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

PRRINN-MNCH Baseline Studies 2009

Summary Report

Katsina

2 Mallam Bakatsine Street
Nassarawa GRA, Kano
Kano State
Nigeria

Save the Children UK

Health Partners INTERNATIONAL

GRID Consulting Limited

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Introduction

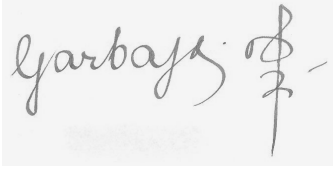
The PRRINN-MNCH programme is working to strengthen maternal, newborn and child health services within Katsina, Yobe, Zamfara and Jigawa states. All four states experience higher than average rates of maternal and child mortality, and high rates of poverty. In 2007 the DfID-funded PRRINN programme was 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.



Dr Garba Idris
National Program Manager
PRRINN-MNCH

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.

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*.

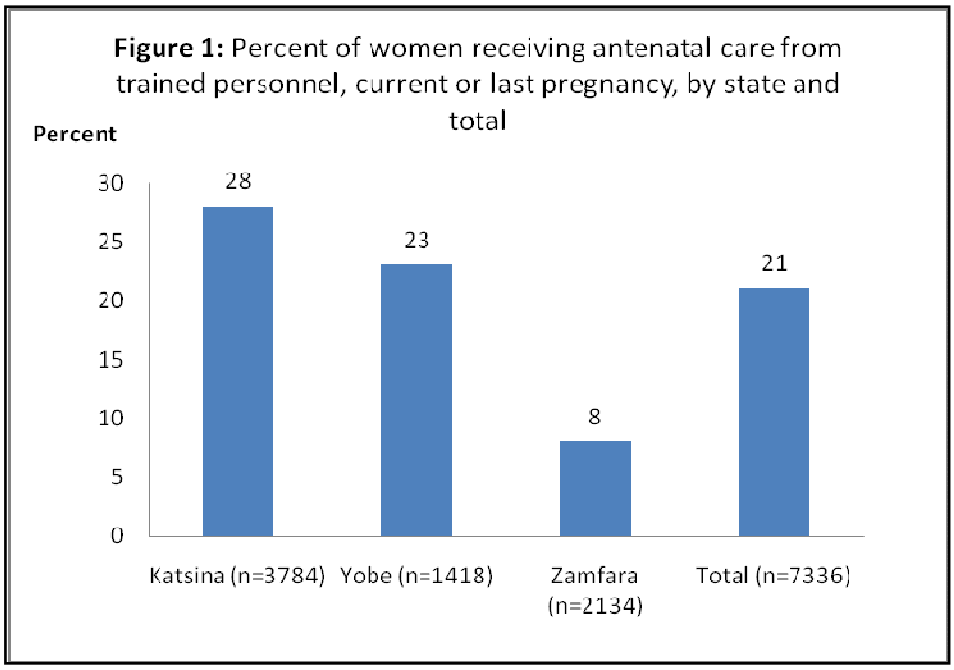
Questionnaires were translated into the local language (Hausa) in order to ensure clarity and standardisation of questionnaire administration. Interviewers were trained on dialects and pronunciation of local terms before conducting the interviews in April-May 2009.

