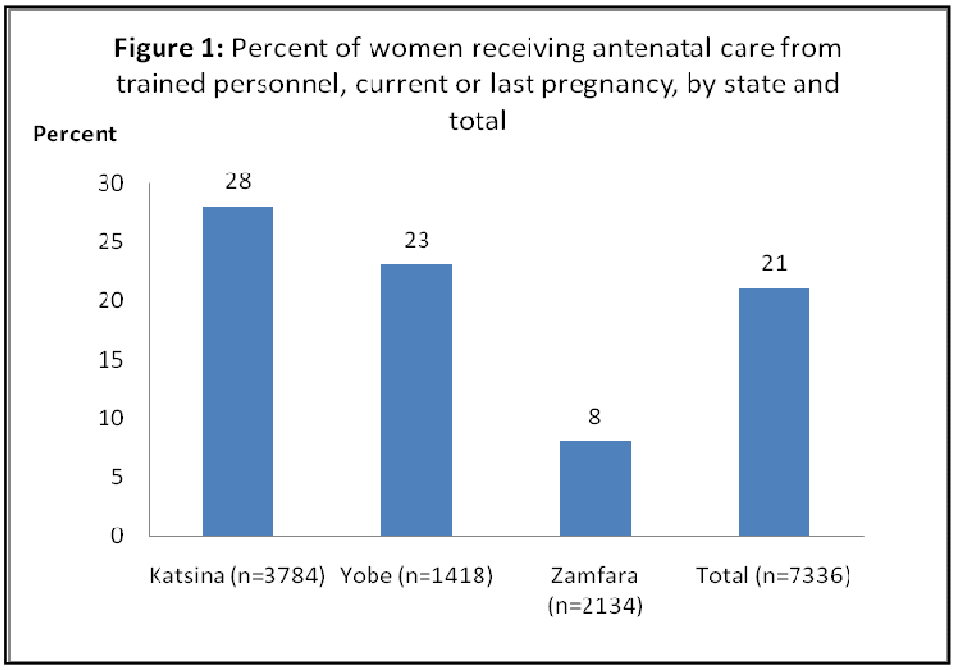
Questionnaires were translated into the local language (Hausa) in order to ensure clarity and standardisation of questionnaire administration. Interviewers were trained on dialects and pronunciation of local terms before conducting the interviews in April-May 2009.

Findings

Six key indicators were calculated as summarised below. The results reported here are preliminary and may change slightly when we complete the more rigorous analyses after more thorough data cleaning.

Antenatal care

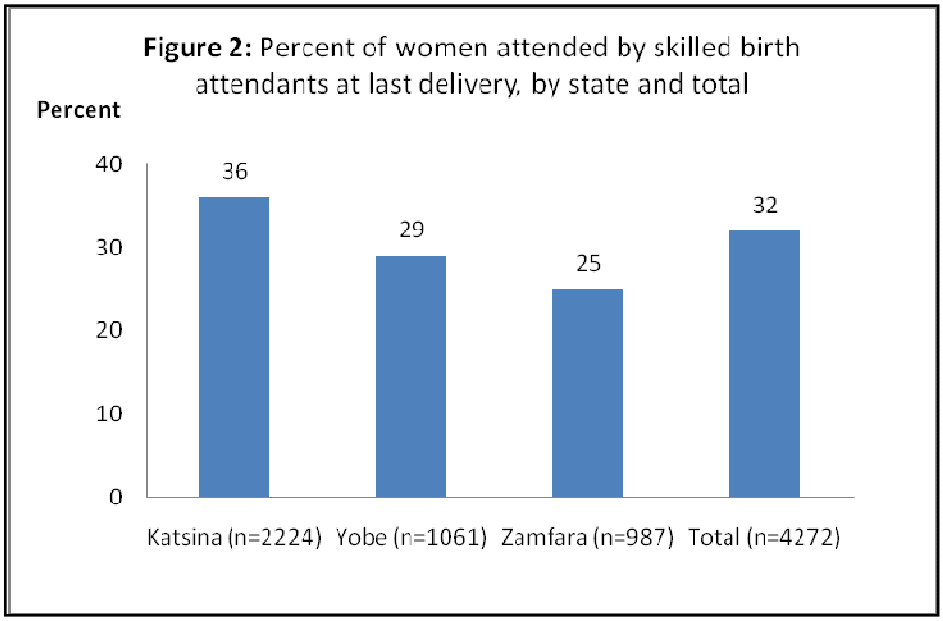
Antenatal care services can help ensure both healthy pregnancies and safe deliveries. Figure 1 shows the percentage of women who received antenatal care (ANC) by trained personnel during their current (at the time of the survey) or last pregnancy. This was calculated as the percentage of women who received <u>any</u> antenatal care by a doctor, nurse/midwife, health extension worker or other health facility personnel, or a trained traditional birth attendant (TBA). These figures includes all pregnancies regardless of place of delivery.



Note: The sample sizes reported in brackets are for all women responding to the question.

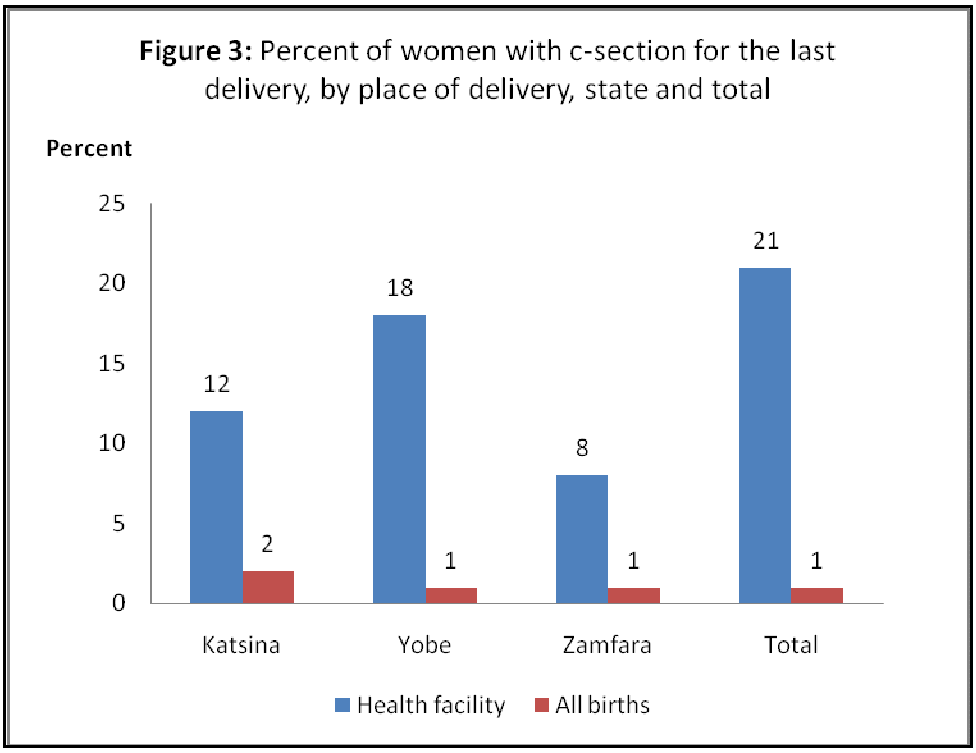
Assistance and medical care at delivery

Another important component of efforts to reduce health risks to mothers and children is increasing the proportion of women who give birth in facilities where medical intervention is available. Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and/or the baby. Respondents were asked to report the place of birth of their last born child if born within the last five years (Figure 2). The results were calculated as the percentage with deliveries attended by a doctor, nurse/midwife, health extension worker or other health facility personnel, or a trained TBA, for births at all facilities.



