DFID HEALTH RESOURCE CENTRE

PRRINN- MNCH Report
Incorporating PRRINN Annual Review and MNCH Inception Review
Narrative Report

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Acronyms

ANC	Ante natal care
BCC	Behaviour change communication
CE	Community engagement
CHEW	Community health extension worker
COMPASS	Community participation for action in the social sector
DFID	UK Department for International Development
DHIS	District health information system
DQA	Data quality assessment
DSS	Demographic surveillance system
EC/EU	European Commission/Union
EOC	Emergency obstetric care
FMOH	Federal ministry of health
GAVI	Global alliance for vaccines and immunization
GoN	Government of Nigeria
HERFON	Health reform foundation of Nigeria
HMIS	Health management information system
HR	Human resources
ICC	Inter Agency Coordinating Committee
IMCI	Integrated management of childhood illnesses
IPDs	Immunisation plus days
ISS	Integrated supportive supervision
KM	Knowledge management
LEC	Local engagement consultant / officer
LGA	Local government authority / area
LLGA	Learning local government authority
LSS	Life saving skills
M&E	Monitoring & evaluation
MDG	Millennium development goals
MLG	Ministry of local government
MLGCA	Ministry of local government and chieftancy affairs
MNCH	Maternal, newborn & child health
MoU	Memorandum of Understanding
NEEDS	National economic empowerment & development strategy
NEPAD	New partnership for Africa's development
NGOs	Non-governmental organisations
NICS	National immunisation coverage survey
NPHCDA	National primary health care development agency
OR	Operations research
OVIs	Objectively verifiable indicators
PATHS (2)	Partnership for Transforming Health Systems
PEI	Polio Eradication Initiative
PHC	Primary health care
PHCDA	Primary health care development agency
PHCDB	Primary health care development board
PPRHAA	Participatory peer rapid health appraisal for action
PRRINN	Programme for reviving routine immunisation in Northern Nigeria
PS	Permanent secretary
RI	Routine immunisation
SBA	Skilled birth attendant
SEEDS	State economic empowerment & development strategy
SIACC	State inter-agency coordinating committee
SMOH	State Ministry of Health

SPARC	State partnerships for accountability, responsiveness and capability
SPHCDA	State primary health care development agency
SRIP	Support to reforming institutions programme
SSMS	Sentinel site monitoring system
SuNMap	Support to the national malaria programme
TOR	Terms of reference
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

1 EXECUTIVE SUMMARY

1.1 Key Findings of the Review

(i) This Review has two elements: first, a routine DFID Annual Review to assess progress in PRRINN against expected outputs since the Inception Report produced in February 2008; second, an Inception Review of MNCH, to examine the original programme logframe to see if this is still appropriate in light of experience, and to identify any changes needed to the technical content or management processes.

(ii) The review consisted of a review of key documents and reports, interviews with PRRINN staff, key stakeholders at national, regional, State and LGA levels and visits to the four States where PRRINN is implemented. Meetings were held with national PRRINN staff at the beginning and end of the field visits with discussion and agreement on findings. Similar meetings were held with each of the State teams.

(iii) The Review Team was made up of representatives from several agencies and Government Departments. It was a large team but brought benefits in terms of multi-sectoral representation, enhanced participation and commitment, healthy competition between states, significant cross learning and knowledge sharing, and wide ownership of the review findings. All participants contributed actively to the discussions, analysis and during the final wrap-up meeting.

(iv) The review team split into two to visit the States – one team visiting Zamfara and Katsina, the other Yobe and Jigawa. This allowed the Review Mission to arrive at an understanding of progress and challenges for all outputs across the four states.

(v) PRRINN-MNCH is being implemented in a complex institutional environment and faces some very real challenges in addressing the deep seated constraints to improved PHC in Nigeria. Despite these difficulties, PRRINN has continued to make good progress against most outputs at state level, and has established a sound basis for progress at Federal level.

(vi) MNCH started in September 2008. Although funding sources for PRRINN and MNCH are different, programme implementation is being undertaken as a single integrated project. The two logframes have been merged with seven outputs. This Review Report is structured according to this new combined framework.

(vii) This remains a High Risk programme with continued concerns around primary health care (PHC) and broader governance and institutional issues. Real government commitment to PHC can not be assumed or guaranteed, and the continuing high profile given to IPDs continues to undermine PHC system strengthening. Policy advocacy has continued and needs a concerted effort, particularly at Federal level.

(viii) There is a need to recognise explicitly that PRRINN-MNCH is not primarily a governance programme and can not be expected to address all of the deep seated institutional problems affecting the health sector. PRRINN-MNCH can make an impact on governance through creating pressures for better performance and accountability and by developing institutional and technical capacity. However, there is a need for everyone to be realistic about how far PRRINN-MNCH can push the governance agenda by itself. Closer relationships with Lead State Programmes, especially PATHS 2 and SPARC could contribute to developing more effective strategies to address institutional constraints.

(ix) PRINN-MNCH has a broad scope, both in terms of activities and geographical reach. It is working across 4 large states with large populations. Although most of the governance/systems work will be state-wide, it will be impossible to reach all of the population for some delivery and demand side activities so it will be important to agree an effective way to respond. This could involve a phased approach, using clusters of LGAs and facilities, starting relatively modestly and expanding over time, using experience and evidence to widen engagement.

(x) Scope of work also related to content and the balance of effort between RI and MNCH work in different states and at Federal level. Within MNCH, the Continuum of Care should be the guiding framework. The questions then are about what to focus on within this, what services to support, and about quality of care issues. For example, there is a need to identify a limited number of key activities, and to define the minimum services that will be supported. This is about being strategic with limited resources, and is an issue in all states and at federal level.

(xi) There is also a balance to be achieved between the need for measurable results and numbers, and the need for improved systems and capacity for sustainability. PRRINN-MNCH is developing its knowledge management strategy and should make use of this to meet the needs and objectives of supporting partners.

1.2 Scoring Assessment

(i) The scoring assessment is complicated by the fact that two programmes – PRRINN and MNCH have been interwoven into one logframe with seven outputs. These programmes were launched at different times and whilst it is possible to ascribe scores to the five original PRRINN outputs, it is too early to score against the specific MNCH outputs. In addition, the PRRINN logframe has been revised since the 2008 Review, and its outputs have been redefined. Nevertheless, it is possible to compare performance this year with that of last year. Results of the PRRINN Annual Review are presented in Annex 1.

(ii) For the PRRINN outputs the scoring is as follows, with last year's scores in brackets:

Output 1 – Effective harmonisation and alignment of all agencies' support for routine immunisation at State and LGA levels: *Score – 2 (2 in 2008)*

Output 2 – Improved capacity at Stat and LGA levels for strategic analysis, policy development, planning and budgeting of routine immunisation: *Score – 2 (3 in 2008)*

Output 3 – Primary health care systems strengthened to support routine immunisation: *Score – 3 (3 in 2008)*

Output 4 – Increased demand for routine immunisation: *Score – 2 (2 in 2008)*

Output 5 – Improved capacity of Federal level to enable States' routine immunisation activities: *Score – 3 (3 in 3008).*

(iii) Overall Outputs Score is therefore '2'.

(iv) Outputs that have scored '2' are those that can achieve results in the shortest time. Of the two that scored only '3', one relates to achievements at Federal level where progress has been more difficult. However, the foundations for more rapid success have been established within the last few months and we anticipate greater progress being achieved in the coming year.

1.3 Risk Assessment

(i) The risks originally identified and discussed in the 2008 Annual Review are still valid. The successful management of mitigation strategies is helping to reduce risks.

(ii) The following new risks identified are:

- Insufficient or inadequately trained staff at PHC facilities.
- Ineffective donor coordination.

(iii) Overall rating of PRRINN-MNCH remains: High Risk.

1.4 Summary of recommendations

(i) Strengthened State and LGA governance of PHC systems geared to RI and other MNCH services

1. Continued efforts need to be made to support partner coordination, especially in Yobe where there is no SIACC or equivalent.
2. The programme needs to continue working with other partners to ensure that efforts to improve policy making, planning and budgeting at state and LGA level can be integrated.
3. In Zamfara, it will be important for PRRINN-MNCH to facilitate progress in implementing State Council on Health resolutions.
4. In Zamfara and Katsina there is a need for more robust approaches by PRRINN-MNCH to get the SMoH to focus on its core roles in policy, stewardship and data management.
5. There is a need to focus state and LGA attention on the size and structure of health budgets and actual expenditure, and seek commitment to make improvements. PRRINN-MNCH needs to provoke debate, with stronger advocacy for more realistic health allocations and more effective implementation.
6. PRRINN-MNCH needs to bring increased pressure on MLGs to play their roles in local government performance management.
7. Weak data management needs continued robust efforts to ensure improvements.

(ii) Improving Human Resources Polices and Practices for PHC

1. In Jigawa, PPRINN should actively engage with PATHS-2 and SPARC to understand, quantify and address the HR issues.
2. In Katsina, PRRINN-MNCH should continue to facilitate discussions between the SPHCDA and the School of Technology re CHEWs and midwives.
3. In Katsina, LGAs are planning to recruit about 3000 personnel in 2009. PRRINN-MNCH needs to support this to ensure the right distribution of skills.
4. In Yobe, PRRINN-MNCH should continue to support pressure on government to lift the embargo on unemployed qualified health workers.

(iii) Improved delivery of RI and other MNCH services via the PHC system

1. Continue broad approach to PHC strengthening through infrastructure, planning, capacity building. MNCH will provide more scope.

2. Continue successful advocacy for increased state and LGA resources to support PHC.
3. Help Katsina state to analyse its use of mobile clinics - ? case for operational research
4. Continue advocacy and technical advice by PRRINN-MNCHand DFID to strengthen RI as a core strategy in polio eradication.
5. Need much better data to support implementation of PHC.

(iv) Operational research providing evidence for PHC stewardship, RI and MNCH policy and planning, service delivery, and effective demand

1. Plan the interventions to be studied very carefully and do not rush to produce results too soon. Involve staff and other stakeholders in this process as much as possible to ensure a collaborative process.
2. Ensure that the whole PRRINN-MNCH has a good understanding of the OR process as academic OR studies are often discussed in very technical language.
3. Potentially, OR could yield some very exciting results. Ensure that all results are tied back into Nigeria at all levels but are also closely linked to the KM plan to ensure some international learning and programme publicity.

(v) Improved information generation with knowledge being used in policy and practice.

1. In Zamfara, PRRINN-MNCH needs to ensure wider players are aware of their work e.g. the State Council on Health.
2. Feed State and Local Government simple graphs and charts that demonstrate their successes.
3. Ensure that PRRINN-MCNH state teams give adequate staff time to the HMIS system.
4. Continue to build HMIS champions in state.
5. Keep good connection between outputs 4&5.
6. Ensure other donor buy-in to the HMIS system.

(vi) Increased demand for RI and MNCH services

1. PRRINN-MNCH could make more use of incentives for states to implement the social 'commitments' in their sector plans. MoUs between the programme and stakeholders at state level involving 'stepped agreements' could play a positive role in gaining greater commitment.
2. PRRINN-MNCH should use the partners' forum in each state to agree more coordinated and strategic approaches for obtaining better responses to citizens' demand.
3. PRRINN-MNCH state teams need to make use of the National Communication Strategy Document for Immunization (which was supported by EU PRIME and launched by the NPHCDA on 6 February 2009) as a foundation for their own communication strategies.

(viii) Improved capacity of Federal Ministry level to enable States' Routine Immunisation and MNCH activities

1. To work productively at federal level it will be important to adopt approaches based on trust and a willingness to work within the system, whilst using opportunities to exert influence.
2. Focus at federal level should be upon policy support, not national level capacity development. The policy focus should be developed around the continuum of care and effective responses to the health MDGs.
3. PRRINN needs to be strategic at federal level as it has limited resources at that level. It will be important to agree joint strategies with key players – mainly FMoH (especially the Family Health Department) and NPHCDA.

4. There is a need for robust advocacy for short-term and medium-term solutions for skilled birth attendants.

(ix) Project Management

1. DFID Nigeria needs to ensure reporting is consistent and compatible with ARIES.
2. Collaboration and coordination with PATHS 2 and other Lead State Programmes needs to be strengthened.
3. DFID Abuja should support PRRINN-MNCH at Federal level to promote partner harmonisation.

2 Introduction

2.1 Background

2.1.1 The last PRRINN Review was the Inception Review, undertaken one year ago in February 2008. Since then PRRINN initiatives have focused on:

- Support to policy and planning
- Strengthening planning and budgeting at state and LGA levels,
- Supporting national level to improve IPDs and RI,
- Strengthening the cold chain, micro-planning and transport for RI,
- Systems strengthening for HR, HMIS and financial management,
- Community engagement activities to improve demand, voice and accountability,

2.1.2 In 2007, discussions were held with the Norwegian Government who agreed to implement a maternal, newborn and child health programme in the PRRINN States to provide much needed support to the primary health care system. This led to the inclusion of a MNCH component in the over?? programme.