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

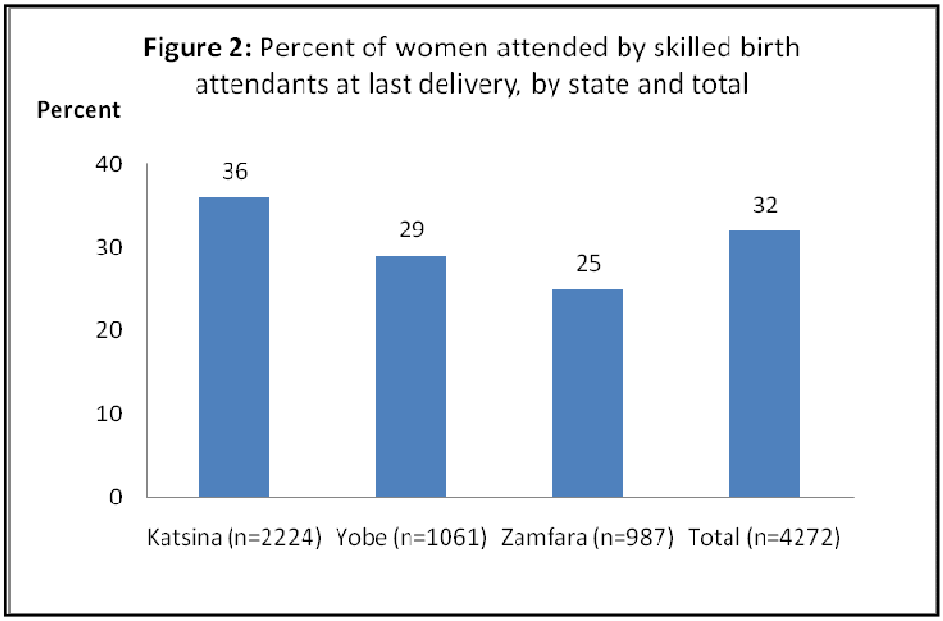
Antenatal care services can help ensure both healthy pregnancies and safe deliveries. Figure 1 shows the percentage of women who received antenatal care (ANC) by trained personnel during their current (at the time of the survey) or last pregnancy. This was calculated as the percentage of women who received <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.