Caesarean section at birth

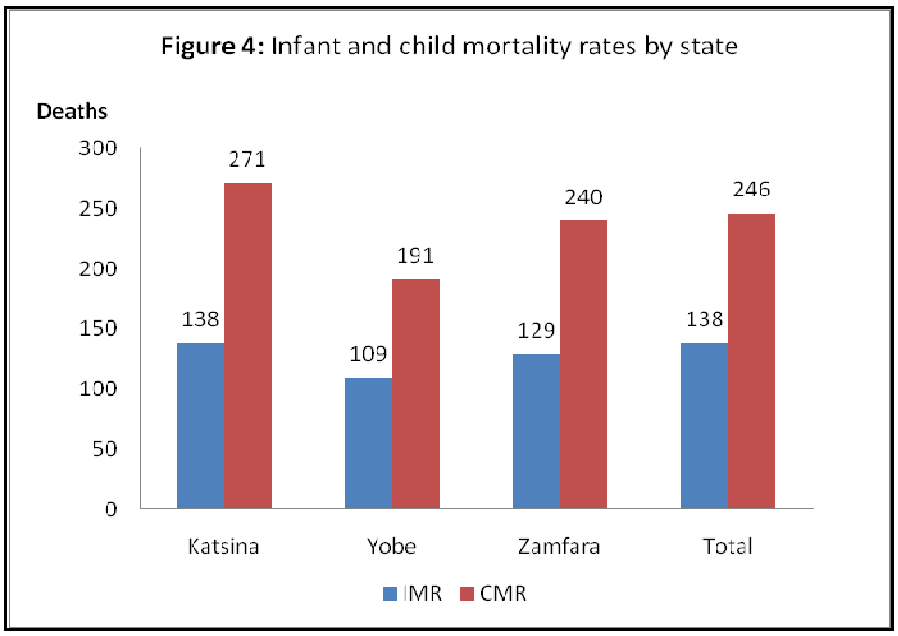
The percentage of pregnancies with delivery by caesarean section (c-section) were analyzed in two categories: percentage of c-section at any health facility and percentage of c-section of all deliveries.



Infant and child mortality

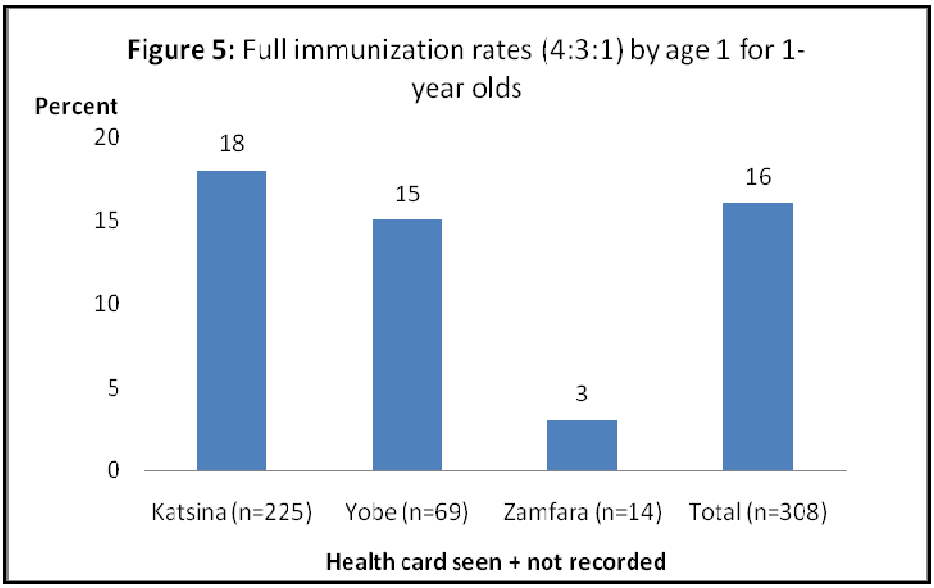
Estimates of infant and childhood mortality are based on information from the birth history section of the questionnaire administered to individual women. For each birth reported, more detailed information was then collected on the child's sex, age in completed years, whether the child was still alive, and age at death if applicable.

In this report, infant mortality rate (IMR) is defined as deaths among children before reaching age 1 (per 1,000 live births) whereas child mortality rate (CMR) is defined as deaths among children before reaching age 5 (per 1,000 children). It is important to note that, amongst other factors, the quality of mortality estimates depends upon the completeness with which births and deaths are reported and recorded.



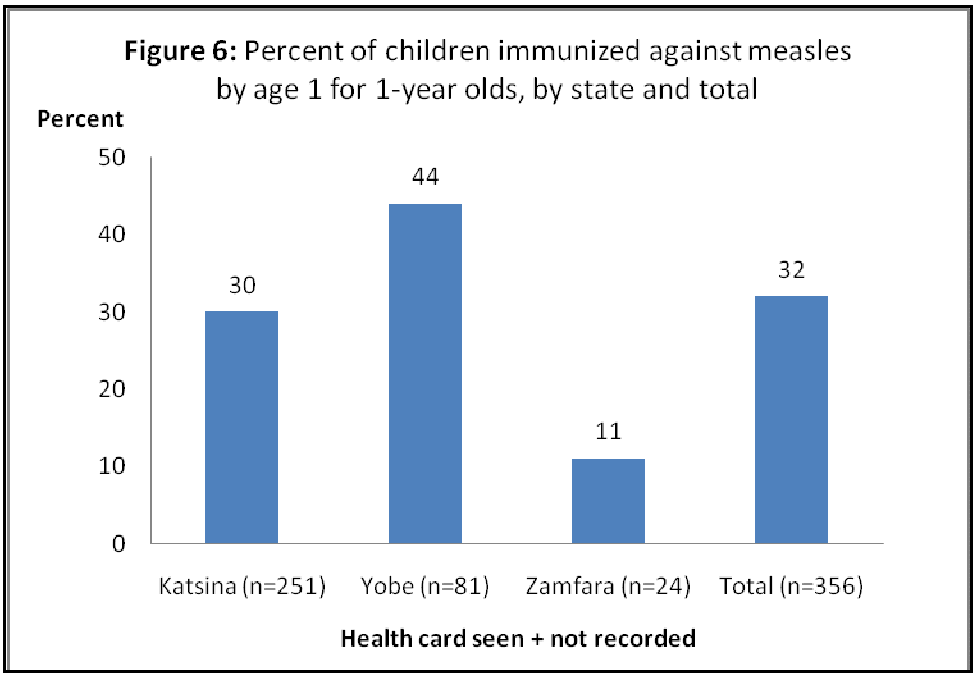
Full immunization by age 1

To evaluate efforts to encourage women to immunize their children, the baseline survey collected information on immunization coverage for all children born in the five years preceding the survey. Consistent with the standard Nigeria Expanded Programme of Immunization (EPI), infants are considered fully vaccinated based on the 4:3:1 vaccination rate (plus BCG): Infants receiving 1 BCG, 4 Polio (including 0 Polio), 3 DPT, and 1 measles by age 12 months. Here, immunization rates are calculated based on immunizations recorded on the child's immunization card (as read by the interviewer) plus those immunizations given to the child but not recorded on the card, as reported by the mother. Immunizations reported only by the mother without a card were not included.



Immunization against measles by age 1

Figure 6 presents information on children born within the last year who received a measles immunization before their first birthday. This information is also calculated based on two sources of information: (1) health card seen and measles vaccination recorded plus (2) health card seen, and measles vaccine reported as given by the mother but not recorded on the health card.



Conclusion

The baseline survey provides an opportunity for generating a number of indicators that can be used to gauge the impact of the project in the near future. This report focused on six indicators that are crucial to assessing the direction and impact of the project. To a large extent, the results show very low proportions of women receiving ANC from trained personnel, low proportions of women attended by skilled birth attendants during delivery, very high infant and mortality rates and very low coverage of immunization against the vaccine-preventable diseases. There are some variations in the selected indicators across states, with Zamfara generally ranking lowest. These results challenge the PRRINN-MNCH project to intensify efforts to increase essential care services to all mothers and children in the focal areas.

Health Management Information Systems (HMIS)
Baseline Studies Summary – Katsina

Introduction

In 2007, data quality assessment (DQA) was conducted for the PRRINN project and it revealed a very weak health management information system (HMIS). With the advent of the MNCH component, a need was identified to assess the HMIS in a broader and comprehensive manner in terms of instruments, infrastructure, processes and flow, human capacity and information use in each state. This situational analysis was designed as a comprehensive evaluation of the HMIS in the PRRINN-supported states. This assessment adopted a broad perspective that involved evaluating the existing policy framework, planning and budgeting/finance, infrastructure, processes, data flow, data quality and human resources. The aim of the assessment is to inform plans for HMIS strengthening over the medium to long term.

The project was conducted in two phases. First, the planning phase involved desk review of existing HMIS assessments and materials, tool and methodology design and project management. The tools were piloted in Katsina and revised before implementation. Secondly, the HMIS assessment tool was applied in Yobe in six LGAs and seventeen health facilities. Key informant interviews were also conducted to gain insight from different perspectives and explore key issues in depth.

