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

PRRINN-MNCH Baseline Studies 2009

Summary Report

Yobe

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Contents

Introduction

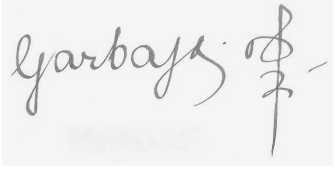
The PRRINN-MNCH programme is working to strengthen maternal, newborn and child health services within Katsina, Yobe, Zamfara and Jigawa states. All four states experience higher than average rates of maternal and child mortality, and high rates of poverty. In 2007 the DfID-funded PRRINN programme was 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 – 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[1]
- 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

[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

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.

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*.

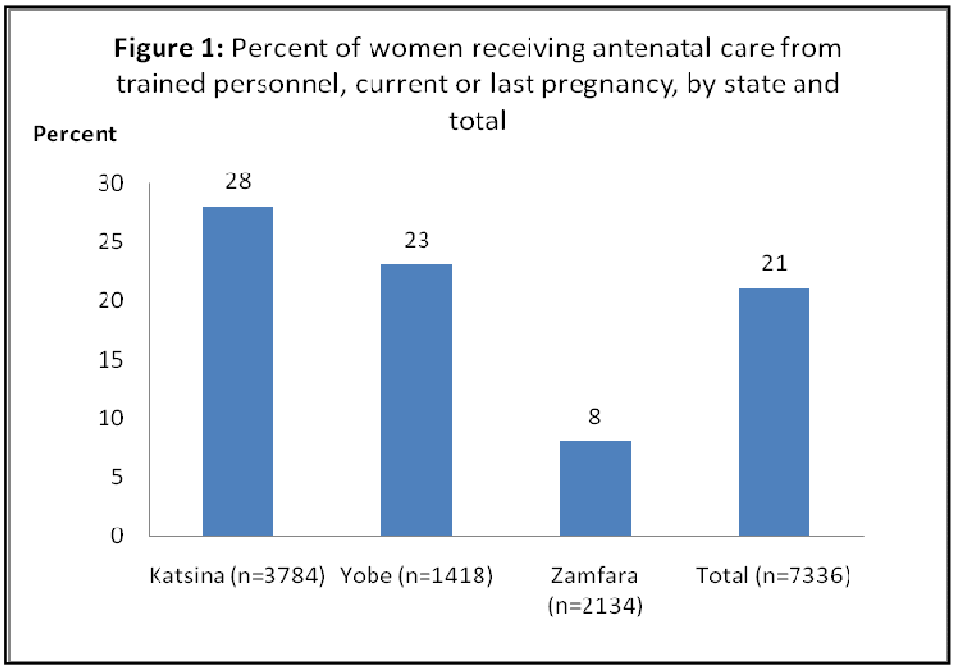
Questionnaires were translated into the local language (Hausa) in order to ensure clarity and standardisation of questionnaire administration. Interviewers were trained on dialects and pronunciation of local terms before conducting the interviews in April-May 2009.

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

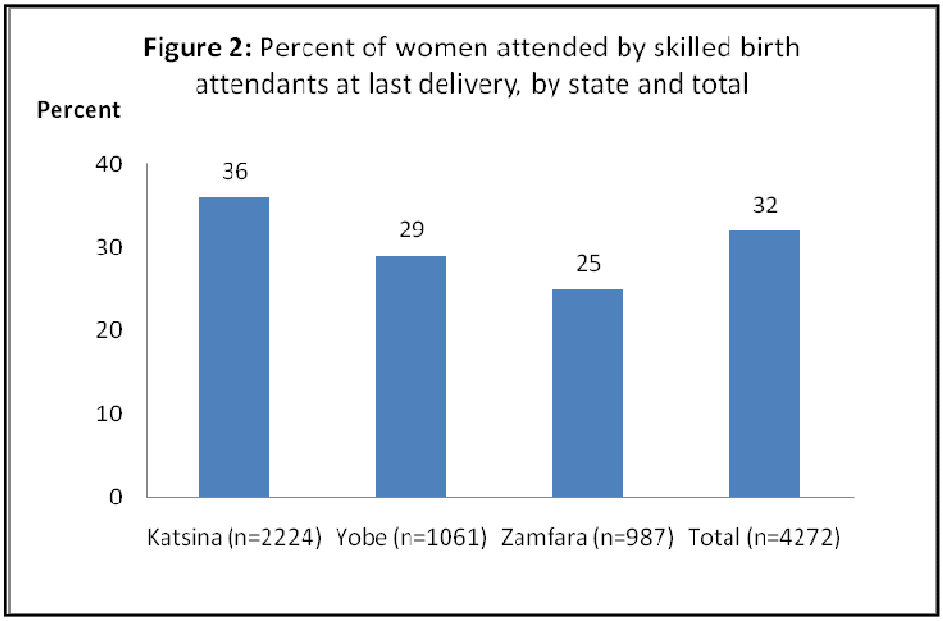
Antenatal care services can help ensure both healthy pregnancies and safe deliveries. Figure 1 shows the percentage of women who received antenatal care (ANC) by trained personnel during their current (at the time of the survey) or last pregnancy. This was calculated as the percentage of women who received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