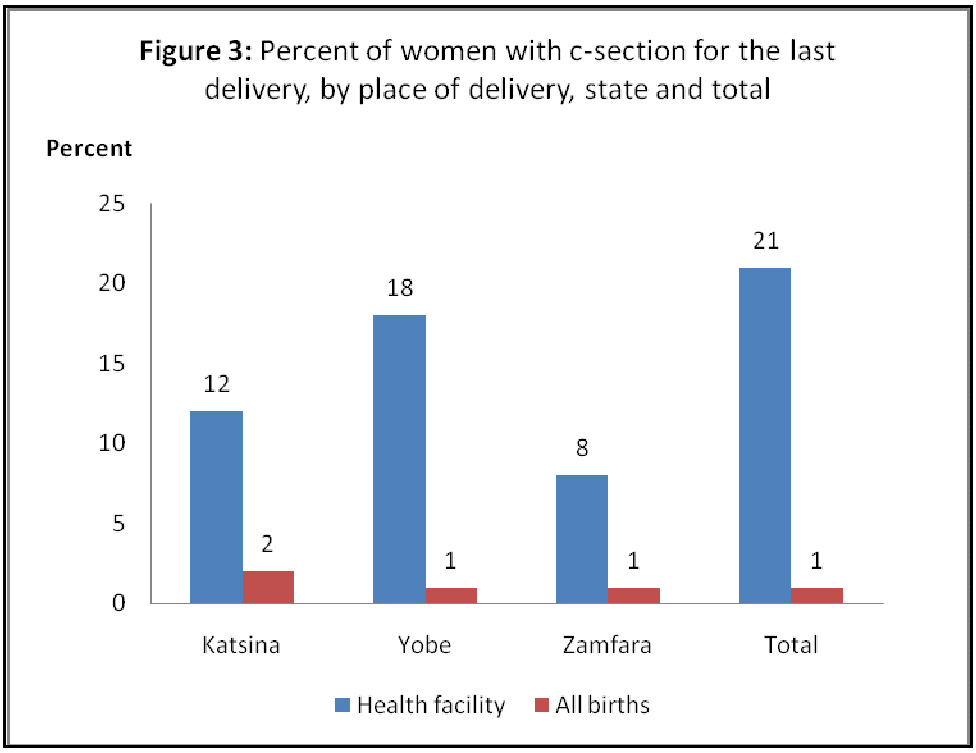
Assistance and medical care at delivery

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

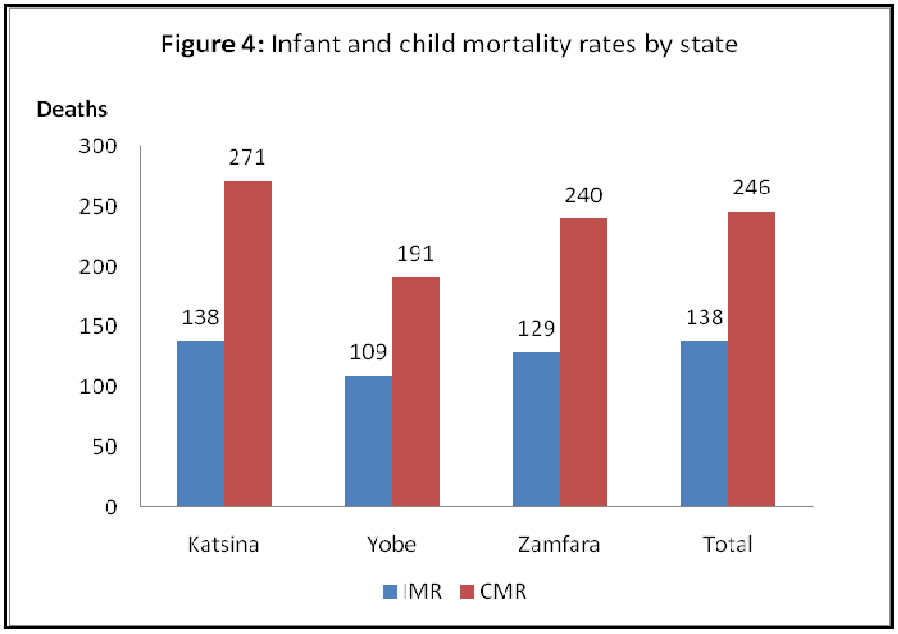
The percentage of pregnancies with delivery by caesarean section (c-section) were analyzed in two categories: percentage of c-section at any health facility and percentage of c-section of all deliveries.



Infant and child mortality

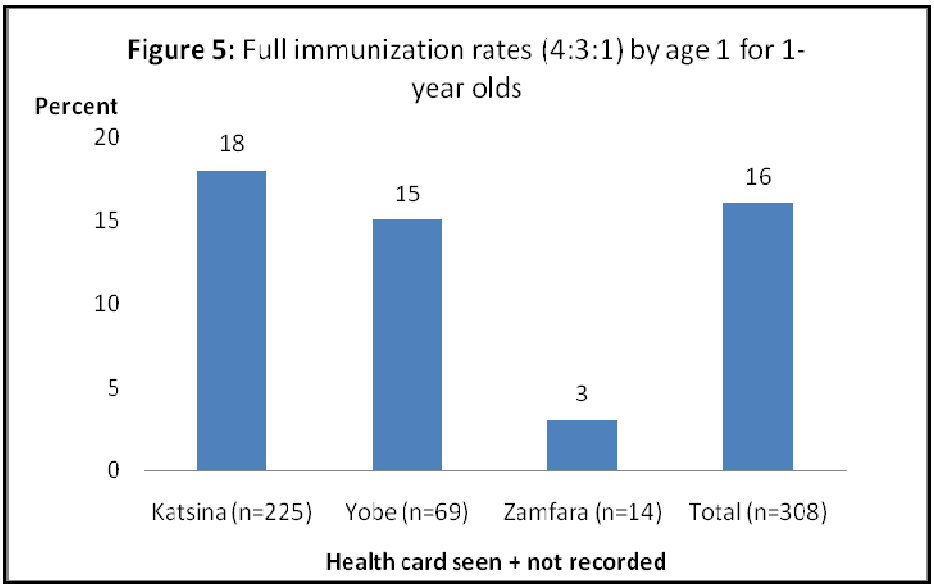
Estimates of infant and childhood mortality are based on information from the birth history section of the questionnaire administered to individual women. For each birth reported, more detailed information was then collected on the child's sex, age in completed years, whether the child was still alive,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