Findings

The analysis revealed revealed significant coordination failures due to the weak capacity of the state HMIS team. While an active and effective State Primary Health Care Development Agency (SPHCDA) is established in Katsina, the state HMIS is not able to take advantage of this opportunity primarily because data collected by the SPHCDA is not made available to the state HMIS team. Further, there is minimal reporting from the hospitals and LGAs to the state HMIS. Reporting is sustained by a data-pull strategy where state HMIS officers don't expect to receive complete data unless they visit the LGAs to collect the reports themselves. Evidence shows that LGA M&E officers will report data if there are appropriate incentives. The reality is that currently, there is neither support for the HMIS officers to "pull" the data nor for the LGA M&Es to "push" the data. On the other hand, the SPHCDA has adequate support for HMIS activities and therefore has been able to collect data from LGAs. Support for the SPHCDA is mainly in the form of Zonal Technical Officers who are paid to go round their respective LGAs to collect data. This arrangement allows the SPHCDA to develop a mechanism to support the consistency of the data flow. A more detailed analysis of the situation in Katsina is presented below.

State HMIS

a) Policy and planning framework

Although there is a National HMIS policy at the federal level, there is no HMIS policy or planning framework in the state. The absence of an official policy on HMIS reviews reflects a poor understanding of the essential components of a successful HMIS. This lack of in-depth understanding filters through in the weak collection and use of data for health planning. A major factor that seems to bear negatively on the formulation of a state HMIS policy is that most of the activities of the HMIS team are unsupported. The drive for data is usually external to the state (e.g. from the FMOH) and therefore the value placed on data is short-lived because it is limited to the point of demand.

b) Resource levels

The state does not have a budget for HMIS. There is therefore an undue reliance on donor assistance (mainly from HSDP) for carrying out core HMIS functions.

c) Data cycle

The weak capacity of the state to sustain its HMIS team contributes to incomplete data returns at the state level. HMIS officers don't have the capacity to collect data from LGAs and M&E officers at the LGA do not have adequate funds and transport support to submit the data to the state. The case is different with the SPHCDA where adequate budget is allocated for data collection and a mechanism is in place for data validation and verification. However, the Agency also faces the challenge of data analysis. As the State M&E officer says, "I have up to eight software systems to collect and/or analyze data but I cannot use any of them easily."

LGA and Facility HMIS

a) Policy and planning framework

The HMIS policy document is not well known. Most LGAs don't have a copy of the policy. Less than half of the LGAs visited had a work plan for HMIS activities and significantly fewer follow the work plan.

b) Resource levels

- *Infrastructure*: Having a dedicated office space is not a challenge at the LGA level except for a few who responded that the space wasn't adequate. However, for facilities, it appears that many are constrained by inappropriate office space, furniture and filing cabinets for keeping health records.
- *Finance*: Funding of HMIS/M&E activities at LGA and facility levels is poor and there is limited understanding of the need to factor these into budgetary plans and forecasts.
- *Human Resources*: Staff are inadequate in number and skill at both LGA and facility level. So far, partners have done training mostly at LGA level. Not much has been done to cascade training to HF staff.
- *Technical*: Important tools such as computers, printers, photocopiers, calculators and filing cabinets are not available at both LGA and facility levels.

c) Data cycle

- *Collection tools:* there is insufficient supply of forms and lack of resources to ensure that HFs are adequately stocked.
- Quality: while survey respondents state that there is some data reporting and validation system, it seems that this is only done at a superficial level. This is directly related to the lack of forms. For example, only 7% of HFs had community tally sheets and summaries.
- *Analysis:* despite the poor use of graphs and tables, analytical capacity at the LGA seems fair. For instance, all LGAs analyse immunisation data (e.g. coverage) and almost 9 out of 10 analyse ANC data (e.g. attendance), but only 45% analyse the prevalence or incidence of disease
- *Dissemination, use and flow:* all LGAs claimed that they give feedback to facilities but 40% of facilities maintain that LGAs do not give them feedback.
- *Integration*: there is a lack of coordinating mechanism for data collection, flow, integration and use at LGA level.

Recommendations

- Convene a health data consultative committee (HDCC) to develop state level coordination:
  - Set up a forum to include the DPRS, State HMIS officer, Executive Chairman SPHCDA, State M&E officer and General Manager HMB. This forum will constitute the HDCC.
  - The HDCC should develop a policy and planning framework for health data review. This will include policies on data collection and reporting to the state HMIS team.
  - The forum should also formulate and implement a strategy to either recruit or redeploy qualified staff for the state HMIS team. This team should consist of the state HMIS officer and at least 5 assistants.
  - Concrete measures should be decided and taken to ensure that there are adequate HMIS forms available to LGAs and HFs.
- A foundation course on HIS should be arranged for all LGA M&E officers and their assistants. This should include training on filling in the HMIS forms. A mechanism must be in place to facilitate and monitor the cascading of training to both primary and secondary HFs.
- Procurement of computers including the installation of DHIS software is imperative at the state level. This should be incorporated with training of trainers who would cascade the training down to LGA M&E officers.

Health Management Information Systems (HMIS) Baseline Studies Summary – Yobe

Introduction

In 2007, data quality assessment (DQA) was conducted for the PRRINN project and it revealed a very weak health management information system (HMIS). With the advent of the MNCH component, a need was identified to assess the HMIS in a broader and comprehensive manner in terms of instruments, infrastructure, processes and flow, human capacity and information use in each state. This situational analysis was designed as a comprehensive evaluation of the HMIS in the PRRINN-supported states. This assessment adopted a broad perspective that involved evaluating the existing policy framework, planning and budgeting/finance, infrastructure, processes, data flow, data quality and human resources. The aim of the assessment is to inform plans for HMIS strengthening over the medium to long term.

The project was conducted in two phases. First, the planning phase involved desk review of existing HMIS assessments and materials, tool and methodology design and project management. The tools were piloted in Katsina and revised before implementation. Secondly, the HMIS assessment tool was applied in Yobe in six LGAs and seventeen health facilities. Key informant interviews were also conducted to gain insight from different perspectives and explore key issues in depth.

Findings

The analysis revealed that the HMIS infrastructure is in a suboptimal state in Yobe. HMIS activities are underfunded and budgeting for health record keeping and M&E activities at both LGA and facility levels seem to be non-existent. Human resources are a major constraint in terms of the shortage of staff as well as the dearth of required skills. Also, data collection tools are often in short supply and a number of vertical programmes provide their own forms for HF staff to fill in, increasing the burden of work. These findings are summarised below:

State HMIS

a) Policy and planning framework

Although there is a National HMIS policy at the federal level, this is not translated into a state-specific policy. The absence of an official policy on HMIS is reflected in a poor understanding of the essential components of a successful HMIS. This lack of in-depth understanding filters through in the weak collection and use of data for health planning. A major factor that seems to bear negatively on the formulation of a state HMIS policy is that most of the activities of the HMIS team are unsupported. The drive for data is usually external to the state (e.g. from the FMOH) and therefore the value placed on data is short-lived because it is limited to the point of demand.

b) Resource levels

Financial: There is a budget for M&E in the state and details of this are currently being worked out for this year. The DPRS complains that, "*the budget for M&E is N60m out of the total for health (N3.87bn).*" He further states that the allocation process is based on a recurrent funding basis, which means that funds are released each month for specific activities and in practice nothing is budgeted for M&E. Moreover, the local governments are not budgeting and/or allocating sufficient funds to M&E activities.

c) Data cycle

At the state level, the information bottleneck is attributed to "*a poor way of generating data,,, that borders more on training [and the lack of forms]. The state only has immunisation and LDR*

forms but nothing for ANC". The capacity to analyse data is also weak. This stems from inadequate level of training. The DPRS understands that even though data is reported it is incomplete. He states that: *"The problem is not printing of forms if [the forms are] not utilised; The problem is a problem of collecting data; the reporting is not an issue. If you take [the forms] to the HF they don't know what to do with it."*

LGA and Facility HMIS

a) Policy and planning framework

The state has not articulated its own HMIS policy framework or measures to institutionalize and clearly spell out M&E activities. The HMIS policy document is fairly well known – four (4) out of six (6) LGAs had a copy. Generally, HMIS activities are not planned for and when planned for, they are hardly followed through. For instance, only two of the LGAs visited had a work plan for HMIS activities for the year 2008 and only one had implemented any of the activities. None of the facilities had a plan for M&E activities.

b) Resource levels

- *Infrastructure*: All LGAs have a dedicated office space but this is mostly inadequate. This applies to facilities too. In Yobe, most facilities felt they had enough desk/chairs but only 4 LGAs out of 6 felt adequate. Insufficient supply of writing materials. Respondents said they frequently have to purchase these from their own funds.
- *Finance*: There is poor funding of HMIS/M&E activities at LGA and facility levels.
- *HR*: Staff are inadequate in number and skill at both LGA and facility level. So far, partners have done training mostly at LGA level. Not much has been done to cascade training to HF staff in the respective LGAs.
- *Technical*: Computers were found to be available at all six LGAs but 4 of them were not functioning. Printers are also available at the LGAs There is however a generally poor maintenance culture. There are no computers at the facility level and the DHIS software is not in use at LGA or facility level.

c) Data cycle

There are no mechanisms at most LGAs to ensure the timeliness, completeness or consistency of data reporting. Consequently, this impacts negatively on data quality.