2.1.3 The MNCH programme was launched on 1 September 2008 and good progress has been achieved during the Inception period. Whilst Inception of the new MNCH programme did delay the implementation of some planned PRRINN activities, it has also provided a wider range of entry points and renewed energy for reviving PHC.

2.1.4 This Review has two elements. First, it involved a routine DFID Annual Review to assess progress in PRRINN against expected outputs since the Inception Report produced in February 2008. Second, it involved an Inception Review of MNCH. As an inception review, its purpose was to examine the original programme logframe to see if this is still appropriate in light of experience, and to identify any changes needed to the technical content or management processes.

2.1.5 The main body of this report presents the findings of a review against the combined PRRINN-MNCH logframe, which has integrated the outputs of the two programmes. The combined PRINN-MNCH logframe has 7 outputs. For the purposes of comparing progress with PRRINN over the past 12 months, a separate assessment against the outputs is presented in Annex 1.

2.2 Methodology

2.2.1 The review consisted of a review of key documents and reports, and interviews with PRRINN staff, key stakeholders at national, regional, State and LGA levels (see Annexes 7 and 8), and visits to the four States where PRRINN is implemented (see Annexes 2-5).

2.2.2 The core review team consisted of nine participants, each with a specific responsibility for a section of the Review Report. These were:

- Jack Eldon – Team leader, responsible for writing Output 7, for integrating the final report and for overall team management;
- Carol Bradford, Consultant, responsible for Outputs 5 and overall M&E issues;
- Carolyn Sunners, DFID Health Adviser, responsible for Output 3;

- Jakesh Mahey, DFID Governance Adviser, responsible for Output 1;
- Joy Ufere, FMoH, responsible for Output 2;
- Binta Ismail, NPHCDA, responsible for Output 4;
- Jummai Bappah, DFID Sovial Development Adviser, responsible for Output 6;
- Bob Leverington, DFID Programme manager, responsible for Programme and Risk Management;
- David Ukagwu, DFID Programme Manager, responsible for Financial Management issues.

2.2.2 This core team was joined by a number of observers without specific responsibilities but who contributed to discussions and cross learning. There included:

- Dr Ibrahim Yisa of EU PRIME;
- Florence Shirehwa of WHO;
- Dr Abubakar Haliru Musa of SuNMap, Kano;
- Abubakar Kende of PATHS 2, Jigawa;
- Bala Aliyu of the Ministry of Budget and Economic Planning, Zamfara State;
- Dr Ma'awuya Aliu of the SPHCDA, Katsina State;
- Alh. Usman Tahir of the Department of Planning, Gunduma, Jigawa State;
- Alh. Bulama Umar Sulleiman of the Ministry of Health, Yobe State..

2.2.3 This constituted a large team and did raise management issues, but these were outweighed by the benefits of multisectoral representation, enhanced participation and commitment, healthy competition between states, significant cross learning and knowledge sharing, and wide ownership of the review findings. All participants contributed actively to the discussions, analysis and during the final wrap-up meeting.

2.2.4 The review team split into two to visit the States – one team visiting Zamfara and Katsina, the other Yobe and Jigawa. The two teams were arranged so that named individuals in each team had responsibility for a specified output. After the visits, individuals were able to meet in pairs and discuss findings from the states they had visited, thus allowing them to arrive at an understanding of progress and challenges against their specific output. In this way the review was able to build up a detailed picture for all outputs across the four states.

2.2.3 Meetings were held with national PRRINN staff at the beginning and end of the field visits with discussion and agreement on findings. Similar meetings were held with each of the State teams.

Recommendations

- DFID and partners continue to use multi-sectoral and multi-agency teams for future reviews. To be effective it is important to allow sufficient time for planning and debriefing.

3 Assessment against Logframe Outputs

3.1 General Progress

3.1.1 The Review Team acknowledges the complex and, at times, difficult environment in which the programme operates, and we do not underestimate the very real challenges involved in addressing the deep seated constraints to improved PHC in Nigeria. We also recognise the challenges brought by operating in a multi-donor environment – in a non donor-dependent country - where partner harmonisation is still evolving.

3.1.2 Despite these difficulties, PRRINN has continued to make good progress against most outputs at state level, and has established a sound basis for progress at Federal level.

3.1.3 In October National and State stakeholders convened a formal MNCH Inception Meeting in Kano, where they agreed a Vision for the overall programme, strategies for each output and priorities for each state. Although funding sources for PRRINN and MNCH are different, programme implementation is to be undertaken as a single integrated project. The two logframes have been merged and a combined planning and reporting framework with seven outputs drawn up and approved by DFID. This Review Report is structured according to this new combined framework.

3.2 Output 1: Strengthened State and LGA governance of PHC systems geared to RI and other MNCH services

3.2.1 The key relevant partners continue to be:

- UN – WHO, UNICEF
- USAID – COMPASS, ACCESS
- EU - PRIME, SRIP, WSSRP
- DFID – PATHS2, SPARC (in Jigawa)
- Rotary International
- A NEPAD financed Special Adviser to the Governor in Yobe.

Partner coordination

3.2.2 The State Inter Agency Coordinating Committee (SIACC) in each state is the key mechanism for partner coordination. In Katsina, the State PHC Development Agency plays this role. PRRINN-MNCH has made good progress in helping to strengthen State capacity to coordinate and integrate activities through, e.g. capacity building and training, facilitating government to lead in planning and managing coordination meetings.

3.2.3 Partners in all four states reported that PRRINN-MNCH plays a uniting factor and is highly regarded. In general, donor coordination has strengthened in all states, and there is an increase in contributions from partners. PRRINN-MNCH plays an important role as facilitator / secretariat, ensuring meetings are planned, reports are shared, minutes are taken and acted upon, etc. Benefits include developing joint supervisory checklists, harmonising clinic registers and forms, work together on HMIS, and sharing advocacy for specific improvements. Partners increasingly provide more effective support to enable government institutions to lead immunization programmes.

3.2.4 In Jigawa, the SIACC functions but is relatively weak. There is some tension between WHO, PRRINN-MNCH, PATHS 2 and development partners. Some of this tension is due to

differing perspectives on the role of IPDs, although overall coordination does need to be improved.

3.2.5 In Zamfara, PRRINN-MNCH has helped to strengthen coordination by coaching weaker partners and building their capacity. A Partners Forum has been established to work on technical issues, and met about 6 times over the year. Partners are increasingly seeing the importance of RI, although it is acknowledged that 'ways of working' will sometimes be different. This forum is now chaired by the SMoH and provides opportunities to improve engagement with the Ministry.

3.2.6 In Katsina, PRRINN-MNCH is seen by partners and State departments as a supporting resource for their own on-going programmes, rather than as just another donor funded programme. This allows PRRINN-MNCH to play a range of roles, from acting as a sounding board for new ideas, through facilitating joint analysis and planning, to more proactive technical assistance, training, piloting new models etc. This supporting role will allow PRRINN-MNCH to 'back out' of the programme at its close without having to 'hand over' any responsibilities to the State and bodes well for long term sustainability.

3.2.7 The Review Team found that PRRINN-MNCH state teams are making efforts to facilitate stronger engagement with key ministries but not always with very positive results. In some cases ministry engagement seems to depend upon more upon the good will or interests of the individuals in post rather than any commitment to core responsibilities.

3.2.8 PRRINN-MNCH has developed good links with most key State Ministries and Departments, although there are clear variations. For example, in Zamfara, the Ministry of Budget and Economic Planning is the main stakeholder at state level and plays an active role in advocating for health resource mobilization. The SMOH and Ministry of Local Government and Chieftancy Affairs (MLGCA) – both key players in PHC – demonstrate limited enthusiasm and their engagement is more difficult. There is a need to focus attention of the engagement of the SMOH and MLGCA to help them to understand their core roles in ensuring improved PHC.

3.2.9 In Jigawa, the Health Sector Reform Forum continues to provide a mechanism for higher level coordination. In Katsina, PRRINN-MNCH has developed good relations with the SPHCDA, supporting it to build capacity at LGA level, to provide consultants, M&E capacity building, planning in LGAs, epidemic response, in-service training at hospitals. Collaboration between SMOH, SPHCDA and PRRINN-MNCH is improving, though there is a pressing need for continued efforts to ensure the involvement of the SMOH and that it fully understands (and undertakes) its core functions in health sector stewardship, data management and policy development. At present the SMOH seems to ignore these core responsibilities.

3.2.10 Jigawa State Government expressed interest in moving towards a SWAP type approach. Whilst this may be ambitious and not entirely appropriate in the conventional sense of pooled funding (most development partners provide technical assistance), it is something that PRRINN-MNCH and PATHS 2 could support Jigawa to explore. This could provide a more formal mechanism for development partners to coordinate around.

3.2.11 PRRINN-MNCH has invested intensive energy into building relationships with government counterparts in Yobe. Progress has been slow but steady. The Governor of Yobe passed away very recently and the Deputy Governor has taken up the Governorship. The previous Governor was supportive of the programme, and PRRINN has good contacts with the current Deputy Governor. There is likely to be increased interest in the support that the programme can provide once the contestation for the Governorship has been settled. The programme will need to be prepared to respond to any renewed interest within the boundaries of what it can realistically offer.

3.2.12 A challenge expressed in most states was the concern that whilst at state level there are concerted efforts to coordinate, at national level there was little evidence that head offices were moving out of their 'silos'. So, for example, missions from Abuja are undertaken separately by individual agencies, undermining efforts at state level.

Health policy and planning

3.2.13 PRRINN-MNCH has continued to make reasonable progress in most areas of health policy and planning, though there are differences between the states, largely dependent on the commitment of key state stakeholders. In Katsina, there is evidence of improvement in the commitment of the State, the Governor, and LGAs towards PHC and RI. A Special Adviser to the Governor in charge of the Local Government Inspectorate has been selected as Chair of a recently inaugurated State Task Force on Immunisation. The biggest challenge in Katsina lies in fully engaging the SMoH to play its lead role in policy development and stewardship of the health sector.

3.2.14 In Zamfara, PRRINN-MNCH supported the State Council on Health. This was a State led strategic planning initiative, with high level support and involvement of the Governor and LGA Chairmen. The Council itself was led by the PS Health. PRRINN-MNCH played a key part in supporting and steering the Council, which led to a series of resolutions and a detailed operational plan. One important resolution was the need for state PHC Agency, to get PHC 'under one roof'. It will be important for PRRINN-MNCH to follow up on progress in implementing these resolutions and to provide the appropriate support.

3.2.15 In Jigawa, PRRINN-MNCH supported the State Government to take forward work on developing the Gunduma system and supporting the SMOH and Gunduma councils in between PATHS 1 finishing and PATHS 2 starting. PRRINN-MNCH has worked hard since the transition to ensure the PATHS 2 has been fully briefed. The State Government has access to PATHS 2 and SPARC in Jigawa to provide technical advice on outputs 1 and 2 of the PRRINN-MNCH combined log frame. It may be worth exploring the extent to which outputs 1 and 2 could be combined under the wider governance activities of PATHS 2 and SPARC. The key challenge for PRRINN-MNCH in Jigawa is to be clear about where it can add most value in relation to the other DFID programmes. It will also be important that PRRINN-MNCH and PATHS 2 take care not to be seen as leading the health sector in Jigawa; they will need to work hard to ensure other development partners 'buy in' to the systems strengthening approach.

3.2.16 In Jigawa, the Director of Planning (Budget and Planning) reported that the quality of plans is still weak at local level. PRRINN-MNCH has provided technical support to the health sector review forum which discussed progress, challenges and the way forward in the sector. PRRINN-MNCH has also provided continuing technical support to the SMOH and SW to review the repositioning of the ministry. PRRINN-MNCH also supported the revision and costing of the State strategic plan (2008-2012) and supported the development of the State 2009 Health Plan, including the Gunduma Council Plan.

3.2.17 PRRINN-MNCH should continue working closely with PATHS 2 to ensue support to planning and budgeting for RI is coordinated with MNCH activities to ensure a 'continuum of care' approach.

3.2.18 PRRINN-MNCH only recently started working at LGA level and there has been limited progress in policy and planning to date. Local Engagement Consultants (LECS) have been recruited to work with LGAs to improve planning, vaccines distribution, immunization sessions and supervision. PRRINN-MNCH is putting pressure on LGAs for improved data management and is helping by printing out forms as an interim process to get the ball rolling. All indications are that health policy and planning at the LGA level are weak, and that effective data management and data tools need to be strengthened.

3.2.19 In Zamfara, the MLGCA is weak and does not appear to undertake any LGA monitoring or supervision. It refuses to believe that there are any systemic capacity weaknesses at LGA level, even when confronted with the evidence. The MLG was not even aware of plans for a State PHC Development Agency, even though it is a member of the committee following up on resolutions from health council.