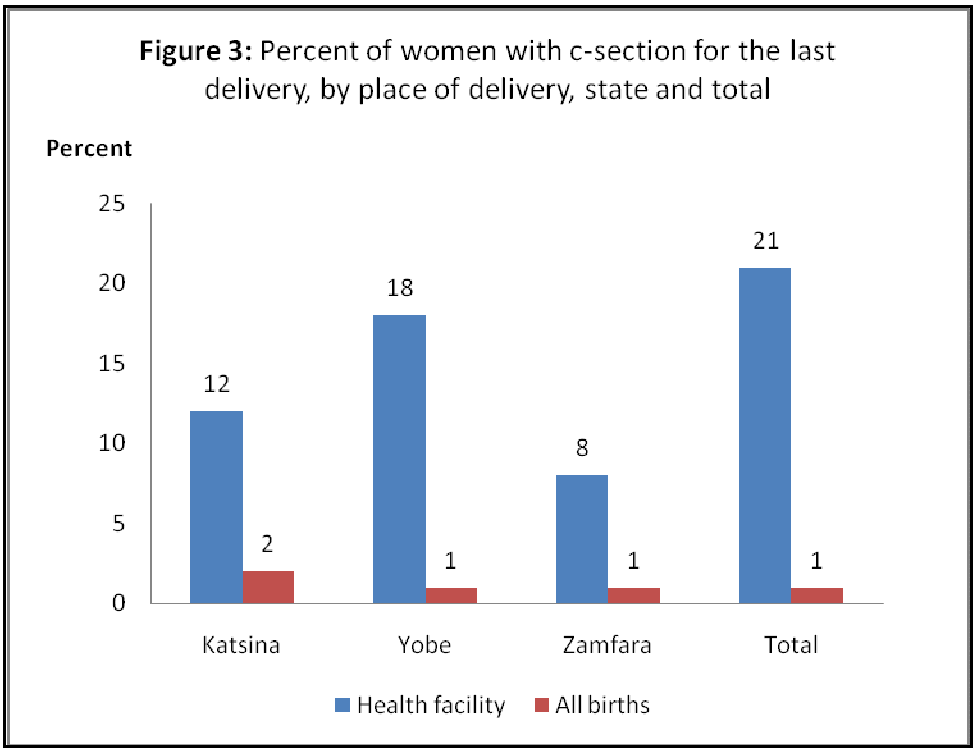
Assistance and medical care at delivery

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

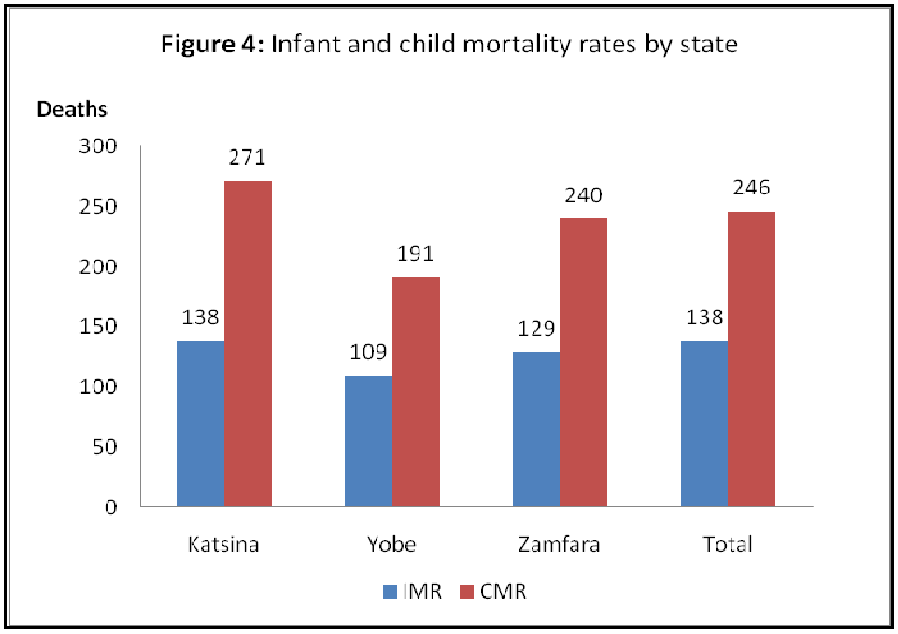
The percentage of pregnancies with delivery by caesarean section (c-section) were analyzed in two categories: percentage of c-section at any health facility and percentage of c-section of all deliveries.