- *Collection tools*: Only 17% of LGAs had the household cards. The same proportion of HFs had all the required community tally sheets forms Also, only a few facilities had all the required form registers.
- *Quality*: The timeliness of submission is apparently poor as some (2) LGAs had not yet received any data from their respective facilities (as at the time of the interview).
- *Analysis and presentation*: Use of graphs and maps at LGA level is poor. This is even worse at the facility level as respondents could not appreciate the need for data analysis. The exception is for immunization data, reflecting a recent emphasis placed by partners.
- *Dissemination, use and feedback*: The dissemination of data through the use of graphs and annual publication is lacking in LGAs (only 17%) while this does not occur at the HFs.18% of HFs claim to receive feedback from LGAs, while half of LGA M&E officers are reported to give regular feedback to HFs. Generally, data use is limited.
- *Integration*: Although there is not much data flowing, there is good coordination and integration of information systems.

Recommendations

- Constitute and maintain a health data consultative committee (HDCC) consisting of executives from the major data producers and users in the state. Their role should include the monitoring and evaluation of the HMIS. While this committee does not exist in Yobe, its establishment will support the coordination and integration of HMIS activities in the state.
- Technical support should be provided by PRRINN-MNCH to the state in translating national HMIS policy into clear strategies and plans of action.
- Provide technical support to DPRS in conducting advocacy and sensitisation of state political stakeholders (e.g. health commissioner and Permanent Secretary) to raise the profile of HMIS activities in the state.
- Advocacy for the state and LGAs to commit to spending, at the minimum, the required 0.5-1.0% of the health budget on HMIS. Budget on HMIS should be prioritised for the provision of HMIS forms, supportive supervision and training.
- Training of state team and training of trainers. Mechanism should be established to cascade training down to facility level.
- Provision of filing cabinets and shelves.
- Advocacy for the recruitment of workers may be done. However, this should be done with an understanding of the lean funding for the health workforce.

Health Management Information Systems (HMIS) Baseline Studies Summary – Zamfara

Introduction

In 2007, data quality assessment (DQA) was conducted for the PRRINN project and it revealed a very weak health management information system (HMIS). With the advent of the MNCH component, a need was identified to assess the HMIS in a broader and comprehensive manner in terms of instruments, infrastructure, processes and flow, human capacity and information use in each state. This situational analysis was designed as a comprehensive evaluation of the HMIS in the PRRINN-supported states. This assessment adopted a broad perspective that involved evaluating the existing policy framework, planning and budgeting/finance, infrastructure, processes, data flow, data quality and human resources. The aim of the assessment is to inform plans for HMIS strengthening over the medium to long term.

The project was conducted in two phases. First, the planning phase involved desk review of existing HMIS assessments and materials, tool and methodology design and project management. The tools were piloted in Katsina and revised before implementation. Secondly, the HMIS assessment tool was applied in Zamfara. The national consultants assessed the state level while three teams over two days, assessed one LGA and three HFs each per day. This made a total of six (6) LGAs and eighteen (18) HFs. Key informant interviews were also conducted to gain insight from different perspectives and explore key issues in depth.

Findings

The analysis revealed that there have been remarkable efforts towards computer-based health information systems in Zamfara. Most local government M&E officers have access to a computer with the DHIS installed. A majority of M&E officers interviewed use the software to capture data and report these electronically. However, the dataset captured at present is limited to immunisation indicators. Nevertheless, plans are underway to expand the dataset to incorporate the NHMIS MDS. Lack of adequate resources is a major constraint in strengthening the HMIS. This is detailed below.

State HMIS

a) Policy and planning framework

There is a national policy on HMIS comprising the goals, priorities, main directions and structure that are suited to the social needs and economic conditions in the different States and this forms part of national, social and economic development policies. Copies of this policy were found to be present at the state level in Zamfara. However, these policies need to be translated through various stages of planning at the state and local levels into strategies to achieve clearly stated objectives.

b) Resource levels

The state has a budget for HMIS. However, the inadequacy of this budget for HMIS activities means reliance on donor assistance for carrying out core HMIS functions. The HSDP had supplied computers and accessories to the state and LGAs. Some of these are no longer functioning, mostly due to lack of maintenance. The DPRS states that the state and the LGAs signed a MoU, which clearly defined the role of the recipient local governments as that of the maintenance of supplied hardware. But this support has been poor.

c) Data cycle

Data collection is severely hampered by the general lack of data collection tools. The dataset currently in use focuses on immunization data and plans are underway to expand this to include

data elements for maternal care and then the national HMIS requirement. Quality is still low as reported data is mostly incomplete and inconsistent. HMIS officers at state level do not have the capacity to collect data from LGA M&E officers because of inadequate transport support.

LGA and Facility HMIS

a) Policy and planning framework

The HMIS policy document is fairly well known. Half of the LGAs visited had a copy of the policy. Generally, HMIS activities are not planned for and when planned for, are rarely carried out.

b) Resource levels

- The insufficiency of funds has significant implications mostly at facility level.
- *Infrastructure*: The inadequacy of space at HFs reflects the endemic problem of inadequate resources. Computers and printers were widely found at the LGAs in Zamfara – five (5) out of the six (6) LGAs visited had a functional computer system. The HMIS software, DHIS, is in use at LGA level (five out of six LGAs) and three LGA M&E officers said they send data electronically (DHIS export).
- *Finance*: HMIS/M&E activities at LGA and facility levels are poorly funded. There is poor understanding of the need to factor HMIS into the budget.
- *Human Resources*: Staff are inadequate in number and skill at both LGA and facility level. Not much has been done to cascade training to HF staff in the respective LGAs.

c) Data cycle

- *Collection tools*: There is insufficient supply of forms resulting from a lack of a mechanism to ensure their sustained supply. There is also the presence of multiple forms from vertical systems – not designed within the routine HMIS - that increase the burden of data collection at the facility level.
- *Quality*: In five LGAs, the reporting rate was about 81%. In only one LGA was it found that no health facility within the LGA reported data for the previous months. All LGAs have some mechanism for ensuring the consistency and completeness of data.
- *Analysis*: Data analysis is generally poor at all levels. There is very poor use of graphs. At the LGA and facility levels, analysis is chronically poor including the use of monitoring charts. Immunization data is generally the most analyzed because of the graph template provided for the assessment of immunization targets.
- *Dissemination, use, flow and feedback*: Dissemination of information is a challenge and very few facilities/LGAs summarize their statistics. There is currently no yearly or periodic publication. Collection and use of data is principally centrally- (state-) driven. There is poor use of data at LGA and facility levels. Data flow is well coordinated in Zamfara as there is one central coordinating unit – the HMIS – for data from primary and secondary healthcare facilities.

Recommendations

- Convene health data consultative committee (HDCC) to:
  - formulate state HMIS policy and planning guidelines
  - commit the state and LGAs in maintaining the computer-based HMIS
  - strategise on how to expand the current dataset to incorporate the MDS contained in the NHMIS
  - address and resolve shortage of HMIS forms

- Through strong advocacy, HMIS should be allocated the prescribed 0.5-1% of the health budget at both state and LGA level.
- The state HMIS team and LGA M&E officers should be re-trained on the HIS and DHIS foundation course with particular emphasis on analysis and presentation.
- Training should be conducted on HIS and DHIS foundation course for LGA M&E assistants. The HIS foundation course should be cascaded down to all health workers at PHCs and HROs/HRAs at secondary facilities.
- Provision of appropriate filing cabinets to maximise limited health record space in PHCs.

Demand Side Barriers to Utilization of MNCH Services Baseline Study – Katsina

Introduction

A rapid social assessment of demand side barriers to utilization of maternal, newborn and child health (MNCH) services was undertaken on behalf of the Katsina State Ministry of Health (SMOH) and State Primary Health Care Development Agency (SPHCDA) by a team of consultants from PRRINN-MNCH in January 2009.

The assignment set out to gather qualitative information about the factors at household and community level affecting maternal, new-born and child health care and service utilization. Information on these issues is very limited in Katsina. The idea behind the rapid assessment exercise was therefore to improve the evidence base so that the state could devise an appropriate response to the poor MNCH indicators.