3.2.20 PRRINN-MNCH is also trying to revive a bottom-up planning system in Zamfara so that local communities can be engaged in planning processes. Community empowerment was piloted in two wards and is now being rolled out. Village health committees have been established in 10 wards, following NPHCDA guidelines, and action plans have been developed. The challenge is to develop capacity in these committees and to get them to prioritise their needs. It will be important that bottom-up planning is realistic as it will be undermined if expectations can not be met.

3.2.21 PRRINN-MNCH provided intensive support to Yobe on the development of the Primary Health Care Development Board (PHCDB) Bill. The Bill offers an opportunity to support the State Government on political reform. Supporting the passage of the Bill through the State House of Assembly also offers an opportunity to work with development partners to bring together supply and demand activities. The Bill is currently with the State House of Assembly. PRRINN-MNCH is continuing to work with the State Government to develop rules and regulations to aid speedy implementation once the Bill is finally passed.

3.2.22 PRRINN-MNCH also supported the development of a Health Sector Plan which was submitted to Ministry of Budget and Planning as part of the formulation of Yobe's SEEDS document.

3.2.23 Advocacy has been a key activity for PRRINN-MNCH in Katsina, facilitating the involvement of the Governor, the Emir, and LECS, and with links to HERFON.

3.2.24 PRRINN-MNCH supported the first round of LGA planning in Katsina. PPRHAA activities were undertaken in all LGAs and comparisons with previous years were used for advocacy. This resulted in the purchase of ambulances by the State. PRRINN-MNCH's work has complemented efforts by the State Local Government Special Advisor, based in the LG Inspectorate, to pressure LGAs to commit more resources. LGA attitudes towards PHC seem to be improving, and there is a degree of competition between LGAs as to which can be most effective. LGAs recently committed N50,000 per month for routine immunisation, and put N5m into a basket fund to purchase drugs. In addition they purchase drugs for the mobile clinics. LGAs have set up new budget lines for blood safety and reproductive health. LECS can play a key role in monitoring disbursements from LGAs to PHC, and will important for PRRINN-MNCH to follow up on LGA implementation.

3.2.25 In Yobe the EU SRIP programme is about to begin a second phase of supporting the State Government to strengthen governance performance. SRIP has four focus LGA areas and established relationships with civil society groups.

3.2.26 At the state level in Jigawa, PRRINN-MNCH led advocacy visits to the Governor, SSG, CoH. PRRINN-MNCH also procured motorbikes for political ward focal persons and LGA surveillance officers, allocating N 45 million for running costs. PRRINN-MNCH also targeted LGA chairman, traditional and religious leaders. The State Government created a new budget line for RI support and increased LGA and state allocations for RI. PRRINN-MNCH also helped Jigawa to retire 2005 GAVI funds and supported access to 2007 GAVI funds.

3.2.27 In Katsina, growing political commitment has seen the budget for health increased from N500m to N600m for the current year. PRRINN-MNCH has been able to engage with key stakeholders and support improvements in planning and budgeting processes.

3.2.28 PRRINN-MNCH has developed strong relations with the Ministry of Budget and Economic Planning in Zamfara and is working to improve health budgeting processes. Following the State Council on Health new budget lines were included in the State Health Budget for ISS and vaccine distribution. The health budget is now activity based, providing clearer opportunities to track expenditure and service delivery. The involvement of the Ministry of Budget and Economic Planning was key in this process and it is clear that this ministry is a central stakeholder for PRRINN-MNCH. The Department now wants to extend activity budgeting to other sectors.

3.2.29 Despite this progress, budget allocations to health in Zamfara and elsewhere are pitifully small. In Zamfara, according to the 2007 Budget Document, allocations to the state health sector represented less than 2% of the state budget in 2006. This has reportedly increased to around 5% for 2009 but verification of this was not possible. Budgets are heavily skewed towards capital expenditure at the expense of recurrent funding. In 2007 for example, roughly two thirds of the health budget was allocated to capital expenditure. There are other monies for health transferred directly from the Governor to LGAs, but figures on this are difficult to obtain. An analysis of LGA budgets might shed some light on overall health allocations. Moreover, State health allocations often remain unspent; in Zamfara in 2006, little more than 50% of the health budget was actually drawn down by the SMOH. The Review Team discussed these issues with the PS in SMOH, though there was no real acknowledgement of the problems that need to be addressed. The Review Team acknowledges that PRRINN-MNCH is not a governance programme per se, nor can it be expected to address the many deep seated institutional problems in the Nigeria political economy. Nevertheless, there is a pressing need to focus state attention on the size and structure of health budgets and to seek commitment to make improvements.

3.2.30 PRRINN-MNCH has only just started working at LGA level and there is a large agenda to follow up re budgeting and financial management at that level. Many LGAs consider themselves as more or less autonomous bodies and assume that they have a right to do and spend as they see fit. Even many key state officials do not challenge this assumption. The consequence is that pressure for performance and accountability is extremely weak. Unless this is addressed, any improvements will continue to rely upon the good will of individuals. A start could be made by undertaking an assessment to ascertain the proportion of funds in LGA budgets allocated to health, and the actual amounts subsequently transferred and spent. Such an exercise could provide important information for advocacy and continued pressure for greater commitment and improved performance at LGA level.

Recommendations

- Continued efforts need to be made to support partner coordination. PRRINN-MNCH should support Yobe to establish a SIACC or equivalent as coordination there is still relatively weak.

- The programme needs to continue working with other partners to ensure that efforts to improve policy making, planning and budgeting at state and LGA level can be integrated, and that issues around performance and accountability are addressed through joint strategies and interventions. For example, the PRRINN-MNCH governance adviser should:

    - offer more intensive support to the Yobe office to develop closer relationships with EU SRIP on financial management, policy development and public service reform in the health sector. PRRINN-MNCH should also continue to support Yobe to pass the PHCDB Bill. However the programme will need to ensure it is not seen to be promoting the Bill.

- undertake an assessment of where PRRINN-MNCH can add most value in relation to the other State Led Programmes in Jigawa (SPARC, PATHS 2). Areas could include data systems and planning and budgeting for RI. PRRINN-MNCH should continue working closely with PATHS 2 to ensue support to planning and budgeting for RI is coordinated with MNCH activities to ensure a 'continuum of care' approach.

- In Zamfara, it will be important for PRRINN-MNCH to facilitate progress in implementing State Council on Health resolutions.

- In Zamfara and Katsina there is a need for more robust approaches by PRRINN-MNCH to get the SMOH to focus on its core roles in policy, stewardship and data management.

- It will also be important that PRRINN-MNCH is not seen as leading the health sector in Jigawa; they will need to work hard to ensure other development partners 'buy in' to the systems strengthening approach.

- There is a need to focus state and LGA attention of the size and structure of health budgets and actual expenditure, and seek commitment to make improvements. PRRINN-MNCH needs to provoke debate, with stronger advocacy for more realistic health allocations and more effective implementation.

- LGA performance and accountability is key to successfully delivering PHC. In some states there is little awareness in State Ministries of Local Government that they have any responsibility for supporting and supervising LGA performance. PRRINN-MNCH needs to bring increased pressure on MLGs to play their roles.

- Weak data management is a major issue in all states – for policy, planning, budgeting and tracking progress, and needs continued robust efforts to ensure improvements.

Observations on the PRRINN-MNCH Work plan

- Sub output 1 is about Health policy and planning; sub output 4 is about health budgeting and financial management. Thus, there is an implied separation between health planning and budgeting. In practice the separation between planning and budgeting is often a major issue, leading to unrealistic plans, and a failure to track plan implementation and expenditure together. Activity based budgeting which is starting in the states brings together planning and budgeting processes and is a very positive step. The programme has worked hard to achieve this and it should be reflected in the work plan. Sub output 1.1 should focus on stewardship, oversight and policy development; sub output 1.4 should focus on health planning and budgeting, expenditure, and financial management.

3.3 Output 2: Improving Human Resources Polices and Practices for PHC

3.3.1 Human resource issues have become a much clearer focus for the programme since the introduction of MNCH. HR is a major constraint in all states, for two core reasons – an absolute shortage of key health workers, particularly SBAs and midwives, and the maldistribution of health sector workers across each state. In summary:

3.3.2 In Jigawa, there is no HR policy or plan yet in existence, the shortage of skilled health workers is a huge problem, and there are high attrition rates of community volunteers. In

Katsina, most LGAs have only 2 midwives, and there are over 100 vacancies. Katsina has started training all staff, including CHEWS in LSS. In Katsina, approximately one third of 1000 nurses are due to retire in next 3 years. The Hospital Services Management Board has recently recruited enough Medical Officers to have 2 for each LGA and 250 nurses, although 275 nurses are needed for the new MNCH hospital. In Yobe, there are no HR policies or plans, and no obvious HR reform process. There is very limited capacity for HR planning and management and the system is very centralized. There is an embargo on the employment of skilled health workers in PHC facilities, whilst unqualified Birth Attendants are used. Supervision of health workers in facilities is inadequate. In Zamfara there are major shortages of SBAs with CHEWs filling the gaps.

3.3.3 Other challenges in all states include:

- The absence of integrated HR management
- Fragmented and inconsistent approaches to HR management
- Weak capacity for HR management and planning across all the four states.
- The interactions between HR issues and deeply rooted governance challenges, e.g. the virtual absence of performance management
- Extremely poor and unreliable HR data

3.3.4 To address these challenges, PRRINN-MNCH has established an HR working group and developed strategies for HR information and planning, HR policies and practices, and workforce training for MNCH. Current activities include:

- HR audits for Jigawa, Yobe, Zamfara and Katsina, and data analysis of audits in Yobe and Katsina;
- Review of midwifery training curriculum, and needs assessments on the availability of SBAs;
- HR information systems development for Jigawa and Zamfara;
- Initial work in Jigawa and Zamfara States on establishing paper based information systems at facility level, with electronic HR data bases at state level. The intention is to establish an electronic Human Resource Information System linked to the District Health Information System (DHIS).

3.3.5 To move forward with the HR agenda during the next review period, PRRINN-MNCH will focus on completing HR data capture and analysis in Yobe and Katsina, to provide a basis for more systematic work on HR policy, planning and workforce management. PRRINN-MNCH will also undertake training of trainers to build the capacity of data clerks. PRRINN-MNCH will complete its baseline assessment of training institutions, including a review of the midwifery curriculum in all States, and identify HR champions to promote HR reform.

Recommendations

- In Jigawa, PPRINN should actively engage with PATHS-2 and SPARC to understand, quantify and address the HR issues. This includes supporting the state to undertake facility mapping – this will help identify where the skilled birth attendants (doctors, midwives and nurses) and Community Health Extension Workers (CHEWs) are and what they are doing. A HR audit is ongoing.

- In Katsina, PRRINN-MNCH should continue to facilitate discussions between the SPHCDA and the School of Technology re CHEWs and midwives.

- In Katsina, LGAs are planning to recruit about 3000 personnel in 2009. PRRINN-MNCH needs to support this to ensure the right distribution of skills. There is also a growing need for retraining MNCH staff in LSS and IMCI.

- In Yobe, PRRINN-MNCH should continue to apply pressure on government to lift the embargo on recruiting unemployed qualified health workers.

- In Zamfara, the State Council on Health has resolved to set up a human resources development unit headed by a Deputy Director and to develop a 10 year HR plan. PRRINN-MNCH should support implementation of resolutions, but also raise the possibility of a wider HR Forum to get a broader understanding of important issues.

3.4 Output 3: Improved delivery of RI and other MNCH services via the PHC system

3.4.1 This output seeks to address PHC systems and services, focussing on the basic and essential requirements to deliver PHC, especially MNCH and RI. On-going systems strengthening work includes transport management; vaccine distribution and storage; developing sustainable drug supplies; supportive supervision; and enabling equipment management and maintenance. Service aspects focus on MNCH, especially revitalising emergency obstetric care (EOC) services in line with accepted norms and improving the quality of care (especially antenatal and postnatal care services). The quality of neonatal care will be assessed and improved, while child health services support will include strengthening IMCI services. A particular focus is on identifying and reaching the hard-to-reach in terms of immunisation services.

3.4.2 Overall, there have been good improvements in some areas of service delivery, although there is still a long way to go to improve PHC services. Good progress was reported in improving supplies for routine immunisation, but the lack of data to verify this make if difficult to confirm. It was widely recognised that the introduction of MNCH will provide more entry points and greater scope to improve PHC.

3.4.3 IPDs still pose a major challenge. There were 8 campaigns in 2008, each of which took up between 2-3 weeks of health workers' time. There is concern that immunisation is being viewed as a separate issue from PHC by the community and possibly by some members of staff because of the campaigns. Some people appear view the campaigns as synonymous with RI. PRRINN-MNCH provides consultants to support each campaign, predominantly with monitoring but also some planning and training, as required.

3.4.4 Vaccine availability appears to have improved at LGA level, and there were suggestion of improvements at facility level, with fewer stock-outs reported. However, this progress was difficult to confirm.