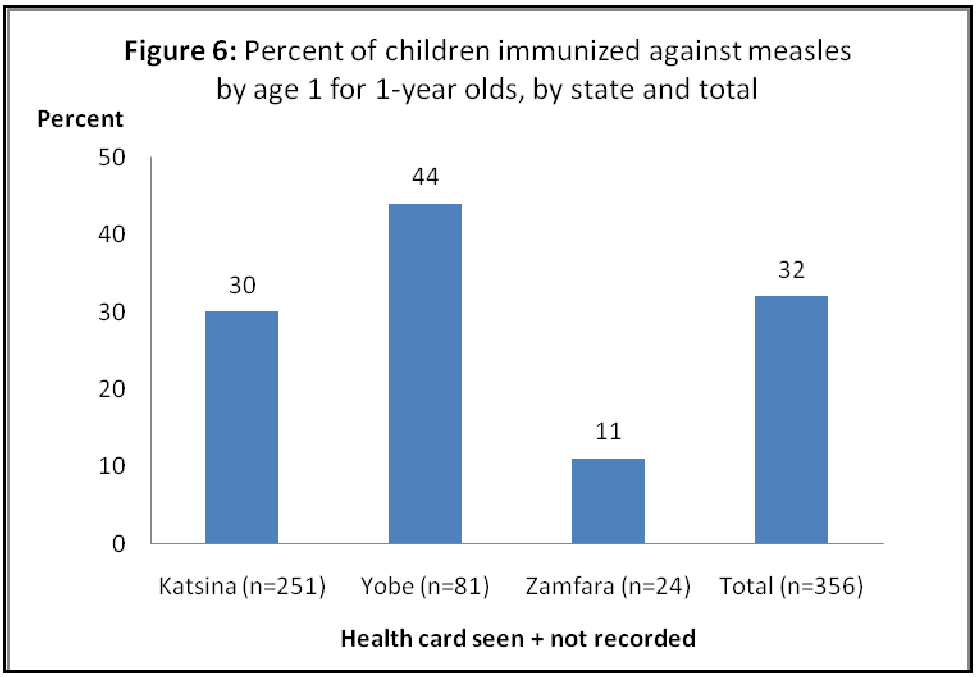
Full immunization by age 1

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.

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.

KATSINA STATE PRESENTATION

PRRINN-MNCH Baseline Studies Review
1st-2nd June 2009. Tahir Hotel, Kano.

Katsina State Group Work on State MNCH constraints and priority interventions

1. HUMAN RESOURCE

HR Challenges

1. Inadequate number of qualified Health personnel at post especially
    a. Doctors
    b. Midwives
    c. Female CHEWs
2. Mal-distribution of qualified of health personnel to the disadvantage of rural areas and lower levels of care
3. Retention of specialists/consultants in hospitals
4. Training Institution

Pre-Service Training:

- staffing – lack of tutors
- improving curriculum
- teaching aids and equipment
- Intakes number limited by Council ('pegging') not meeting requirements of the State
- Infrastructure – classroom and accommodation

5. Strategic HRM – weak strategic capacity, structures and frameworks to guide HR interventions
6. HR Dept- weak capacity – staff shortages, lack of skilled HRM staff
7. Difficult to scale up IST

Activities to address challenges

SHORT-TERM MEASURES

1. In-service training being conducted (with Federal support) but needs to be scaled up. Federal Ministry have done TOT in Katsina (on some of the areas below), these trainers should cascade training to lower levels (targeting TBAs, Headmasters, Community Resource persons, etc)
    - MLSS & EMONC training for CHEWS
    - LSS and EMONC for midwives
    - ELSS for doctors
    - Community and facility based Essential Newborn Care
    - IMCI case mgt training for Doctors and CHEWS
    - Community IMCI training
    - PMTCT
    - IYCF –Infant and young child feeding (nutrition)
    - Family Planning
2. Midwives service scheme to start in July – 6 clusters per state – 4 PHC facilities and 1 GH per cluster, 4 mws per PHC facility to target unemployed and retired mws, same conditions of

service as other mws on fixed contracts.LGA will provide housing – could be linked to MNCH Programme Clusters