The rapid assessment exercise focused on six local government authorities (LGAs) in the three senatorial zones of Katsina. The LGAs were: Kaita and Kurfi in Katsina Zone; Zango and Mani in Daura Zone; and Matazu and Danja in Funtua Zone. Because not all communities and LGAs were involved in the rapid assessment exercise, the findings cannot claim to be comprehensive. Nevertheless, they give a good indication of the nature and extent of the factors that undermine households' and communities' capacity to respond appropriately to MNCH problems.

Findings

Obstetric near-misses (i.e. 'lucky escapes') seem to be happening on a very significant scale in Katsina. These near-misses often result in unnecessary deaths of neonates and leave many women with serious health problems that will affect them for the rest of their lives. For some women a maternal complication leads to an unnecessary and avoidable death.

Knowledge of obstetric danger signs was incomplete in the fieldwork sites. Lack of clarity about the most appropriate response means that families have a variety of options when responding to a MNCH problem – choices that can lead to life-threatening delays.

Concerns about the **high cost of emergency health care**, combined with very **substantial physical access barriers**, especially in remote locations, contribute very significantly to the delays in getting to a health facility.

Once a decision has been made to seek care, the financial outlays associated with using emergency health services can be very substantial, and catastrophic for some households, forcing families into a **cycle of asset depletion, indebtedness and, ultimately, greater vulnerability to future shocks** (such as a failed harvest).

Supply-side failures contribute to the delays. It is not uncommon for clients to be referred from one health facility to another when seeking emergency treatment, or to be sent home from a facility, only to have to return later. These service delivery failures increase the potential that clients will suffer poor outcomes, and can substantially increase the cost of care.

Gaps in **knowledge about the causes and most appropriate treatment** for common childhood and new-born illnesses were evident. Knowledge of when symptoms become danger signs was particularly weak. Some potentially harmful practices associated with care of new-borns appeared to be common.

As with emergency maternal health care, the **practical difficulties** associated with reaching and paying for formal health care seemed to provide a large part of the explanation for the delays in appropriate treatment-seeking for children and new-borns. This implies that assumptions about the 'ignorance' of people in the community need to tempered by the understanding that communities are having to cope with limited options within the context of an under-performing (and largely non-pro-poor) health system.

Recommendations

The rapid assessment findings were presented at a stakeholder workshop on 19 January 2009, and the implications of the findings for the state were analysed. Consensus was reached about the way forward.

The findings suggested that in order to increase access to MNCH services, and improve home-based care of pregnant women and their children, interventions were required in a number of areas. These fall broadly into the following areas:

- Awareness raising schemes targeted to the whole community
- Schemes for improving physical access to MNCH services
- Schemes for improving financial access to MNCH services
- Advocacy in support of increasing access to MNCH services

Case studies gathered on obstetric near-misses also implied a need for an intervention focused on improving timely access to blood supplies. It was agreed that a detailed design mission would be fielded to develop these components, identify the most appropriate agency to lead and co-ordinate demand-side MNCH activities, and to identify implementation partners.

A second major implication of the rapid demand-side social assessment findings was that because very few women in Katsina are currently using health services for normal delivery, and because much work still needs to be done to upgrade health facilities to basic and comprehensive emergency obstetric care capability, any strategy that is attempting to increase demand for maternal health services needs to focus initially on promotion of ANC and emergency obstetric care services. Once improvements in services are evident, and, in particular, human resource capacity has increased, awareness-raising efforts can start to focus on the promotion of skilled attendance at delivery. A focus on reducing the number of maternal complications that end tragically will also begin to address some of the challenges relating to the high neonatal mortality rates.

Demand Side Barriers to Utilization of MNCH Services Baseline Study – Yobe

Introduction

Qualitative information on health seeking behaviour relating to maternal and new-born health care and services is currently very limited in Yobe State. The purpose of rapid social assessment of demand-side barriers to utilisation of maternal, new-born and child health (MNCH) services was to provide state-specific qualitative information on the factors at household and community level affecting MNCH care and service utilization. The primary focus was on examining the barriers of access and affordability of emergency maternal and new-born health services.

Fieldwork was conducted in 14 villages in seven (out of 17 LGAs) in January 2009. In each LGA, the work began with a visit to the Primary Health Care Office in order to explain the purpose of the study and involve the staff in a decision about the choice of fieldwork sites. PHC staff selected one village with, and one without, a health facility.

At community level traditional leaders were visited and their permission sought to visit women at home and to talk to men in an informal manner. A mixture of semi-structured interviews and natural group discussions was held. Across the fieldwork sites members of six ethnic groups were interviewed: Kanuri/Manga, Fulani, Karai-Karai, Bolewa, Ngizim, Bade, and Hausa. Kanuris comprised approximately half of respondents. Although no attempt to gain a representative sample of the population was made, there is no reason to suggest that the women and men interviewed were atypical.

Findings and Implications

Cultural and religious practices

Even if accessible, affordable and appropriate services were widely available, demand would not necessarily rise greatly in Yobe. A number of **entrenched cultural and religious practices** keep women away from the health services. The value attached to delivering alone and the observance of a forty day post-partum period are both barriers to care seeking that will not be easily overcome. The implication is that any programme aiming to tackle low demand for these services must work *with* the cultural practices in order to ensure that the services provided are culturally appropriate and acceptable.

Other practices such as **early marriage** are deeply entrenched and not easily changed. Marrying a girl of 13-15 years of age is common in the rural areas in Yobe. Men cited the need to ensure that the girl is married before she can be seduced and the pressure of social norms as reasons for early marriage. Once married, pregnancy is seen as the normal, even inevitable, outcome. Although many men make the connection between early marriage and stillbirths and maternal deaths, they are not doing anything to delay marriage. These beliefs and practices are unlikely to change in the short-term. Nevertheless, thought should be given to appropriateness of providing information to men about the advantages of and ways to delay the first pregnancy in ways that are culturally acceptable.

A cultural **preference for a woman to deliver alone** is widespread in Yobe, as in other states in the north. This practice is linked to female values of modesty, shyness, endurance and the management of pain. There is an element of competition between women to succeed in delivering without assistance; women who deliver alone gain kudos amongst other women. Mothers-in-law recounting stories how they successfully delivered alone spur women on to try and do the same. The preference for delivering alone is deeply entrenched, and therefore not

easily changed through community engagement or any other initiative emanating from outside the community. With facilities for delivery in clinics or hospitals so poor in Yobe, it will be important, at least initially, to focus on promoting other aspects of safe motherhood such as timely use of emergency obstetric care.

The preference for delivering alone means that the services offered by **traditional birth attendants (TBAs)** are minimal in many areas. Typically, TBAs only attend women after they have delivered. Also of note is that there are very few trained TBAs in Yobe; in some areas there are no TBAs. Although it will be important to engage with older women, who may be TBAs, and younger women in the community with regard to harmful practices such as *zirzir* (cutting the mother to ease the passage of the baby), and to highlight the need to seek help without delay if problems are encountered during labour, the limited role of TBAs at community level means that they should not be the primary focus of any community level intervention.

Most Muslim cultures across the world observe a **40 day post partum period of seclusion** of the new mother and her child. During this period, the woman cannot pray and is ritually polluted. The forty day period is a time when a woman can expect visits and support from female relatives and friends, and to enjoy some special foods. Although the forty day period is well known and understood by health workers in many settings, health services make no provision for the practice. The 40 day period is observed across Yobe. It will therefore be important to acknowledge the strength of the custom, which is also a religiously sanctioned period, and not expect women to come to or take their children to health facilities unless there is an emergency. In the vast majority of cases, contact with the new mother and child during the forty days after birth will occur only through home visits. Different ways of providing post-natal care services at community level therefore need to be tested.

Knowledge and understanding of MNCH issues and services

Men had more knowledge of MNCH issues than women. In interviews they demonstrated that they knew more than women about danger signs in pregnancy and those affecting newborns, and more about childhood illnesses. It is important that men continue to hear **health messages that reinforce positive decision-making** with regard to health seeking behaviour. It is also important that women are reached with information about danger signs in pregnancy and new-born babies, as well as other issues relating to MNCH.

Many female respondents talked about **breastfeeding** from the third day because ‘it’s what we’ve done since our grandparents’ time’. However, there were also some women who talked about changing to breastfeeding from the first day. Hence it appears that breastfeeding practices are an area where resistance to change is lower than, for example, the practice of delivering alone. Women who made the change to starting breastfeeding earlier cited hearing messages at the health facility or from other women. Communication of the benefits of breastfeeding is possibly an area where a programme focusing on demand-side MNCH issues could make a difference.