3.4.5 All LGAs are reported to have sufficient cold chain storage for 1 month's supply of vaccine in three of the four states. This compares with no LGAs in Zamfara one year ago. This has been achieved through partnership between PRRINN-MNCH, State and LGAs, and other partners such as UNICEF. For example, while PRRINN-MNCH repaired existing refrigerators, Zamfara has budgeted for an additional 5 solar refrigerators per LGA. Jigawa SMoH has secured funding for the repair of all outstanding solar equipment. To help maintenance and sustainability, PRRINN-MNCH trained a State cold chain maintenance officer who then went on to install the new solar refrigerators the State purchased. However there is still need for more help with the cold chain, particularly down to facility level.

3.4.6 Both Katsina and Zamfara governments have put money (and infrastructure) into improving transport of vaccines to facility level. Yobe is similarly committed but the LGAs have yet to comply.

3.4.7 The lack of data on immunization services, e.g. on the number of sessions or children vaccinated, makes it difficult to assess real progress. Reports suggest that immunisation services are provided by a large number of health facilities, but that these may be irregular in some states, particularly in Zamfara.

3.4.8 It is reported in Katsina that there have been significant increases in immunization rates – including in hard to reach areas - because of the use of mobile clinics, and the statistics are very impressive. In the year up to October 2008 they saw 225,000 ante-natal cases and administered almost 900,000 doses of vaccine.

3.4.9 All states are working on immunization strategies. Health facility and RI mapping has been done and this will help strengthen those facilities already providing services. Jigawa has already developed an immunisation strategy, and Katsina will do so in 2009. Zamfara is not limiting facilities to one per ward as recommended in national strategy. All LGAs in Zamfara have quarterly plans for vaccine distribution, supervision etc.

3.4.10 Locally engaged consultants have proved effective in monitoring routine immunisation plans.

3.4.11 PPRHAA (a quality improvement tool) was undertaken in all four states. Some of the results were taken forward, e.g. results were used to inform 2009 operational planning and in Katsina, recommendations from the PPRHAA led the state government to supply mobile clinics. In Jigawa, the Government has put N 9m into the 2009 budget for PPRHAA.

3.4.12 PRRINN-MNCH has started discussing integration of services at secondary care level in some states. It is recognised in some states (e.g. Zamfara) that there is a need to integrate MNCH services and strengthen PHC. The new MNCH programme will help facilitate this.

3.4.13 Blood transfusion services have been set up in Katsina, although there is still no capacity to store blood. Mobile clinics in Katsina serve hard-to-reach populations, and there is a schedule from each LGA for the provision of curative services, immunisation, ANC and referral.

3.4.14 There are, theoretically, free MCH services in many of the states. In Zamfara, it is proposed to expand this from one hospital to all facilities. Katsina provides considerable resources but money is still inadequate: drugs provided in one facility last approximately 2 months per quarter. During the other month, drugs are provided through the drug revolving fund (with government subsidy) in hospitals and health centres.

3.4.15 There has been a substantial amount of capacity building during the review period and this has been highly appreciated. It has involved strengthening the capacity of health workers in many aspects of routine immunisation, often in collaboration with other partners. Specific training has been provided on micro-planning for hard to reach areas, vaccine management, data management and on cold chain maintenance (i.e. solar fridges).

3.4.16 Integrated supportive supervision is being done in Jigawa, including RI and MNCH health workers, but not in other states.

3.4.17 Site visits to facilities showed extremely variable quality. Facilities were generally better in Katsina and Jigawa; poorer in Yobe and Zamfara. For example, the site visit in Zamfara to Kotorkoshi PHC showed very poor infrastructure, no beds, drugs, etc. and, consequently, very limited services. The site visit in Katsina showed the opposite: good infrastructure, adequate

staffing and good range of PHC services. There had been no supervision to the facility in Yobe and the nurse conducting deliveries had received no training to do so.

Recommendations

- Continue with the broad approach to PHC strengthening through infrastructure provision and maintenance, planning and capacity building. MNCH will provide more scope.
- Continue with successful advocacy for increased state and LGA resources to support PHC.
- Help Katsina state to analyse its use of mobile clinics - ? case for operational research
- Continue advocacy and technical advice by PRRINN-MNCH and DFID to strengthen RI as a core strategy in polio eradication.
- Need much better data to support the implementation of PHC.

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

3.5.1 Operational research is a key cornerstone of PRRINN-MNCH, providing a platform for assessing specific project innovations and capturing overall project successes by providing evidence of what is and is not working. Building on experience in the development of OR organizational capacity in countries such as Ghana and Tanzania, PRRINN-MNCH aims to transform MNCH by institutionalizing evidence-based approaches to improving health policy and programming.

3.5.2 The overall Operations Research plan is to:

a) set up a series of 'Learning Local Government Authorities (LLGAs)—one per state. These LLGAs will offer sites to develop and test health system innovations that address the constraints to MNCH services and their use in Northern Nigeria;
b) set up a Demographic Surveillance System (DSS) in either Zamfara or Jigawa (the final decision is not yet made). This site will allow in-depth demographic research to be tested in a relatively small area; and
c) test various interventions (still to be determined) using the LLGAs and the DSS as testing areas.

3.5.3 Columbia University and Save the Children are taking the lead on this output and are working very closely with Ahmadu Bello University in Zaria.

Improving MNCH through the Learning LGA Concept

3.5.4 The following figure is adapted from PRRINN-MNCH project documents and gives a snapshot of the LLGA concept.

	Phase 1: Planning	**Phase 2: Pre-test**	**Phase 3: replication**	**Phase 4: validation**
Timeline	**1st quarter**	**2nd quarter**	**3rd& 4th quarters**	**4th quarter**
Question	What is a promising and feasible intervention from each output to pre-test? (Participatory planning)	Does it work? (Plausibility trial)	Can what worked in one LLGA be replicated in another LLGA? (Replication trials)	Does the design of the MNCH package impact on MNCH? (Cluster-randomized controlled trial of MNCH package)
Product	Candidate interventions from outputs	Successful interventions	Consensus on interventions ➔ MNCH PACKAGE	Evidence for state planning and policy to improve MNCH in Northern Nigeria

Source: adapted from PRRINN-MNCH project documents (LLFA Concept).

Demographic Surveillance System (DSS)

3.5.5 The DSS will follow a model similar to the Navrongo model in Ghana. It will allow a more sophisticated and deeper site for studying demographic behaviour. It should yield a rich vein of data for more intense study, helping the project understand the situation in Northern Nigeria. Jigawa and Zamfara States are in consideration for the establishment of the DSS. Staff plan a trip soon to visit the Navrongo site in Ghana as a study exchange.

Testing Interventions: Setting the Agenda

3.5.6 The research agenda must make research findings important to all stakeholders including State & LGA governments, project staff, donors, and the international community. Findings from OR activities will enable evidence based decision-making for both the MNCH programme and the Nigerian healthcare system. Modifications to the OR agenda will be made as changes occur in the system as a whole and will be determined on a rolling basis. The agenda for which interventions to test has not yet been set.

Issues

- The project is behind in getting staff in place in Kano and this has slowed down the OR work. Candidates may be in place soon, however.

- Choosing the LLGAs and the site for the DSS has taken longer than anticipated.

- The baseline survey is currently being planned although the instrument and the questions as well as the sites and the sample size are still under consideration. Carrying out the baseline before the interventions are planned may mean that relevant questions are missed in the baseline.

- There is a meeting in the Kano office planned for late February 2009 to discuss the OR plans as well as possible interventions to study.

Recommendations

- Plan the interventions to be studied very carefully and do not rush to produce results too soon. Involve staff and other stakeholders in this process as much as possible to ensure a collaborative process.

- Ensure that all those involved in PRRINN-MNCH have a good understanding of the OR process as academic OR studies are often discussed in very technical language. The OR team should keep the rest of the team abreast of all plans and developments in simple and easy-to-understand language so that the entire team 'owns' this output and its results.

- Potentially, OR could yield some very exciting results. Ensure that all results are tied back into Nigeria at all levels but are also closely linked to the KM plan to ensure some international learning and programme publicity.

3.6 Output 5: Improved information generation with knowledge being used in policy and practice.

3.6.1 Information systems in the Nigerian health sector suffer from parallel data collection, poor quality data, too much of the wrong data, and little use of information generated for developing and improving policy and practice. Output 5 seeks to address these weaknesses. PRRINN-MNCH is building upon earlier activities under PRRINN to strengthen HMIS and M&E at state level, focusing on developing simple data collection tools, clear data flow pathways, clarifying supervisory roles and initiating data quality mechanisms. Knowledge management activities undertaken during the review period include the development of a draft knowledge management strategy and planning for website development and knowledge management strategic plans. Good progress is being achieved, although major challenges to be overcome include a very weak information culture in the health system, weak partner coordination, especially at central level, and too few resources being allocated to HMIS.

3.6.2 PRRINN-MNCH acknowledges that building a HMIS where the 'data culture' is weak will be difficult, and despite the efforts of the previous two years, data is not yet accurate or reliable. Because the HMIS is not yet robust enough to yield reliable data, a Sentinel site system has been developed. This section discusses first the HMIS, then gives a brief overview of the Sentinel site system and concludes with issues & recommendations.

HMIS

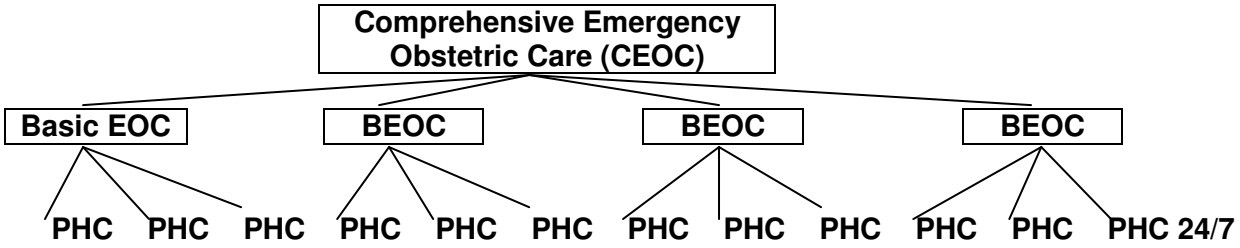
3.6.3 The vision the PRRINN-MNCH staff have for the HMIS is of: "a well functioning HMIS unit in each state that is using up-to-date and accurate data to inform decision making and resource allocation". The DHIS would be functioning as a 'data warehouse' so that it provides an integrated source of data to managers on a variety of services." Project staff already understand that government stakeholders must be encouraged to increase their resources for strengthening routine HMIS and that PRRINN-MNCH state teams must also devote considerable time to the HMIS-building task.

Sentinel site monitoring system (SSMS)

3.6.4 PRRINN has initiated a Sentinel Site Monitoring system in each state. These sites collect data for five RI indicators monthly. An upcoming meeting of the M&E Team will determine a small number of MNCH indicators that will be added to the SSMS. The SSMS will run in parallel to the routine HMIS as the HMIS is being strengthened. Eventually the SSMS will collapse into the routine HMIS.

Clusters will offer a site to show how data flow can work

3.6.5 The current M&E and OR plans require the project to choose a cluster of health facilities in each state. These clusters will be based on the maternal health guidelines for the services required to offer emergency obstetric care. These clusters will look approximately like this:



3.6.6 These clusters in each state will give the project a place to begin to improve the health system at all three levels. These clusters give the project both 'a place to start' and then an area that can be used to demonstrate many things, including the HMIS and the data flows. There will be an attempt to align the clusters around the sentinel survey sites so the data flows will already exist.

Observations at state level

3.6.7 Visits to the states found that:

- The HMIS is still a challenge in Katsina but abundant data is being collected and more use should be made of it;
- Jigawa is ahead of other states as it builds on a six-year Paths1 base and lessons from Jigawa can help the other states;
- There is increased acceptance of inaccurate data in both Zamfara and Katsina and NPCHDA did data quality survey in Zamfara which showed only 41% accuracy. The little data there is shows decreasing coverage but this is believed to be because of improved quality of data.
- In Zamfara, PRRINN-MNCH has offered to supply data collection tools (forms, registration books etc) in the interim until new fund (State, LGA, donor) comes into play.
- PRRINN-MNCH found statisticians in the Department of Planning in Zamfara with little work to do so they are now working on earlier data sets to compile statistics for 2006 and 2007.
- The sentinel site system is functioning in Jigawa and data from the second half of 2008 has revealed a steady increase in attendance for children and pregnant women. (However, problems still exist with missed opportunities for immunisation.) The other states should have sentinel site data for the first quarter of 2009 that will allow an examination of the trends.
- Government HMIS officers in each state do not currently drive the process.

Recommendations

- In Zamfara, PRRINN-MNCH needs to ensure that wider players are aware of their work e.g. the State Council on Health.
- Feed State and Local Government simple graphs and charts that demonstrate their successes. PRRINN-MNCH will need to do this several times until the policymakers begin to ask their staff for the graphs.. Success feeds egos and the data can help.