Infant and child mortality

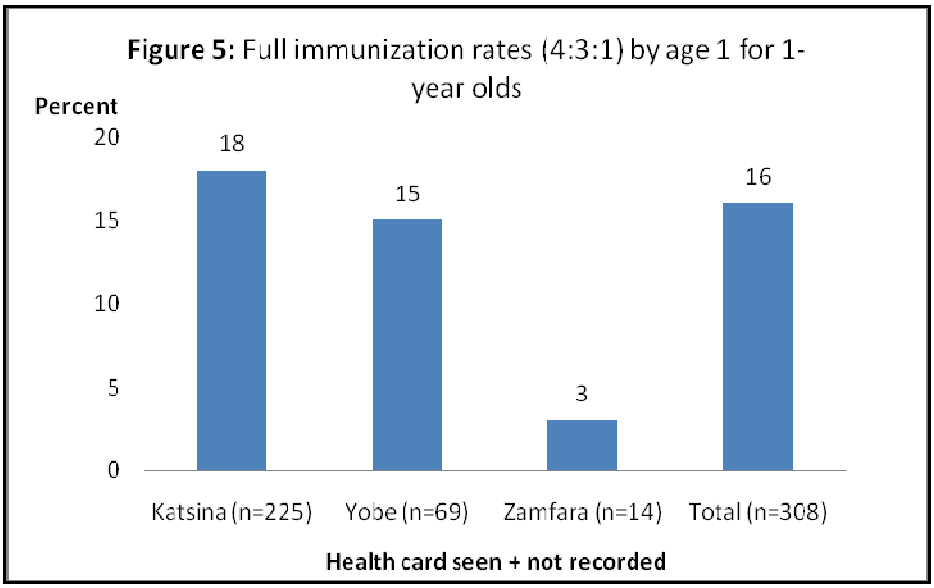
Estimates of infant and childhood mortality are based on information from the birth history section of the questionnaire administered to individual women. For each birth reported, more detailed information was then collected on the child's sex, age in completed years, whether the child was still alive,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



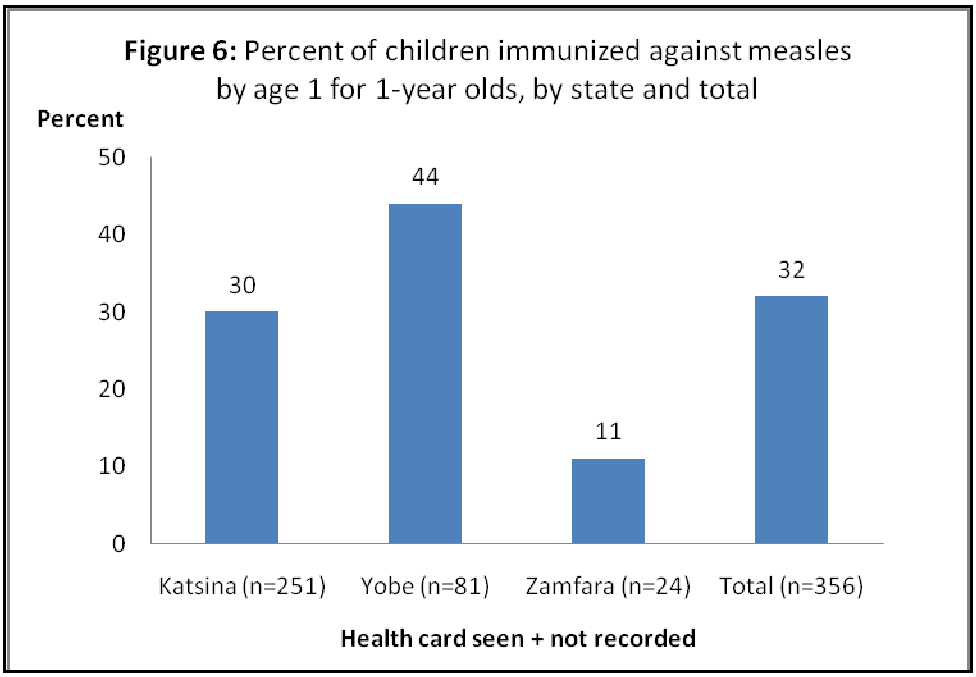
Full immunization by age 1

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 – 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.

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.

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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Appendix 3

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

Minutes of the baseline study review meeting