Most women had little idea of what **antenatal care (ANC)** was and confused it with seeking curative care whilst pregnant. Men claimed to value ANC, but most were not enabling their wives to attend. Changing such health seeking behaviour will not be easy, and will require an emphasis on creating demand as well as improvements in the supply of services. Cost is sometimes an additional barrier to attending ANC with high informal charges being levied in some places.

Treatment seeking patterns and barriers

A common **pattern of treatment seeking** was apparent from the interviews. Decision-making, although formally resting with the husband, was often informed by his mother. The usual sequence of treatment seeking was: herbs and Quran related cures; buying drugs over the counter; then going to a health facility. Improved services at health facilities and a good supply of affordable drugs might cause some people to omit the first two resorts. On the other hand, herbs and over the counter medicines may be highly valued and the demand for clinic/hospital services not increased by the successful tackling of supply side issues. IEC promoting the early recognition of and quick response to danger signs will be key in encouraging people to make timely use of health facilities, even when they are distant from the village.

It was reported that the husband is the **decision maker with regard to health care** in the family. However, his mother appears to be the true 'power behind the throne'. Men talked about seeking 'advice' from their mother, but also doing what she told him without question. On the other hand, many men and women reported that there is no discussion between spouses on health-related issues, and that women do what they have been told by their husbands. The implication of this finding is that any community engagement approach aiming to increase knowledge and use of MNCH services should be aimed at three groups of people: older women (the mothers-in-law), men (the husbands), women of childbearing age (the mothers).

Two major barriers that prevent people from accessing MNCH care – **physical distance from a health facility and financial barriers** – are well known. They apply to conditions in Yobe State, as they do across Northern Nigeria and many other resource-poor, rural settings. The rapid assessment confirmed that physical and financial barriers are high. Lack of knowledge of danger signs is also a barrier, compounded by the physical and financial barriers.

Although it is now common parlance to describe villages as 'communities', the reality is that **each household head is on his own when it comes to raising cash for health care**. If an emergency occurs, cash must be raised quickly by selling assets and borrowing money. This strategy can result in hunger and long-term debt, plunging the family into chronic poverty. There were no community transport funds in the villages visited. However, there were some men's development associations, and these could potentially expand their operations to build up a fund for use in the event of a maternal emergency. Finding ways to support communities to devise their own solutions to financial and physical access barriers will be key to any community engagement strategy.

Demand Side Barriers to Utilization of MNCH Services Baseline Study – Zamfara

Introduction

A rapid social assessment of the factors undermining appropriate home-based care of pregnant women, new-borns and children, and timely utilization of MNCH services was undertaken on behalf of the Ministry of Health (SMOH) and State Primary Health Care Development Agency (SPHCDA) in Zamfara in January 2009, supported by PRRINN-MNCH. The aim of the exercise was to improve understanding of the MNCH challenges in the state and to support local stakeholders to begin the process of identifying potential solutions.

The rapid assessment exercise was carried out in three local government areas (LGAs) in the three senatorial districts of Zamfara. The LGAs were: Gummi in Zamfara West Zone; Birnin Magaji in Zamfara East Zone; and Tsafe in Zamfara central Zone. The fieldwork involved interviews with community leaders, including traditional leaders, and interviews and focus group discussions with married men, women of reproductive age, older women, traditional birth attendants, and women's group leaders. Health facilities and referral hospitals were visited and meetings held with Health Department representatives.

Findings and Implications

Cultural practices

While pregnancy was highly valued in the fieldwork communities, women, young and old alike, reported that they were not usually given special care or attention while pregnant. Women continue to shoulder their everyday responsibilities unless and until they are ill, and are not given special foodstuffs. Within Hausa-Fulani tradition 'weak women' tend to be a target for mockery and this, combined with poverty, and the practical difficulties associated with trying to single out a pregnant woman for attention within a polygamous household, explains the **tendency to down-play pregnancy**. This leaves women at risk of poor nutrition and over-work.

The **preference for home delivery** was widespread, if not universal. The reasons cited were confidentially and privacy at home, and because delivery was – most of the time – a 'normal experience'. Respondents also argued that fear of incurring large out-of-pocket expenses in a health facility acted as a further impetus to deliver at home. The fact that preference for home delivery is so deeply engrained implies that progress towards promoting institutional delivery for normal births is likely to be slow (and should therefore be seen as a long-term agenda).

The belief that women should not cry or shout out during labour, no matter what pain they find themselves in, was widespread. If women fail to adhere to this, they are considered weak and become figures of ridicule. This **resolve to manage labour alone** without recourse to assistance or fuss leaves women susceptible to life-threatening delays when a complication occurs. A slightly more lenient stance was taken in relation to young women who were considered to need more care, not because they were felt to be more at risk of developing a complication, but because they were inexperienced about labour and delivery.

As in other northern Nigerian states there are **traditional birth attendants** (TBAs) in some villages in Zamfara, but many are old and a new generation of TBAs has not emerged. These TBAs are said to have special knowledge of Qur'anic verses and herbs and plants of medicinal importance, which they can use to prepare concoctions for expecting mothers and for new-borns. Unlike other parts of Africa, the majority of TBAs in northern Nigeria do not assist women during delivery and are only called after the birth. At this stage they help to cut the cord, bury the placenta and bath the baby and mother. This limited role means it does not make sense to

centre awareness-raising about danger signs wholly around TBAs as they are usually not in the vicinity when a maternal complication occurs. A whole-community approach to awareness-raising on danger signs makes more sense in this context.

It is common for women to be bought meat and other special foods for several days after delivery. The **care of women after delivery** contrasts with the lack of care given during pregnancy, and is something that any awareness-raising intervention on maternal health can focus on as a positive approach.

Two practices – **consumption of large quantities of potash gruel and taking hot baths** – were said to be common after childbirth. Traditional hot baths, where women sit in or splash hot water over themselves for up to forty days after delivery, are thought to restore women's strength. However, within western medicine they are thought to be a contributing factor to the high rates of peri-partum cardiac failure among Hausa women in northern Nigeria. While the gruel is said to be very pleasant to eat, it has been associated in western medicine with increased strain on the heart. In combination with hot baths and underlying health problems such as anaemia and hypertension, the consumption of potash gruel has been associated with cardiac failure. Awareness-raising on the dangers associated with both these practices is likely to be more successful if their positive aspects – the emphasis on feeding women foods they like after delivery and regular bathing (but with lukewarm water) – are promoted.

New-borns were said to be 'precious gifts from God' who should be given adequate care. Often there is active management of the **baby's cord stump** until it falls off. This might involve warm compresses or applying herbal concoctions, both of which could result in infection. Whether or not the child is breastfed immediately was said to depend largely on the TBA's judgement. TBAs were said to perform a physical examination to decide whether the milk was fit for the baby's consumption. For most respondents immediate **breastfeeding** was not practiced – a delay of one or two days is made to allow for "purification" of the breast milk, while babies are given milk from domestic animals and shea butter. This deprives newborns of health-giving colostrum.

Knowledge and understanding of MNCH issues and services

There was a general belief that there is no need to have a baby checked by a medic after a successful home delivery. Almost all respondents indicated that **post-natal care (PNC)** was only necessary if there were signs that a child or its mother were in danger. Furthermore, in a context where women adhere to a lengthy period of resting and seclusion after delivery and do not usually move out of the community, facility-based PNC services are unlikely to be utilised. This presents a challenge for health planners.

Although many male and female respondents were aware of **common complications** such as bleeding before or after delivery, convulsions, retained placenta, prolonged labour and anaemia in pregnancy, some complications were not known or not recognised as a problem. For example, lower abdominal pain and bleeding after childbirth were considered normal, and fever after childbirth was considered a common sign of mild illness but not necessarily life-threatening. Yet all of these can be signs of sepsis and therefore potentially life-threatening. Severe pallor was seen by some as a sign of beauty attributed to pregnancy, and a symbol of general well-being. This **partial knowledge of danger signs** – and partial understanding of their severity– suggests vulnerability to potentially life-threatening delays when maternal complications occur. Although men are usually not present when women are in labour, as key decision-makers about women's health care they need to be aware of the danger signs and what they mean so that they can respond appropriately.