3. Develop strategic HRM capacity, structures (HR Dept) and develop strategic frameworks/plans to guide HR interventions
4. Strengthen and utilise existing HR Dept to plan, manage and develop HRH – could develop HR Strategic Plan
5. Inclusion and formalisation of TBAs within the health system?? TBAs are being trained to counsel pregnant women and on newborn care, but they are not fully utilised....some LGA Chairmen want to use and pay TBAs but they are not recognised within the civil service scheme. Midwife service scheme intends to utilise TBAs as link between facility and community based service provision. Need to be trained and be clear about the role of TBAs. Retention of TBAs especially those who volunteer – once knowledge is transferred to community volunteers not needed so much so retention not a big problem

LONG-TERM MEASURES

1. Create another intermediary cadre – such as a community/MNCH midwife/Safe Motherhood Assistant- direct entry with 2/3 yrs training – need to consider the Council's resistance to the use of the title 'midwife' used for this new cadre – target those living/settled in the LGA HQ AND Ward HQ. Will be trained through formal training programmes in the training institutions. Develop curriculum and job description (standing order outlining their role and responsibilities. They will be bonded for a specific number of years – 2 yrs of service.

Attract and retain tutors – have provided improved salaries and have advertised for tutors - sent some for training

2. MNCH Delivery

Challenges:

1. Facilities for MNCH services not user friendly (inadequate equipment and infrastructure, electricity and water, no staff housing,
2. Poor staff attitude – poor performance and low workload/output
3. Weak referral systems
4. Constraints to access – distance, roads, public transport (RAFS), cost, cultural, information
5. Waste management poor

Activities/interventions to address the service delivery challenges

SHORT-TERM MEASURES

1. Strengthen and sustain free MNCH services for pregnant women and under 5s at PHC level
2. Strengthen referral systems e.g.
    a. Transport - ambulances? Use public transport (partnership with unions of road transport workers to provide transport for pregnant women who need emergency care in facility) for referrals
    b. Communication?(telephones)
    c. training TBAs to identify danger signs and refer,
3. Access – mobile ambulance services for rural areas, empowering female clients,

4. Minimum service package (MSP) to be Strengthened and implemented
5. Strengthen inter-sectoral collaboration e.g. sanitation and water, education, women's affairs, transport and housing , finance and budgets
6. Reorientation of hws to improve attitudes through IPC&C training, sanctions for poor performance and continuous education and training, reward good performance (e.g. promotion)

LONG-TERM MEASURES

1. Adequate funding for rehabilitation of facilities & supply of equipment

SUSTAINABLE DRUG SUPPLY SYSTEM

Challenges:

1. Poor drug (including consumables) supply & quality (fake drugs, availability, sustainability)
2. Poor storage facility at the LGA
3. Distribution
4. High cost of (branded) drugs
5. Lack of compliance to procure drugs on essential drug list at LGA level
6. Inadequate numbers of pharmacy staff (pharmacist/pharmacy technicians)
7. No regulation of traditional medicine practice

Activities to address challenges with DSS

SHORT-TERM MEASURES

1. Finalise and implement Katsina workplan on SDSS
2. Quantify and cost (and prioritise for Ward level PHC) the drug requirements for free MNCH services and source funding to procure sufficient stocks
3. Support the functioning (administrative costs, guidelines and procedures, etc.) of a **separate** Revolving Drug Funds at State & LGA level (involve local government inspectorate)

LONG-TERM MEASURES

1. Establish Central drug distribution point/market to reduce problem with fake drugs and improve distribution
2. Establish Traditional Medicine Board
3. Finalize the establishment of a Drug Management Agency

DEMAND SIDE

Challenges

1. Poor health seeking behaviour & utilisation
2. Cultural barriers and inhibitions (e.g. women's ability to make decisions and negotiate, female health providers, traditional medication, early marriages,)
3. Lack of knowledge on MNCH care e.g. ANC, danger signs, immunisation, prenatal care
4. Lack of education and literacy
5. Lack of supplies for services
6. Communication for health promotion
7. Poverty

Activities to address challenges

SHORT-TERM MEASURES

1. Promote girl child/basic education in collaboration with MoE and Women Affairs & NGOs
2. Health Promotion/Communication on danger signs
3. Train health promoters – peer groups at community level on danger signs, RI, manage vaccine reactions,
4. Use mass media (radio spots) and traditional methods of communications to get out key messages e.g. on danger signs etc.