- Ensure that PRRINN-MCNH state teams give adequate staff time to the HMIS system.
- Continue to build HMIS champions in state.
- Keep good connection between outputs 4&5.
- Ensure other donor buy-in to the HMIS system. They might understand the importance of the HMIS but they need to also support the work of PRRINN-MNCH, e.g. WHO.

3.7 Output 6: Increased demand for RI and MNCH services

3.7.1 This output focuses on increasing demand for RI and MNCH services within a strengthened PHC system. The PRRINN-MNCH approach involves supporting states to develop sufficient institutional capacity to lead on and oversee 'demand-side' initiatives.

3.7.2 PRRINN-MNCH has helped to establish a working group and supported it to define a vision involving community engagement, communications, voice and accountability and in strengthening government capacity for pro-poor and equitable service delivery. States agreed key activities and budgets to stimulate increased demand and shared these with key stakeholders.

3.7.3 Overall PRRINN has made good progress under this output, in terms of integration with MNCH as well as on the recommendations of the 2008 Inception Review. Key activities during the MNCH inception period that facilitated the progress included Rapid Social Assessment of Demand Side Barriers to the use of MNCH services; Strategic Review of the RI Community Engagement (CE) Approach and related communications activities; and developing state communication strategies and planning.

3.7.4 Communication Strategies have been rolled out in the last 6 months and are making good progress, although it is too early to assess the impact fully. All states, and some LGAs, have also increased financial commitments to Community Empowerment interventions and have made progress in developing CE strategies. The strategy of Health Partnerships comprising female and male community volunteers and service providers has been piloted in 40 wards of 8 LGAs in the 4 states. The benefits of these initiatives include:

- Improved health seeking behaviour amongst increasing numbers of people in the pilot communities.
- Awareness of routine immunization, as part of the MNCH services provided by PHC facilities, has improved in all the states, and there is increased demand, especially in Jigawa, Yobe and Zamfara states and LGAs for regular vaccine supplies.
- Increased awareness and knowledge of common health problems across all four states.
- Increasing level of community empowerment through voice and accountability initiatives (particularly in Jigawa) is leading rapidly to increased involvement, participation, ownership and demand driven service delivery.

However, there have been some dropout of community volunteers from health partnerships because of the lack of monetary incentive. This may need to be further explored although the remaining ones may be more dedicated. PRRINN-MNCH could pay greater attention to mainstreaming equity and inclusion.

Recommendations

- PRRINN-MNCH could make more use of incentives for states to implement the social 'commitments' in their sector plans (e.g in Zamfara, PRRINN-MNCH repaired cold chain fridges as an incentive to get the state to purchase solar refrigerators for all the LGAs). State MoUs involving 'stepped agreements' could play a positive role in gaining greater commitment.

- PRRINN-MNCH should use the partners' forum in each state to agree more coordinated and strategic approaches for obtaining better responses to citizens' demand.

- PRRINN-MNCH state teams need align their own communication strategies with the National Communication Strategy Document for Immunization (which was supported by EU PRIME and launched by the NPHCDA on 6 February 2009).. In addition, make effective use of best practices and lessons learnt from other partner programmes to strengthen its community engagement strategies. For example, the change agent movement (CAM) and journalists for immunization (JFI) network activities in some of the EU-PRIME supported states.

- PRRINN-MNCH should involve government institutions e.g. Ministry of Information, Ministry for Women Affairs and the Ministry for Local Government during the consolidation and scaling up phase of its CE strategy to ensure ownership and sustainability. The story of the Ministry for Women Affairs in the Safe Motherhood Initiative in Jigawa State is one example of success.

3.8 Output 7: Improved capacity of Federal Ministry level to enable States' Routine Immunisation and MNCH activities

3.8.1 PRRINN-MNCH has limited resources for federal level work. The programme works closely with NPHCDA and FMoH to strengthen both RI and PHC services, and avenues to leverage extra resources are being explored.

3.8.2 A new National Advisor was appointed in August 08 and has made good progress, although there are many challenges – political, institutional and technical. The TORs of the National Advisor have been broadened to include national level support to the MNCH programme, and the post has been renamed National Immunization and MNCH Policy Advisor. The National Advisor provides the interface between PRRINN-MNCH and key Federal level institutions (FMoH, NPHCDA, and other parastatals, agencies, partners and sector ministries). The focus of the National Advisor is upon supporting the implementation of health sector reform in immunization and maternal and child health initiatives; and contributing to the achievement of health-related MDGs (particularly MDGs 4 and 5) in Jigawa, Katsina, Yobe and Zamfara states.

3.8.3 Overall PRRINN has made good progress, and has succeeded in integrating PRRINN with MNCH. PRRINN-MNCH has raised the profile of the ICC, and continues to advocate for RI and strengthening the PHC system. PRRINN-MNCH continues to strengthen relations with FMoH and NPHCDA, and an advocacy strategy has been developed, for which approaches to implementation are being agreed.

3.8.4 More specifically, within NPHCDA PRRINN-MNCH is supporting the review of PEI. It has supported PATHS 2 in wider reform activities, such as institutional and organizational development, and PHC systems strengthening. The National Advisor also provides technical backstopping to NPHCDA.

3.8.5 Within the FMoH, PRRINN-MNCH has contributed to the review of the draft MNCH Situational Analysis and Communication and BCC Strategy document. It has provided technical support to donor mapping for MNCH, and is actively involved with efforts to improve partner coordination and harmonization at Federal level

3.8.6 The new Lead State Programmes are taking time to mobilize. PRRINN needs to work closely with these – especially PATHS 2 and SPARC – to tackle some of the key constraints that have their roots at federal level, e.g. midwifery training.

3.8.7 Other challenges at Federal level include:

- Changes in senior management within NPHCDA, FMoH and FMoH Departments,
- Developing trust and influence within key agencies and ministries in a complex political environment,
- Weak coordination between partners at federal level,
- Weak strategic thinking within ministries, departments and agencies,
- Growing number of international actors in health sector, especially MNCH,
- Ensuring RI is seen as the core of PEI,
- MNCH perceived as a vertical and top down programme

Recommendations

- Nigeria is not donor-dependent. Federal level actors appreciate donors but do not revere them. To work productively at federal level it will be important to adopt approaches based on trust and a willingness to work within the system, whilst using opportunities to exert influence.

- Agreement, clarity and realism is needed to define scope of work at federal level. Focus at federal level should be upon policy support, not national level capacity development. The policy focus should be developed around the continuum of care and effective response to the health MDGs.

- PRRINN needs to be strategic at federal level. It has limited resources at that level and there political / institutional environment is challenging. It will be important to agree joint strategies with key players – mainly FMoH (especially the Family Health Department) and NPHCDA, to agree strategies with each partner. Shared strategies between PRRINN – FMOH, and PRRINN – NPHCDA would provide a basis for partners to appreciate more clearly what PRRINN is supporting and to what degree, and what PRRINN itself needs to achieve. Strategy meetings will also help identify potentially productive operational areas.

- There is a need for robust advocacy for short-term and medium-term solutions for skilled birth attendants. There has been some pressure advocating for a 2-3 year course for women with 3 credits but this has been blocked by the national level. There is a need for more robust pressure for a change in the rules. Advocacy should target the Northern Governors Forum and the Nursing Council.

4 Amendments to the logframe

A new combined framework has been developed, integrating the PRRINN and MNCH logframes into a single framework with seven outputs. This has been developed using the new DFID format (see Annex 10). There have been proposed changes to the indicators based on the lessons learnt from this last year of monitoring. These changes will be confirmed at the end of the MNCH Inception period when the baseline assessments are completed.

For PRRINN itself, the Review Team has made no changes to the logframe, and all the indicators are included in the combined version. The PRRINN logframe needs to be restructured according to the new DFID format and this will be done in due course.

5 Risk Assessment

5.1 The risks originally identified and discussed in the 2008 Annual Review are still valid. The successful management of mitigation strategies could reduce or eliminate many risks. However, whilst the risks remain, in some instances good progress in mitigation has been achieved in some states, and this progress is reflected in Section 2 of this report – Assessment against Logframe Outputs.

5.2 The following new risks identified are:

- Insufficient or inadequately trained staff at PHC facilities. PHC are often inadequately staffed, or staffed by health workers with insufficient training to safely perform the range of functions that facilities should provide. There are particular shortages of trained midwives and unrealistic qualifications are demanded for entry into health training institutions. An embargo on health personnel recruitment in Yobe further complicates the issue.

- Insufficient support for PHC and RI in Yobe, following the unexpected death of the Governor of Yobe in January 2009. A new Governor (his former Deputy) has been sworn in, although his position, like that of his predecessor, is being challenged in the courts and may not be 00% secure. Full commitment to PHC and RI is essential for the success of the programme in Yobe, where the SMoH needs to be encouraged to play its role in full.

- Ineffective donor coordination. Donor coordination structures, especially in Yobe where there is no SIACC, remain sub-optimal. The inability of donors to present a united front to Government lessens traction and influence. WHO and donors involved in IPDs continue to give insufficient priority to coordination.

- Failure of data management systems to improve. Data generation, analysis, recording, and its use for planning, management and monitoring for PHC is seriously deficient across all four states. The absence of data makes it virtually impossible to confirm reported improvements.

5.3 Overall rating of PRRINN-MNCH remains: High Risk.

See Annex 9 for a full revised Risk Table.

6 Project Management

Management

6.1 The review looked at internal management within PRRINN/MNCH and DFID management of the PRRINN/MNCH programme. There are no substantive concerns with PRRINN/MNCH management of their programme and State offices. Finances and delegations to State offices from the Kano office appear to be pragmatic and efficient.

Reporting to DFID

6.2 PRRINN-MNCH continues to provide interim quarterly reports and 6 monthly substantial reports. There are also improvements with quarterly reports against logframe outputs, and a combined logframe has been developed which has merged the logframe outputs for both PRRINN & MNCH and developed 7 combined outputs.

6.3 PRRINN-MNCH has worked with the Health Adviser in the DFID's Kano office to agree a suitable format for reporting against the programme logframes.

Financial Reporting & Budget Performance:

6.4 Financial reporting to DFID in Abuja is appropriate. PRRINN-MNCH can breakdown expenditure by State should this be necessary (e.g. if support is to be reflected in State budgets).

6.5 Planned expenditure is in accordance with agreed lines of budget, however some challenges do occur in states when state governments are slow in responding with own share of funding commitment.

6.6 Another recent challenge with budget performance and financial reporting is the delay in confirming procurement spend lines on the new ARIES system introduced by DFID.

Recommendation

- DFID Nigeria needs to ensure reporting is consistent and compatible with ARIES.

6.7 On financial and administrative management response times have improved after a slow start. PRRINN-MNCH welcomes the final transfer of vehicles from Save the Children, though wishes to draw attention to the slow pace of this transfer and the length of time it has taken to complete.

Transition to PRRINN-MNCH

6.8 This is a challenge but it has proceeded relatively smoothly, greatly benefiting from the MNCH programme being managed by the same consortium: additional partners taken on for MNCH have joined below the senior level HPI/SCF/GRID board.

Procurement

6.9 So far only vehicles have been procured through Crown Agents. This was completed speedily and efficiently.

Management by DFID

6.10 PRRINN-MNCH is very satisfied with the technical/advisory management and oversight, greatly valuing the inputs from the Kano based DFID Health Adviser.

6.11 The DFID Kano Health Adviser continues to lead in the PRRINN-MNCH programme management, with support from the Programme Management team in Abuja. It is expected that before the end of the second quarter, a Norwegian Secondee will be on board to support the MNCH initiative.

Recommendations

- Collaboration and coordination with PATHS 2 and other Lead State Programmes needs to be strengthened.
- DFID Abuja should support PRRINN-MNCH at Federal level to promote partner harmonisation.

ANNEXES

1. Annual review against PRRINN outputs
2. Jigawa State report
3. Katsina State report
4. Yobe State report
5. Zamfara State report
6. Terms of Reference
7. Itinerary
8. Persons/Organisations met
9. Risk Assessment
10. Combined PRRINN-MNCH logframe

7 Annex 1

Annual Assessment against PRRINN Logframe Outputs

General Progress

PRRINN has continued to make good progress against most outputs at state level, and has established a sound basis for progress at Federal level.

Output 1 – Effective harmonisation and alignment of all agencies' support for routine immunisation at State and LGA levels

The key relevant partners continue to be:

UN – WHO, UNICEF
USAID – COMPASS, ACCESS
EU - PRIME, SRIP, WSSRP
DFID – PATHS2, SPARC (in Jigawa)
Rotary International
A NEPAD financed Special Adviser to the Governor in Yobe.

The State Inter Agency Coordinating Committee (SIACC) in each state is the key mechanism for partner coordination. In Katsina, the State PHC Development Agency plays this role. PRRINN has made good progress in helping to strengthen State capacity to coordinate and integrate activities through, e.g. capacity building and training, facilitating government to lead in planning and managing coordination meetings.