Knowledge of **new-born symptoms of illness and danger signs** was rather muddled, highlighting the importance of increasing communities' knowledge of common health problems and how best to respond. Newborn danger signs were said to include severe pallor, darkened skin, prominent veins on the abdomen, inability to cry, failure to suckle, excessive crying, difficulty breathing, and 'high fever'. These were variously associated with evil spirits, 'natural causes', or in many cases respondents did not know the cause. Beliefs about the causes of illness influence ideas about the most appropriate remedy (e.g. a spiritual remedy will be sought first if evil spirits are believed to have caused an illness). This introduces a delay in getting a new-born to a health facility promptly.

Treatment seeking patterns and barriers

Health-seeking behaviour in the event of a maternal complication was complex. In all the communities visited there were up to five different sources of assistance and treatment open to women and their families: TBAs (who could provide both herbal and spiritual remedies), Mallams (spiritual remedies), traditional healers (herbal remedies), patent medicine vendors, hospitals and health centres. Most respondents reported that they would use a combination of the informal sources of health care first, resorting to formal health care only once other options had been exhausted. **Convenience and cost** were the primary drivers behind these choices. MNCH services were reported to be grossly inadequate in the fieldwork sites. Respondents cited long distances to a functional health facility, inadequate staffing, long waiting times, poor staff attitudes, lack of female providers, health workers' poor knowledge, the patient's lack of familiarity with hospital environment, and inadequate supplies and equipment, as factors that delayed the decision to seek care in the formal sector, and which encouraged use of local providers who were cheaper and confidential, and could deliver services 'to the doorstep'.

There was a high level of acceptance of the value and usefulness of **antenatal care** (ANC). However, whether or not women actually utilised services was said to depend on a range of factors, including poverty, proximity to a health facility, long waiting times, and concerns about being seen by a male health provider. The implication was that if ANC services were available 'on the doorstep' and provided by the right type of provider, many more women would go. The decision about whether or not women go to ANC is usually taken by her husband, highlighting the important role that men play as gatekeepers to women's health. This highlights the need to treat men as a key target group for any community mobilisation around MNCH issues.

A **multitude of physical access barriers** contribute to delays in transferring a woman with a complication to a health facility. These include difficult terrain, seasonal lack of connectivity and lack of transport options, especially at night. Many of the communities were only visited by commercial drivers once a week on market day and had to rely at other times on oxen and carts, motorbikes and donkeys, which are either unsuitable for a woman experiencing a complication or are extremely slow. This highlights the importance of working with communities to devise locally appropriate, sustainable emergency transport options.

Lack of affordability of emergency maternal health care was said to be a major cause of delays in seeking appropriate treatment. Many households in the fieldwork sites were reliant on annual sales of agricultural produce, with male under-employment common at other times of year. Paying for health care was said to result in households drawing down their assets or being indebted, resulting in a deepening of poverty. Addressing the high cost of emergency health care requires action on a number of fronts. The feasibility of introducing free or subsidized emergency maternal health care services requires consideration by policy-makers. At the same time communities need to be supported to devise their own solutions to affordability issues, such as establishing community emergency loans and savings schemes.

Appendix 1

Acronyms and abbreviations

ANC	Antenatal care
BCG	Bacille Calmette-Guérin (vaccine against tuberculosis)
BEOC	Basic Essential/Emergency Obstretic Care
CBOs	Community Based Organizations
CEOC	Comprehensive Essential Obstretic Care
CHEW	Community Health Extension Worker
CSO	Civil Society Organization
DfID	Department for International Development
DHA	District Health Authority
DHIS	District Health Information System
DPT	Diphtheria, pertussis (whooping cough) and tuberculosis vaccine
DRF	Drug Revolving Fund
EDP	Essential Drugs Programme
EOC	Essential/Emergency Obstretic Care
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunisation
HDCC	Health Data Consultative Committee
HF	Health Facility
HMIS	Health Management Information System
HRH	Human Resources for Health
HSR	Health Sector Reform
ICC	Inter Agency Coordinating Committee
IFAD	International Fund for Agricultural Development
IPD	Immunization Plus Days
IMCI	Integrated Management of Childhood Illnesses
LG/LGA	Local Government/Local Government Area (or Authority)
LSS	Life Saving Skills
M&E	Monitoring and evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MLM	Mid-level manager
MNCH	Maternal and Newborn Child Health
MoH	Ministry of Health
MOU	Memorandum of Understanding
MSP	Minimum Service Package
MSS	Midwifery Service Scheme
NGO	Non-Governmental Organization
NIA	National Immunisation Advisor
NPHCDA	National Primary Health Care Development Agency
NPI	National Program on Immunization
PATHS2	Partnership for Transforming Health Systems2
PHC	Primary Health Care
PNC	Post-natal care
PPRHAA	Peer Participatory Rapid Health Appraisal
REW	Reaching every ward
RI	Routine Immunisation
SBA	Skilled Birth Attendant

SDMA	Social Development and Mobilization Advisor
SDSS	Sustainable Drug Supply System
SEEDS	State Empowerment and Economic Development Strategy
SIA	Supplemental Immunisation Activities
SIACC	State Inter-Agency Coordinating Committee
SMoH	State Ministry of Health
SM	Safe Motherhood
SOP	State Operational Plan
SPHCDA	State Primary Health Care Development Agency
SSMO	State social mobilization officer
SSP	State Strategic Planning
STA	Senior Technical Advisor
STM	State team manager
TBA	Traditional Birth Attendant
TAG	Technical Advisory Group
TFI	Immunisation Task Force (WHO)
TOR	Terms of reference
TOT	Training of trainers
WHO	World Health Organisation

Appendix 2

Participants and attendees at the baseline studies review meeting, Kano 1-2 June 2009

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Hussein Mursal	Country Director, SC UK
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Jan Hofman	LATH/LSTM
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Jenna Treen	UK Programme Support Manager, HPI
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Appendix 3

MINUTES OF THE BASELINE STUDIES REVIEW MEETINGS

Tahir Guest Palace, Kano
01-02.06.2009

Introduction (Bryan Haddon)

This review has three main purposes:

- To provide the current status of baseline indicators and to compare with and complement the findings of the 2007 PRRINN baseline studies.
- To enable the programme to refine its approach, strategy and plans.
- To support stakeholders, especially at the state and LGA levels, in their MNCH services development agenda.

The discussion following the initial presentations will focus on clarifications, with the opportunity to discuss details during the second day when the states give presentations.

1. BASELINE STUDIES REVIEW PRESENTATIONS

1.1. Demography presentation (James Phillips and Alastair Ager)

Key points of subsequent discussion:

- This is a **population-based survey** so not focused on a particular LGA. Samples are focused on priority areas – cluster areas where the programme is investing particular effort. Advantage of a population-based survey is that it shows typical data re women's experiences. Disadvantage that doesn't give detailed facility information (other than women's reports on this).

- Although **financial constraints** preventing access to health services were not tabulated for this presentation, this is a key issue and is covered under the demand side review.

- **Maternal mortality** was not covered in the presentation as not possible to measure accurately with this particular tool. However, a smaller, more intense demographic survey (HDSS – see HMIS summary) is planned in Zamfara, which will provide direct estimates of maternal mortality. Very soon the team will be able to map this with new technology, to look at causes and how these could be changed with specific project interventions.

- Important to recognise that the survey could not cover every aspect of maternal, newborn and child health in great detail – each interview already takes 1-1.5 hours and decisions had to be made about **what to include and what to exclude in interviews**.

- To check **validity of responses re immunisations** given (e.g. DPT3 mentioned as though administered at home when can only be administered in a health facility or outpost), procedures were used which allowed the working out of antigen coverage by exact age.

- Data collected includes the **socio-economic background of households** so it is possible to analyse data in these terms, e.g. to identify the backgrounds of women with few or no maternal or child deaths or morbidity problems.

- Further **data cleansing** will take place before the final report. Clarifications will also be made e.g. splitting out multiple and single immunisations in table on source of immunisations (Table 10 in presentation).

- Encouraging to see evidence of knowledge/implementation of **essential newborn care practices** which can be provided at home even without skilled assistance, e.g. wrapping, warming, clean cord care.

1.2. Human Resources presentation (Margaret Caffrey)

Key points of subsequent discussion:

- Important to ensure the **quality of curriculum** for health workers, not just the quality of physical infrastructure. Training must be improved to ensure not only the full accreditation of training institutions but also that the products of the institutions have the capacity and competencies to deal with prevailing health challenges.

- Although **short-term** measures to address immediate shortages, such as the Midwifery Service Scheme (MSS) designed to recruit midwives into placements in remote areas, are welcomed, it is imperative to also address **longer-term** shortages.

- There is **limited HR capacity at all levels** so the programme is here to support all states to develop improved HR management capacity.