LONG-TERM MEASURES

1. Women empowerment e.g. microcredit, training
2. Developing voice and accountability to improve services

HMIS/M&E

Challenges

1. No HMIS policy and planning
2. Resource constraints – human, financial and material
3. Processes –collection, collation, analysis, presentation/dissemination, interpretation, use, & feedback
4. Quality & integration

Activities to address HMIS challenges

SHORT-TERM MEASURES

Translate and adapt Federal policy to develop a State level HMIS Policy and implement to:

   a. Provide guidelines on how information is shared
   b. Central Clearing House
   c. Improve/strengthen information flows between PHC levels and state

2. Establish and inaugurate HDCC – Health Data Consultative Committee - to coordinate and harmonise health information mgt within the State
3. TOT for State HMIS officers to cascade training to lower levels – LGA M&E officers, records officers and OICs
4. Advocacy at state and local level to implement national policy e.g. only 2 of the sample 9 LGAs met criteria for HMIS
5. Train managers on the use of monitoring tools for ISS
6. Undertake Data Quality Assessment on a quarterly basis
7. Conduct state level quarterly review and monitoring meetings to review HMIS data

LONG-TERM MEASURES

8. Procure computers and install software and provide training at zonal & LGA levels to manage and maintain information systems
9. Address supply constraints e.g. printing & distribution of data collection tools (forms), include forms to be used at community levels

Governance

Challenges

1. Translating political commitment into action
2. Undocumented policies
3. Multiple agencies responsible for PHC services
4. HR challenges –
5. Recurrent expenditure:
    a. Decision makers not adequately informed to effect release of funds
    b. Inadequate provision of funding for recurrent services/activities

Activities to address challenges

1. Update and document policies in collaboration with stakeholders – translate Federal level policies to State specific policies
2. Advocacy on the issues supported by data and plans to effect the release of funds
3. Advocate for improved levels of recurrent funding and reporting/accounting systems
4. Systems in place to reassure decision makers that funding will be used as intended.

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

Abubakar Kehinde	STL PATHS2, Jigawa
Adamu Garba Abubakar	HMIS Office SMOH, Jigawa
Ahmad Abdulwahab	State Team Manager, Zamfara, PRRINN MNCH
Aisha H Godowori	PS, M.OWA Yobe
Aisha S. Abubakar	Midwifery Advisor, PRRINN MNCH
Alh. Abubakar Anka	Director Statistics, Zamfara
Alh. Idrisa A B.	Hon. Commissioner for Health, Yobe
Alistar Ager	Professor, Columbia University
Andrew McKenzie	Senior Technical Advisor, HPI
Anita McDuke	Administrator/Logistician, PRRINN MNCH
Anne McArthur	Senior Technical Advisor, PATH
Anthony Aboda	MNCH Adviser, PRRINN MNCH
Apera Iorwakwagh	Business Manager, SC UK Nigeria
Bello Ado Madak	DAF, Gunduma Health, Dutse
Ben Anyene	National Immunization Policy Advisor, PRRINN MNCH
Binta A. Ibrahim	PS MOWA
Binta Ismail	NPHCDA Abuja, CMCHO
Bryan Haddon	Chair, PRRINN-MNCH Program Management Board, HPI
Bulama U. S	DPRS SMOH Yobe
C. M Akinsami	CWO, FMOH, FHD
Carolyn Sunners	Health Adviser, DFID
Cathy Green	Senior Technical Advisor, HPI
Cohham Nsa	SS Consultant
Dr. A. Tanimu	P.S MOH, Katsina
Dr. A.R Adeniran	Deputy Director, FMOH, FHD
Dr. A.T Gidado	MOH Katsina
Dr. Garba Idris	National Programme Manager, PRRINN MNCH
Dr. Habibu Yalwa	Hospital Service Board, Gusau
Dr. James O.I	MO/RH FMOH, Abuja
Dr. Joy Ufere	FMOH, Abuja
Dr. Jurgen Schmidt	Consultant, HPI
Dr. M.A. Kaiuwa	Director of Planning, SPHDA Jigawa
Dr. M.S. Bello	Rep. DHPRS/FMOH
Dr. Ma'awuya Aliu	DPHC
Dr. Matazu U. M	State Program Officer, Zamfara, PRRINN MNCH
Dr. S.M. Chiromari	Special Adviser, Yobe
Dr. Sa'ad Idris	Hon. Commissioner for Health, Zamfara
Dr. Said Ahmad	Senior State Program Officer, Katsina, PRRINN MNCH
Dr. Saka	HERFON, Abuja
Dr. Sam Bugri	State Team Manager, Katsina, PRRINN MNCH
Dr. Shehu Sule	Governance Advisor, PRRINN MNCH
Ebenezer Ajimoku	Senior Technical Advisor, GRID
Emmanuel Sokpo	Health Systems Management Advisor, PRRINN MNCH
Eric Amuah	State Team Manager, Yobe, PRRINN MNCH
Eve Surddey	SC UK
Giorgio Conetto	Deputy Head Health, SC UK