Partners in all four states reported that PRRINN plays a uniting factor and is highly regarded. In general, donor coordination has strengthened in all states, and there is an increase in contributions from partners. PRRINN plays an important role as facilitator / secretariat, ensuring meetings are planned, reports are shared, minutes are taken and acted upon, etc. Benefits include developing joint supervisory checklists, harmonising clinic registers and forms, work together on HMIS, and sharing advocacy for specific improvements. Partners increasingly provide more effective support to government institutions to lead immunization.

In Jigawa, the SIACC functions but is relatively weak. There is some tension between WHO, PRRINN, PATHS 2 and development partners. Some of this tension is due to differing perspectives on the role of IPDs, although overall coordination does need to be improved.

In Zamfara, PRRINN has helped to strengthen coordination by coaching weaker partners and building their capacity. A Partners Forum has been established to work on technical issues, and met about 6 times over the year. Partners are increasingly seeing the importance of RI, although it is acknowledged that 'ways of working' will sometimes be different. This forum includes the SMoH and provides opportunities to improve engagement with the Ministry.

In Katsina PRRINN is seen by partners and State departments as a supporting resource for their own on-going programmes, rather than as just another donor funded programme. This allows PRRINN to play a range of roles, from acting as a sounding board for new ideas, through facilitating joint analysis and planning, to more proactive technical assistance, training, piloting new models etc. This supporting role will allow PRRINN to 'back out' of the programme at its close without having to 'hand over' any responsibilities to the State and bodes well for long term sustainability.

The Review Team found that PRRINN state teams are making efforts to facilitate stronger engagement with key ministries but not always with very positive results. In some cases ministry engagement seems to depend upon more upon the good will or interests of the individuals in post rather than any commitment to core responsibilities.

PRRINN has developed good links with most key State Ministries and Departments, although there are clear variations. For example, in Zamfara, the Ministry of Budget and Economic Planning is the main stakeholder at state level and plays an active role in advocating for health resource mobilization. The SMOH and Ministry of Local Government and Chieftancy Affairs (MLGCA) – both key players in PHC – demonstrate limited enthusiasm and their engagement is more difficult. There is a need to focus attention of the engagement of the SMOH and MLGCA to help them to understand their core roles in ensuring improved PHC.

In Jigawa, the Health Sector Reform Forum continues to provide a mechanism for higher level coordination. In Katsina, PRRINN has developed good relations with the SPHCDA, supporting it to build capacity at LGA level, to provide consultants, M&E capacity building, planning in LGAs, epidemic response, in-service training at hospitals. Collaboration between SMOH, SPHCDA and PRRINN is improving, though there is a pressing need for continued efforts to ensure the involvement of the SMOH and that it fully understands (and undertakes) its core functions in health sector stewardship, data management and policy development. At present the SMOH seems to ignore these core responsibilities.

Jigawa State Government expressed interest in moving towards a SWAP type approach. Whilst this may be ambitious and not entirely appropriate in the conventional sense of pooled funding (most development partners provide technical assistance), it is something that PRRINN and PATHS 2 could support Jigawa to explore. This could provide a more formal mechanism for development partners to coordinate around.

PRRINN has invested intensive energy into building relationships with government counterparts in Yobe. Progress has been slow but steady. The Governor of Yobe passed away very recently and the Deputy Governor has taken up the Governorship. The previous Governor was supportive of the programme, and PRRINN has good contacts with the current Deputy Governor. There is likely to be increased interest in the support that the programme can provide once the contestation for the Governorship has been settled. The programme will need to be prepared to respond to any renewed interest within the boundaries of what it can realistically offer.

A challenge expressed in most states was the concern that whilst at state level there are concerted efforts to coordinate, at national level there was little evidence that head offices were moving out of their ‘silos’. So, e.g. missions from Abuja are undertaken separately by individual agencies, undermining efforts at state level.

Recommendations

Continued efforts need to be made to support partner coordination. PRRINN should support Yobe to establish a SIACC or equivalent as coordination there is still relatively weak.

Weighting – 15%
Score – 2

Output 2 – Improved capacity at State and LGA levels for strategic analysis, policy development, planning and budgeting of routine immunisation

PRRINN has continued to make reasonable progress in most areas of health policy and planning, though there are differences between the states, largely dependent on the commitment of key state stakeholders. In Katsina, there is evidence of improvement in the commitment of the State, the Governor, and LGAs towards PHC and RI. A Special Adviser to the Governor in charge of the Local Government Inspectorate has been selected as Chair of a recently inaugurated State Task Force on Immunisation. The biggest challenge in Katsina lies in fully engaging the SMoH to play its lead role in policy development and stewardship of the health sector.

In Zamfara, PRRINN supported the State Council on Health. This was a State led strategic planning initiative, with high level support and involvement of the Governor and LGA Chairmen. The Council itself was led by the PS Health. PRRINN played a key part in supporting and steering the Council, which led to a series of resolutions and a detailed operational plan. One important resolution was the need for state PHC Agency, to get PHC 'under one roof'. It will be important for PRRINN to follow up on progress in implementing these resolutions and provide the appropriate support.

In Jigawa, PRRINN supported the State Government to take forward work on developing the Gunduma system and supporting the SMOH and Gunduma councils in between PATHS 1 finishing and PATHS 2 starting. PRRINN has worked hard since the transition to ensure the PATHS 2 has been fully briefed. The State Government has access to PATHS 2 and SPARC in Jigawa to provide technical advice on outputs 1 and 2 of the PRRINN combined log frame. It may be worth exploring the extent to which outputs 1 and 2 could be combined under the wider governance activities of PATHS 2 and SPARC. The key challenge for PRRINN in Jigawa is to be clear about where it can add most value in relation to the other DFID programmes. It will also be important that PRRINN and PATHS 2 take care not to be seen as leading the health sector in Jigawa; they will need to work hard to ensure other development partners 'buy in' to the systems strengthening approach.

In Jigawa, the Director of Planning (Budget and Planning) reported that the quality of plans is still weak at local level. PRRINN has provided technical support to the health sector review forum which discussed progress, challenges and the way forward in the sector. PRRINN has also provided continuing technical support to the SMOH and SW to review the progress of implementation of the repositioning of the ministry. PRRINN also supported the revision and costing of the State strategic plan (2008-2012) and supported the development of the State 2009 Health Plan, including the Gunduma Council Plan.

PRRINN has only recently started working at LGA level and there has been limited progress in policy and planning to date. Local Engagement Consultants (LECS) have been recruited to work with LGAs to improve planning, vaccines distribution, immunization sessions and supervision. PRRINN is putting pressure on LGAs for improved data management and is helping by printing out forms as an interim process to get ball rolling. All indications are that health policy and planning at LGA level is weak, and that effective data management and data tools need to be strengthened.

In Zamfara, the MLGCA is weak and does not appear to undertake any LGA monitoring or supervision. It refuses to believe that there are any systemic capacity weaknesses at LGA level, even when confronted with the evidence. The MLG was not even aware of plans for a State PHC Development Agency, even though it is a member of the committee following up on resolutions from health council.

PRRINN is also trying to revive a bottom-up planning system in Zamfara so that local communities can be engaged in planning processes. Community empowerment was piloted in two wards and is now being rolled out. Village health committees have been established in 10 wards, following NPHCDA guidelines, and action plans have been developed. The challenge is to develop capacity in these committees and get them to prioritise their needs. It will be important that bottom-up planning is realistic as it will be undermined if expectations can not be met.

PRRINN provided intensive support to Yobe on the development of the Primary Health Care Development Board (PHCDB) Bill. The Bill offers an opportunity to support the State Government on political reform. Supporting the passage of the Bill through the State House of Assembly also offers an opportunity to work with development partners to bring together supply and demand activities. The Bill is currently with the State House of Assembly. PRRINN is continuing to work with the State Government to develop rules and regulations to aid speedy implementation once the Bill is finally passed.

PRRINN also supported the development of a Health Sector Plan which was submitted to Ministry of Budget and Planning as part of the formulation of Yobe's SEEDS document.

Advocacy has been a key activity for PRRINN in Katsina, facilitating the involvement of the Governor, the Emir, and LECS, and with links to HERFON.

PRRINN supported the first round of LGA planning in Katsina. PPRHAA activities were undertaken in all LGAs and comparisons with previous years were used for advocacy. This resulted in the purchase of ambulances by the State. PRRINN's work has complemented efforts by the State Local Government Special Advisor, based in the LG Inspectorate, to pressure LGAs to commit more resources. LGA attitudes towards PHC seem to be improving, and there is a degree of competition between LGAs as to which can be most effective. LGAs recently committed N50,000 per month for routine immunisation, and put N5m into a basket fund to purchase drugs. In addition they purchase drugs for the mobile clinics. LGAs have set up new budget lines for blood safety and reproductive health. LECS can play a key role in monitoring disbursements from LGAs to PHC, and will important for PRRINN to follow up on LGA implementation.

In Yobe the EU SRIP programme is about to begin a second phase of supporting the State Government to strengthen governance performance. SRIP has four focus LGA areas and established relationships with civil society groups.

At the state level in Jigawa PRRINN led advocacy visits to the Governor, SSG, CoH. PRRINN also procured motorbikes for political ward focal persons and LGA surveillance officers, allocating N 45 million for running costs. PRRINN also targeted LGA chairman, traditional and religious leaders. The State Government created a new budget line for RI support and increased LGA and state allocations for RI. PRRINN also helped Jigawa to retire 2005 GAVI funds and supported access 2007 GAVI funds.

In Katsina growing political commitment has seen the budget for health has increased from N500m to N600m for the current year. PRRINN has been able to engage with key stakeholders and support improvements in planning and budgeting processes.

In Zamfara, according to the 2007 Budget Document, allocations to the state health sector represented less than 2% of the state budget in 2006. This has reportedly increased to around 5% for 2009 but it was not possible to verify this. Budgets are heavily skewed towards capital expenditures at the expense of recurrent expenditures. For example, for 2007, roughly two thirds of the health budget was allocated to capital expenditure. There are other monies for health transferred directly from the Governor to LGAs, but figures on this are difficult to obtain.

An analysis of LGA budgets might shed some light on overall health allocations. State health allocations often remain unspent; in 2006 little more than 50% of the health budget was actually drawn down by the SMOH. The Review Team discussed these issues with the PS in SMOH, though there was no real acknowledgement of the problems that need to be addressed. The Review Teams acknowledges that PRRINN is not a governance programme per se, and can not be expected to address the many deep seated institutional problems in the Nigeria political economy. Nevertheless, there is a pressing need to focus state attention of the size and structure of health budgets and seek commitment to make improvements.

PRRINN has developed strong relations with the Ministry of Budget and Economic Planning in Zamfara and is working to improve health budgeting processes. Following the State Council on Health new budget lines were included in the State Health Budget for ISS and vaccine distribution. The health budget is now activity based, providing clearer opportunities to track expenditure and service delivery. The involvement of the Ministry of Budget and Economic Planning were key in this process and it is clear that this ministry is a central stakeholder for PRRINN. The Department now wants to extend activity budgeting to other sectors.

PRRINN has only just started working at LGA level and there is a large agenda to follow up re budgeting and financial management at that level. Many LGAs consider themselves as more or less autonomous and assume that they have a right to do and spend as they see fit. Even many key state officials do not challenge this assumption. The consequence is that pressures for performance and accountability are extremely weak. Unless this is addressed any improvements will continue to rely upon the good will of individuals. A start could be made by undertaking an assessment to ascertain the proportion of funds in LGA budgets allocated to health, and the actual amounts subsequently transferred and spent. Such an exercise could provide important information for advocacy and continued pressure for greater commitment and improved performance at LGA level.

Recommendations

The programme needs to continue working with other partners to ensure that efforts to improve policy making, planning and budgeting at state and LGA level can be integrated, and that issues around performance and accountability are addressed through joint strategies and interventions. For example, the PRRINN governance adviser should:

Offer more intensive support to the Yobe office to develop closer relationships with EU SRIP on financial management, policy development and public service reform in the health sector. PRRINN should also continue to support Yobe to pass the PHCDB Bill. However the programme will need to ensure it is not seen to be promoting the Bill.

Undertake an assessment of where PRRINN can add most value in relation to the other State Led Programmes in Jigawa (SPARC, PATHS 2). Areas could include data systems and planning and budgeting for RI. PRRINN should continue working closely with PATHS 2 to ensue support to planning and budgeting for RI is coordinated with MNCH activities to ensure a ‘continuum of care’ approach.

In Zamfara, it will be important for PRRINN to facilitate progress in implementing State Council on Health resolutions.

In Zamfara and Katsina there is a need for more robust approaches by PRRINN to get the SMOH to focus on its core roles in policy, stewardship and data management.