1.3. MNCH service delivery presentation (Jan Hofman)

Key points of subsequent discussion:

- This survey focused on assessing facilities rather than users' perspectives on quality of care, so **exit interviews** were not practical in this case. Exit interviews are included in PPRHAA each year in any case.

- **Mobile clinics** were not assessed here as the survey focused on static clinics. However mobile clinics are also useful as a temporary measure to deal with HR shortages, and we need to monitor what services they are providing and of what quality.

- Important to consider population density regarding distribution of facilities, to ensure **equity.** Services tend to be concentrated in urban areas, meaning rural areas are under-served.

- Survey found overemphasis on **hospitals** for ANC and deliveries, and lack of focus on ensuring MNCH care is available at **PHC centres**.

1.4. Sustainable Drug Supply Systems (SDSS) presentation (Monday Egume)

Key points of subsequent discussion:

- Clarification that SMS in presentation refers to **State Medical Store** not Central Medical Store.

- Although there are some **choices** re accessing drugs, choices are not totally free as they are operating within the established model.

1.5. Demand side barriers presentation (Cathy Green)

Key points of subsequent discussion:

- Not really possible here to provide specific examples of **positive deviance** in behaviour patterns or attitudes that could be built on, as requested, as these findings are comprehensive not indicative. Such differences tend to happen in communites close to the government centre, and the research teams gave priority to more distant communities in this instance. **However, looking further at why some women are able to access services and why some others cannot is an important issue the team will be working on.**

- As the majority of deliveries currently take place at home, and many women currently express a **preference for home deliveries**, the programme needs to explore how we can support women in this context. Not seeking to make all women deliver in facilities, but rather to ensure universal access to emergency obstetric care for the minority of births that are problematic. **Possibility of a community-based service delivery model, initially tested in one state**. Need to consider who would provide this service given the current lack of female CHEWs – would it be better to train CHEWs to support women at community level or to focus on upgrading their skills to work in health facilities?

- As the role of **Traditional Birth Attendants (TBAs)** is mainly post-natal they may not be able to help reduce maternal mortality, except to some extent if it is possible to use them as referral agents – to educate them to recognise danger signs and advise.

- Where facility-based ANC is not being fully accessed, **ANC outreach visits** also provide opportunities to give some vaccines and education on clean cord care and breastfeeding.

- As well as addressing financial and geographical barriers to access, it is also imperative to consider **social barriers to access** and in particular the importance of education for women on the danger signs of pregnancy.

- There are now **four barriers** instead of the traditional three barriers. These are: (1) Recognition of the danger signs; (2) Decision making at the household/community level; (3) Transportation/physical barriers; and (4) Quality of care at the facility level.

- The **long-term agenda** should focus on education of the girl child, empowering women, and improving the rural road network.

1.6. Health Management Information Systems (HMIS) presentation (Vincent Shaw)

Key points of subsequent discussion:

- There is a lack of suitable **forms in health facilities** and confusion over who is responsible for providing these *(see section 2.2. below).*

- **Supportive supervision** for M&E officers is necessary to ensure quality of data – need to consider this in financial planning.

- Currently most CHEWs and other workers do not have HMIS skills. To address issue in the longer-term, need to encourage states to start **schools of medical records** to produce personnel with HMIS skills.

1.7. Governance presentation (Andrew McKenzie)

Key points of subsequent discussion:

- As part of the minimum service package, it is crucial to consider **access issues beyond direct financial costs**, especially for the poorest and socially excluded. However there is also a need to be realistic and flexible about what's feasible and what each state will be able to provide.

- 'Free MNCH services' still subsidises the rich through corruption. Can we work on **deferrals and exemptions**?

- **HR issues** are perhaps the biggest challenge for the programme. The previous presentations show this is well understood and is clearly not confined to the health sector, making it more difficult for the MOH to address. It is a complex issue with no easy answers. In the **short term**, establishing state level forums helps to give politicians specific information about the extent and nature of the problems and what actions are required. For the **medium and longer term** it is necessary to shift the focus of medical schools from fees to needs, and to focus on retraining and redistribution of staff.

- Based on the evidence so far, the prospect of **voters acting as a pressure group** to hold state and local governments to account for policies and budgets is theoretically possible although seems fairly unlikely in practice.

- Need to consider the many **different players who have power to influence health** or to influence the people who make decisions on health, and how to engage them and where appropriate bring them together on key issues.

- Findings show **key areas** to address within states: policy, budgets, and Public Finance Management (PFM).

2. STATE FEEDBACK PRESENTATIONS

2.1. Zamfara

Clarifications from Zamfara group on presentation:

- The training for CHEWs should be **MLSS** not ELSS.

- The presentation should have referred to **FMOH/NPHCDA** not just FMOH.

Key points of discussion:

- In order to **increase awareness** of MNCH, as well as seeking to engage traditional and religious leaders, could also include the Ministries of Rural Affairs and of Women's Affairs.

- As there are so many dilapidated health facilities the focus is on **renovation of existing facilities**, although in some areas construction may be required.

- Need to ensure effective **division of responsibilities** for action plan between state and PRRINN-MNCH.

2.2. Katsina

Key points of discussion:

- It was confirmed that the programme would provide Katsina with **HMIS forms** as a priority, and an apology was offered for the unintended delay in doing this.

- The name of a **midwife training scheme** is not important but rather the quality of training provided. Past incentive schemes for midwives have been unsuccessful so it is imperative to look at appropriate approaches for each state.

- Baseline studies have shown that key stakeholders include **husbands and gatekeepers** (e.g. mothers-in-law), so it is vital to develop strategies to address this key group. It was raised that the methods proposed in the Katsina presentation had had limited impact in Jigawa, where the demand side challenges seem very similar.

- Given that a huge proportion of current health service staff are not health workers, and that not all untrained staff can go into the CHEWs programme, the possibility of introducing an entry-level qualification for basic PHC care should be considered. However, it would take three years to get an **intermediate cadre** of workers into the system, so there is also a need for short-term strategies to address immediate needs. Further, there are already trained health workers who are currently unemployed and have not entered the health system.

2.3. Yobe

Clarifications from Yobe group on presentation:

- The group did not have time here to cover **governance** or **PFM**, however are aware of the importance of acting to improve both.

- MNCH strategy is to rehabiliate not only hospitals but also **PHC facilites** which are the main source of PHC and MNCH care.

Key points of discussion:

- Yobe representatives plan to **visit Jigawa** state to learn from their experiences.

- The Commissioner and Minister for Health have said they will now start addressing the issue of **trained but unemployed midwives** – need to establish costing for this.

- As well as filling staff gaps, it is also vital for the state government to **upgrade facilities at schools of nursing** and midwifery.

- There is an urgent need for accreditation of hospitals in Yobe to provide **housemanships**. There are currently over 150 medical students in Yobe whose training the state has invested in, but who will be unable to stay and work in Yobe after graduating as there are no hospitals there providing housemanship placements.

- A meeting is planned to address **demand-side issues** raised with the Ministry of Women's Affairs, the MOH and local government (who are already collaborating in this area).

3. SYNOPSIS AND DISCUSSION

Key points of discussion:

- Whilst the proposed Memoranda Of Understanding (MOUs) between programme and states on specific activities are welcomed, it is important they are understood to be a political tool and are not made too big or complicated which may slow their passing by the Ministry of Justice.

- The possibility was raised of turning this forum into an annual event – to give states and stakeholders opportunities to listen to and challenge one another, and to hold each other to acccount over progress made. There are however budgetary and time considerations with holding events of this size which require careful assessment.

4. NEXT STEPS/CLOSING REMARKS

- PRRINN-MNCH planning meetings on 4-5 June will revise plans and budgets for 2009, based on the outcomes of the baseline review. States can then commence planned activities and incorporate report findings to ensure activities in 2009 and 2010 make the most of all opportunities.

- The baseline review reports should be completed by the end of July, and a summary report will then be compiled and made available to all stakeholders.

- The meeting's Chairman, Dr Idris Garba, thanked everyone for attending and noted that the bringing together of so many stakeholders over the last two days shows great commitment and indicates a bright future.

- Carolyn Sunners of DfID wished to reiterate how enthused she is by the events of the last two days and that attending an event like this is inspiring. She thanked all stakeholders for taking the time to attend which is much appreciated.

Appendix 4

Presentations from baseline studies meeting
(available on request)

Outputs
Governance presentation
Human resources presentation
MNCH service delivery presentation
Demography presentation
Sustainable drug supply system presentation
Health management information system presentation
Demand side presentation

States
Katsina state presentation
Yobe state presentation
Zamfara state presentation