H.H Musa	ABU, Zaria
Hafsat Baba	POD, Katsina
Hajia Wasilat Giwa	Director, CSG NPHCDA
Halilu H Bakura	Zamfara DPHC Min. for L. G
Hussein Mursal	Country Director, SC UK
Ime Asangansi	Consultant, HISP
Jan Hofman	LATH/LSTM
Jeff Mecaskey	Managing Director, HPI
Jenna Treen	UK Programme Support Manager, HPI
Jim Phillips	Senior Technical Advisor, Columbia University
Jody Williams	Project Support Officer, HPI
Kanir Lawal	Ministry for LG, Katsina
M.D. Egume	Director, GRID
Margaret Amshi G.	POS, PRRINN MNCH
Margaret Caffrey	Senior Technical Advisor, LATH
Michael Siebert	Senior Technical Advisor, HPI
Mohammed Qabasiyyu	SPHCDA Katsina
Mohd Lawal Aliyu Mni	PS Ministry of Finance Katsina
Nana Enyimayew	Health Systems Consultant, HPG
Oma J. Asu	SS Consultant
Pat Okonji	GRID Consulting
Pieter De Ruijter	Technical Advisor, HPI
Prof. K Sabitu	ABU, Zaria
Radheshyam Bairagi	Columbia University
Rodion Kraus	Deputy National Program Manager, PRRINN MNCH
Sabiu Ahmed Koki	SS Consultant
Salma A. Mijinyawa	POD, PRRINN MNCH
Sani Chamba	D.S.S
Sani Musa lawal	Hon. Commissioner for Budgets, Yobe
Sani Musa Lawan	Ministry of Budget, Yobe
Saude M. Tasiu	State Program Officer, PRRINN MNCH
Simon Amase	SS Consultant
Solomon Mengiste	State Team Manager, Jigawa, PRRINN
Solvi Taraldsen	DFID
Susan Aradeon	Communication Adviser, PRRINN MNCH
Tolu Aduloju	Program Officer, GRID
Tony Klouda	Senior Technical Advisor, SC UK
Tukur Umar	Hon. Commissioner, MLG & LA
Usman A. Tahir	DPME GHSB, Jigawa
Vincent Shaw	Senior Technical Advisor, HISP/University Oslo
Yusuf Yusufari	State Program Officer, Yobe, PRRINN MNCH
Zainab Abdul	POD, Yobe, PRRINN MNCH
Zainab Y. Dari	PS MOWA

Appendix 3

Documents 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

Minutes of the meeting