There is a need to focus state and LGA attention of the size and structure of health budgets and actual expenditure, and seek commitment to make improvements. PRRINN needs to provoke

debate, with stronger advocacy for more realistic health allocations and more effective implementation.

LGA performance and accountability is key to successful PHC. In some states there is little awareness in State Ministries of Local Government that they have any responsibility for supporting and supervising LGA performance. PRRINN needs to bring increased pressure on MLGs to play their roles.

Weak data management is a major issue in all states – for policy, planning, budgeting and tracking progress, and needs continued robust efforts to ensure improvements.
Weighting – 20%
Score – 2

Output 3 – Primary health care systems strengthened to support routine immunisation

This output seeks to address PHC systems and services, focussing on the basic and essential requirements to deliver RI. On-going systems strengthening work includes transport management; vaccine distribution and storage; developing sustainable drug supplies; supportive supervision; and enabling equipment management and maintenance. A particular focus is on identifying and reaching the hard-to-reach in terms of immunisation services.

Overall, there have been good improvements in some areas of service delivery, although there is still a long way to go to improve PHC services. Good progress was reported in improving supplies for routine immunisation, but the lack of data to verify this make if difficult to confirm. It was widely recognised that the introduction of MNCH will provide more entry points and greater scope to improve PHC.

IPDs still pose a major challenge. There were 8 campaigns in 2008, each of which took up between 2-3 weeks of health workers' time. There is concern that immunisation is being viewed as a separate issue from PHC by the community and possibly by some members of staff because of the campaigns. Some people appear view the campaigns as synonymous with RI. PRRINN provides consultants to support each campaign, predominantly with monitoring but also some planning and training, as required.

Vaccine availability appears to have improved at LGA level, and there were suggestion of improvements at facility level, with fewer stock-outs reported. However, this progress was often difficult to confirm.

All LGAs are reported to have sufficient cold chain storage for 1 month's supply of vaccine in three of the four states. This compares with, for example, none in Zamfara one year ago. This has been achieved through partnership between PRRINN, State and LGAs, and other partners such as UNICEF. For example, while PRRINN repaired existing refrigerators, Zamfara has budgeted for an additional 5 solar refrigerators per LGA. Jigawa SMoH has secured funding for repairs of all outstanding solar equipment. To help maintenance and sustainability, PRRINN trained a State cold chain maintenance officer who then went on to install the new solar refrigerators the State purchased. However there is still need for more help with cold chain, particularly down to facility level.

Both Katsina and Zamfara governments have put money (and infrastructure) into improving transport of vaccines to facility level. Yobe is similarly committed but the LGAs have yet to comply.

The lack of data in immunization services, e.g. on the number of sessions or children vaccinated, makes it difficult to assess real progress. Reports suggest that immunisation

services are provided by a large number of health facilities, but that these may be irregular in some states, particularly in Zamfara.

It is reported in Katsina that there have been significant increases in immunization – including in hard to reach areas - because of the use of mobile clinics, and the he statistics are very impressive, e.g. up to October 2008 they saw 225,000 ante-natal cases and administered almost 900,000 doses of vaccine.

All states are working on immunization strategies. Health facility and RI mapping has been done and this will help strengthen those facilities already providing services. Jigawa has already developed an immunisation strategy, and Katsina will do so in 2009. Zamfara is not limiting facilities to one per ward as recommended in national strategy. All LGAs in Zamfara have quarterly plans for vaccine distribution, supervision etc.

Local engagement consultants have proved effective in monitoring routine immunisation plans.

PPRHAA (a quality improvement tool) was undertaken in all four states. Some of the results were taken forward, e.g. results were used to inform 2009 operational planning and in Katsina recommendations from the PPRHAA led the state government to supply mobile clinics. In Jigawa, the Government has put N 9m into the 2009 budget for PPRHAA.

PRRINN has started discussing integration of services at secondary care level in some states. It is recognised in some states (e.g. Zamfara) that there is a need to integrate MNCH services and strengthen PHC. The new MNCH programme will help facilitate this.

Blood transfusion services have been set up in Katsina although there is still no capacity to store blood. Mobile clinics in Katsina serve hard-to-reach populations, and there is a schedule from each LGA for the provision of curative services, immunisation, ANC and referral.

There has been a substantial amount of capacity building during the review period and this has been highly appreciated. It has involved strengthening the capacity of health workers in many aspects of routine immunisation, often in collaboration with other partners. Specific training has been provided on micro-planning for hard to reach areas, vaccine management, data management and on cold chain maintenance (i.e. solar fridges).

Integrated supportive supervision is being done in Jigawa but not in other states.

Site visits to facilities showed extremely variable quality. Facilities were generally better in Katsina and Jigawa; poorer in Yobe and Zamfara. For example, the site visit in Zamfara to Kotorkoshi PHC showed very poor infrastructure, no beds, drugs, etc. and, consequently, very limited services. The site visit in Katsina showed the opposite: good infrastructure, adequate staffing and good range of PHC services. There had been no supervision to the facility in Yobe and the nurse conducting deliveries had received no training to do so.

Recommendations

Continue broad approach to PHC strengthening through infrastructure, planning, capacity building. MNCH will provide more scope.
Continue successful advocacy for increased state and LGA resources to support PHC.
Help Katsina state to analyse its use of mobile clinics - ? case for operational research
Continue advocacy and technical advice by PRRINN and DFID to strengthen RI as a core strategy in polio eradication.
Need much better data to support implementation of PHC.
Weighting – 30%
Score – 3

Output 4 – Increased demand for routine immunisation

This output focuses on increasing demand for RI services within a strengthened PHC system. The PRRINN approach involves supporting states to develop sufficient institutional capacity to lead on and oversee 'demand-side' initiatives.

PRRINN has helped establish a working group and supported it to define a vision involving community engagement, communications, voice and accountability and strengthening government capacity for pro-poor and equitable service delivery. States agreed key activities and budgets to stimulate increased demand and shared these with key stakeholders.

Overall PRRINN has made good progress under this output. Key activities include strategic review of the RI Community Engagement (CE) Approach and related communications activities; and developing state communication strategies and planning.

Areas of progress include:

The Communication Strategy has been rolled out only in the last 6 months, and it may be too early to assess it fully. However it is making good progress.

Awareness on routine immunization, as part of MNCH service provided by PHC facilities, has improved in all the states.

The strategy of Health Partnerships comprising female and male community volunteers and service providers has been piloted in 40 wards of 8 LGAs in the 4 states.

Increasing level of community empowerment through voice and accountability initiatives (particularly in Jigawa) is leading rapidly to increased involvement, participation, ownership and demand driven service delivery.

The CE strategy is also leading to increasing level of awareness and knowledge about common health problems in all 4 states. The health seeking behaviour amongst increasing number of people in the pilot communities has also improved.

There has been increased demand, especially in Jigawa, Yobe and Zamfara states and LGAs for regular vaccine supplies.

All states, and some LGAs are increasing financial commitments to CE interventions

PRRINN seemed to have paid less attention to the last key area of the output (mainstreaming equity and inclusion)

Recommendations

PRRINN could make more use of incentives for states to implement the social 'commitments' in their sector plans (e.g in Zamfara, PRRINN repaired cold chain fridges as an incentive to get the state to purchase solar refrigerators for all the LGAs). State MoUs involving 'stepped agreements' could play a positive role in gaining greater commitment.

PRRINN should use the partners' forum in each state to agree more coordinated and strategic approaches for obtaining better responses to citizens' demand.

PRRINN state teams need to make use of the National Communication Strategy Document for Immunization (which was supported by EU PRIME and launched by the NPHCDA on 6 February 2009) as a foundation for their own communication strategies.

Weighting – 25%
Score – 2

Output 5 – Improved capacity of Federal level to enable States' routine immunisation activities

PRRINN has limited resources for federal level work. The programme works closely with NPHCDA and FMoH to strengthen both RI and PHC services, and avenues to leverage extra resources are being explored.

A new National Advisor was appointed in August 08 and has made good progress, although there are many challenges – political, institutional and technical. The TORs of the National Advisor have been broadened to include national level support to the MNCH programme, and the post has been renamed National Immunization and MNCH Policy Advisor. The National Advisor provides the interface between PRRINN and key Federal level institutions (FMoH, NPHCDA, and other parastatals, agencies, partners and sector ministries).

Overall PRRINN has made good progress. PRRINN has raised the profile of the IACC, and continues to advocate for RI and strengthening the PHC system. PRRINN continues to strengthen relations with FMoH and NPHCDA, and an advocacy strategy has been developed, for which approaches to implementation are being agreed.

More specifically, within NPHCDA PRRINN is supporting the review of PEI. It has supported PATHS 2 in wider reform activities, such as institutional and organizational development, and PHC systems strengthening. The National Advisor also provides technical backstopping to NPHCDA.

Within the FMoH, PRRINN has contributed to the review of the draft MNCH Situational Analysis and Communication and BCC Strategy document. It has provided technical support to donor mapping for MNCH, and is actively involved with efforts to improve partner coordination and harmonization at Federal level

Recommendations

Agreement, clarity and realism is needed to define scope of work at federal level. Focus at federal level should be upon policy support, not national level capacity development. The policy focus should be developed around effective response to the health MDGs.

PRRINN needs to be strategic at federal level. It has limited resources at that level and there political / institutional environment is challenging. It will be important to agree joint strategies with key players – mainly FMoH (especially the Family Health Department) and NPHCDA, to agree strategies with each partner. Shared strategies between PRRINN – FMOH, and PRRINN – NPHCDA would provide a basis for partners to appreciate more clearly what PRRINN is supporting and to what degree, and what PRRINN itself needs to achieve. Strategy meetings will also help identify potentially productive operational areas.

Weighting – 10%
Score – 3

Amendments to the logframe

The Review Team has made no changes to the PRRINN logframe. The PRRINN logframe needs to be restructured according to the new DFID format and this will be done in due course.

8 Annex 2

Jigawa Summary

PRRINN has performed well in Jigawa. The team enjoys strong and friendly relations with the State Government: the PS Health, the DG Gunduma and their respective staff all spoke knowledgably and warmly about their engagement and about the PRRINN programme. The PS particularly noted that PRRINN's activities were synchronised with State plans.

PRRINN has contributed substantively to key policy and strategy initiatives, eg the State Health Plan. They are seen as a key stakeholder by Government and their advice is routinely sought.

Reform and transformation in the health sector in Jigawa is of course a long term job. Good progress is being made, but at an understandably modest pace given resource and capacity constraints across the State.

Recommendations/areas for the programme to address include:

a) Making the Gunduma system work: Governing Councils at cluster level were only inaugurated in December. However this means that the system is ready to operate fully. The Gunduma's success is critical to establishing accountability and effective management structures within the primary and secondary health care system. PRRINN will need to work with PATHS2 and other donors to help ensure that financial resources flow down to health facilities through the system (i.e. that it works properly) and will need to help the State manage it's limited human resources effectively to ensure that the system is sufficiently staffed to deliver improved services to communities (and so justify the new system). This would build on PRRINN's HR Audit work.
b) Agreeing a practical division of work with PATHS 2. In the interregnum between PATHS 1 and PATHS 2 PRRINN filled the gap and supported state level policy and governance issues. It should now let that work revert to PATHS. Working at the LGA/cluster level, using the LECs seems a clear area of focus. PRRINN is already considering these issues and on a practical interface with PATHS. It will also be important that PRRINN is not seen as leading the health sector in Jigawa; they will need to work hard to ensure other development partners 'buy in' to the systems strengthening approach.
c) Data: PRRINN and PATHS have worked on DHIS. However there still does not seem to be a consistent set of figures that all donors use. WHO collect and use their own data. Government's limited use of data for evidence based planning might contribute to the difficulties by providing no strong lead. Through their membership of the Health Data Consultative Committee (HDCC) PRRINN can help address this.
d) Donor coordination: SIACC is operating but there is clearly some tensions between WHO and PRRINN, perhaps because PRRINN has become the "go to" external partner for JSG and are beginning to question the efficiency of IPDs and the WHO approach. The same tensions appeared to exist between EU-PRIME and WHO. PRRINN will need to work hard to sustain and improve coordination and, with other donors, to encourage WHO to be a constructive partner.
e) DFID clarify JSG wishes for operational research, and then respond substantively to the Governor's request for DFID support in this area.

9 Annex 3

Katsina Summary

Background

Whilst Katsina State poses serious challenges for primary health, it also presents some interesting opportunities, including a committed and active State PHC Development Agency. The fact the President of Nigeria is from Katsina has brought pressures for improved performance.

The State Primary Health Care Development Agency (SPHCDA) continues to be the lead organisation at state level that provides Primary Health Care across the State. The Agency oversees PHC in the state and provides a technical officer in each of the state's seven zones. It is also builds model PHC facilities and provides drugs for 34 mobile clinics run by LGAs.

The State Ministry of Health does not appear to see PHC - including routine immunisation and much of MNCH - as part of its mandate; it relies entirely on the SPHCDA for support to the primary health care system. The Ministry does not seem to acknowledge its central role in overall policy development, stewardship of the health sector, M&E and strategic data management. Integration between primary and secondary health care systems remains weak, despite the SPHCDA providing a 'stepping stone'. The HMIS section of the SMOH was not reviewed but would probably benefit from strengthening.

LGAs control PHC facilities within their areas. The SPHCDA provides money for drugs and equipment which are managed directly by the LGAs. As in other states, PHC staff above grade 7 are appointed and managed by the Local Government Service Commission; below Grade 7 by the LGAs themselves.

The Local Government Inspectorate – a parastatal that reports to the Deputy Governor's Office – is responsible for the allocation of LGA finances. The SPHCDA has considerable influence over this funding.

PRRINN

The new PRRINN State Team Manager arrived in March 2008 and inherited an existing workplan. He was able to use this to catch up quickly and make up time lost since the resignation of the previous STM.

The PRRINN team see MNCH as a useful addition to the overall programme, providing greater scope for engagement and clearer entry points into PHC. The team is actively preparing the groundwork for this. Katsina was selected by the FMOH as one of 12 (now 20) pilot states for new IMNCH, providing additional impetus to make progress on MNCH and PHC.

PRRINN in Katsina is seen by most stakeholders as a resource, a support for their own on-going work. Inter-agency coordination is improving, with PRRINN acting as a secretariat and resource, providing specific support to partners. There is a strong sense of collaboration, with benefits in advocacy, capacity development, PHC supply and demand. PRRINN seems highly respected amongst partners.

The SPHCDA is central to progress in Katsina. PRRINN has good relations with the Agency, supporting it to build capacity at LGA level, to provide consultants, M&E capacity building, planning in LGAs, epidemic response, in-service training at hospitals.

PRRINN is making steady progress in gaining the involvement of SMOH, and facilitating collaboration between SMOH, SPHCDA and PRRINN. This will be important for improved stewardship and governance of the health sector.

PRRINN has supported the first round of LGA planning. This has complemented efforts by the State Local Government Special Advisor, based in the LG Inspectorate, to pressure LGAs to commit more resources. It will be important for PRRINN to follow up on LGA implementation.

PRRINN has employed a number of Local Engagement Consultants (LECS) to work with LGAs. LECS are playing an increasing role in supporting planning and data collection, demand creation, making IDPs more effective through independent monitoring, data management, quality assessment, and reactivating community involvement.

Advocacy has been a key activity for PRRINN in Katsina, facilitating the involvement of the Governor, the Emir, and LECS, and with links to HERFON.

Progress on RI supply includes improvements in the cold chain, with more solar fridges, distribution of existing fridges, and the development of maintenance capacity. 25 staff have been trained on running the cold chain. This has led to increased vaccine storage capacity. All LGAs now have enough solar fridges to store vaccines for 1 month. The delivery of vaccines to facilities has improved. Mobile clinics are used for RI outreach, ANC, referrals, and health education. These are big wins for PRRINN.

PRRINN is planning for MNCH. It has surveyed 18 hospitals in the state to assess basic and comprehensive EOC functions and made recommendations for upgrading. It has undertaken a HR audit, and although analysis is incomplete PRRINN is currently providing advice on staffing norms. It has also undertaken a Health Technology Inventory

PRRINN is now considering how to achieve some quick wins. Current options being explored include providing anti shock garments, resuscitation kits for midwives, motor bike ambulances, and mobile phones to improve speed of referrals.

Data generation, data quality and management has made some progress, through e.g. DQS and the PPRHAA strategy. PRRINN has supported LGAs to analyse data for operational planning. However, poor data management remains an area of concern. Interestingly, the data that is available indicates declining performance, both in terms of RI indicators and the number of facilities providing RI services. This may be because data is becoming more accurate and reliable, exposing the true extent of the problems.

There has been limited progress with operational research. It is anticipated that this will be an area of more focus under MNCH. Arrangements are being made for exchanges between Katsina and other states to link with Ghana Health Services through technical exchanges. Links have also been established with Ahmadu Bello Teaching Hospital in Zaria.

Demand side activities have been relative slow to evolve. Community engagement processes have been piloted, though results are not yet clear.

HR continues to present major problems, both in terms of absolute numbers and the maldistribution of staff. A challenge is to get commitment from all levels of government to address HR issues. HR problems will come into clear focus as MNCH comes on stream and there will be a need for clear strategies to tackle them. PRRINN will need to work with the State to evaluate options.

Other key challenges include:

- Ensuring coordination meetings are actually used to ensure progress.
- Poor partner coordination at Federal level which affects harmonisation at State level.
- The need to monitor LGA plan implementation and that LGAs stick to plans.
- Data generation, quality, management, and use for planning, tracking etc. PRRINN needs to respond effectively to SPHCDA requests for support with data tools.
- The continued separation of primary and secondary health. SPHCDA can be a stepping stone but the SMOH has a key role to play in ensuring integration.

10 Annex 4

Yobe Summary

The PRRINN team in Yobe are doing an excellent job in a very challenging environment. They have developed good working relationships with the State Ministry of Health, contributing to the Health Sector Plan and to the health components of Yobe SEEDS. PRRINN is closely involved with the State's initiative to establish a PHCDA. Particularly good relations have been established with the Director Primary Health care in the Ministry of Local Government.

After a difficult start PRRINN successfully engaged the Governor in the sector, with the strong support from his Special Adviser (the former Commissioner of Health and chair of HERFON in Yobe). This has provided some protection to the health budget and delivered (very) modest increases in finances provided to LGAs for primary health care (N50,000 per month). It is unfortunate that the Governor recently died and that a new relationship has now to be forged with his successor, particularly as the Governorship remains contested in the courts and this is likely to distract the new Governor.

Despite the positive PRRINN achievements Government commitment is perceived by PRRINN and by other donors – EU, WHO – as modest. Shared goals with the highest level of Government are not immediately apparent. There is no strong impetus for reform. The Jigawa representative on the Review team noted that Yobe was at the same stage as Jigawa before reforms started (2002 under PATHS 1). It is also worth noting that PATHS 1 did stimulate an appetite for reform which has been sustained in Jigawa, even through the challenging Touraki administration.

The PRRINN team need to continue to engage and push the State Government, whilst ensuring that they do not take on an overt leadership role. All areas of the health service are weak and need addressing, prioritisation is key. Recommendations and areas of focus include:

a) Donor Coordination. This is weak, there is not even a functioning SIACC. PRRINN and donors had prepared a submission to the previous Governor on this. It should now be energetically raised with the new Governor. PRRINN and the health sector donors need to coordinate closely to agree shared goals and strategies for progressing these. It is important that wider governance programmes, eg EU SRIP are included in coordination and that the health sector donors and SRIP agree shared agendas and look to see their programmes can be mutually supportive.
b) High level back up from DFID and from PRRINN/MNCH in Kano. The programme would benefit from more regular high level engagement from DFID in Kano, and from maximised support from the programme office in Kano.
c) The establishment of a PHCDA provides an opportunity for the State to address the weak management and lack of accountability issues. It will require the State to address it's clear financing problems – not just adequate budgeting but also ensuring approved budget finance actually flows through the system to intended destinations. It will also require them to address chronic HR constraints in order to make the PHCDA able to function. It is not clear that the State understands the magnitude of the task facing them in establishing the Agency. PRRINN could usefully support more regular cross State lesson learning exercises with Jigawa, Katsina and Zamfara.
d) Data is poor and not used by State planners. Coordinated donor action should be taken to get agreed data sets that all stakeholder use.
e) IPDs, as ever, undermine the PHC system. The PRRINN State Team Leader has been exploring with his WHO counterpart an approach which would focus IPD activities on a a

limited number of polio “hotspot” LGAs, whilst allowing WHO and PRRINN/MNCH to pursue a more sustainable PHC focused programme in other LGAs. This is worth exploring, as a pilot transition although it will need endorsement at national level by WHO and other IPD donors and by Federal and State Govts. The working group established to look at transition issues (which has made little progress) might wish to consider this.

11 Annex 5

Zamfara Summary

There are many deeply rooted challenges to PHC in Zamfara, including: poor governance and stewardship of the health sector, poor health planning, weak PHC systems, extremely weak data management, poor support and supervision of frontline staff, inadequate essential drugs, poor community involvement, low motivation of health staff, and inadequate resources allocated to the health sector.

Zamfara State has a Federal Medical Centre, 17 General Hospitals, a Psychiatric Hospital and about 502 PHC facilities. According to the State's SEEDS document there are a total of 1758 health workers, comprising 90 doctors, 4 pharmacists, 336 nurse/midwives, 200 CHEWs, 50 Community Health Officers, 6 Medical Laboratory Scientists and a number of technicians, assistance, attendants, etc. There are two health training institutions in the State – a School of Health Technology at Tsafe, and a new School of Nursing and Midwifery at Gusau.

PRRINN's main stakeholder at state level is the Ministry of Budget and Economic Planning. This has helped PRRINN since the beginning of the programme and has provided most of the key entry points into state health systems.

PRRINN

PRRINN recognises the scope for further strengthening of the PHC brought by the addition of MNHC. Much of the groundwork for the inclusion of MNCH has already been completed.

Interagency coordination and relations with other partners are good. PRRINN has helped to strengthen coordination by coaching weaker partners and building their capacity. A Partners Forum has been established to work on technical issues, and met about 6 times over the year. Partners are increasingly seeing the importance of RI, although it is acknowledged that 'ways of working' will sometimes be different. PRRINN acts as a secretariat for partner meetings, which the SMoH now chairs.

PRRINN supported the State Council on Health. This was a State led strategic planning initiative, with high level support and involvement of the Governor and LGA Chairmen. The Council itself was led by the PS Health. PRRINN played a key part in supporting and steering the Council. The State Council led to a series of resolutions which formed the basis of a detailed operational plan, and a framework for progress reviews. One important resolution was the need for state PHC Agency, to get PHC 'under one roof'. It will be important for PRRINN to follow up on progress in implementing these resolutions and provide the appropriate support.

Allocations to the state health sector represent a tiny proportion of the overall budget. According to the Approved State Budget, in 2006 the health sector was allocated N445 million – representing less than 2% of the state budget for health operations (there are other monies for PHC transferred directly from the Governor to LGAs but figures on this are difficult to obtain. An analysis of LGA budgets might shed some light). Health allocations often remain unspent; in 2006 little more than 50% of the health budget was actually drawn down by the SMOH.

Overall, state budgets are heavily skewed towards capital expenditures at the expense of recurrent expenditures For example, for 2007, N 702 million was allocated to health sector capital development at state level, compared to N330 million for salaries and operations.

The Review Team discussed these issues with the PS in SMOH, though there was no real acknowledgement of the problems that need to be addressed. To improve the situation as far as possible, PRRINN has developed strong relations with the Ministry of Budget and Economic Planning and is working to improve health budgeting processes. Following the State Council on Health new budget lines were included in the State Health Budget for ISS and vaccine distribution. The health budget is now activity based, providing clearer opportunities to track expenditure and service delivery. The involvement of the Ministry of Budget and Economic Planning were key in this process and it is clear that this ministry is a central stakeholder for PRRINN. The Department now wants to extend activity budgeting to other sectors.

All indications are that health planning and budgeting at LGA level are extremely weak, and that effective data management and data tools are weak or absent. The review team did not visit any LGAs though it did meet with the Ministry of Local Government at state level, and hold brief discussions with the PHC Chairman at Kotorkoshi Health Centre. The Ministry is weak does not appear to undertake any LGA monitoring or supervision. It refuses to believe that there are any systemic capacity weaknesses at LGA level.

PRRINN has only recently started working at LGA level and there is little progress to date. Local Engagement Officers (LECS) have been recruited to work with LGAs to improve planning, vaccines distribution, immunization sessions and supervision. WHO also employs LECS and PRRINN is coaching engagement officers to share and cross reference data. PRRINN is putting pressure on LGAs for improved data management and is helping by printing out forms as an interim process to get ball rolling.

PRRINN is also trying to revive a bottom-up planning system so that local communities can be engaged in planning processes. Community engagement strategy was piloted in two wards and is now being rolled out. Village health committees have been established in 10 wards, following NPHCDA guidelines, and action plans have been developed. The challenge is to develop capacity in these committees and get them to prioritise their needs. It will be important that bottom-up planning is realistic as it will be undermined if expectations are not met.

PRRINN has helped train M&E officers in some LGAs. This was a roll out of earlier training of state HMIS officers and included installation of DHIS software on LGA computers. Some LGAs are now beginning data capture and there will be a need to support this. PRRINN is also working with the state to reactivate the Health Data Consultative Committee. This would encourage better management and use of data.

There is still a long way to go to improve PHC services. Some progress is reported in supplies for RI, but the lack of data makes this difficult to confirm. Vaccine availability has improved at LGA level. All LGAs are reported to have sufficient cold chain storage for 1 month's supply of vaccine in three of the four states. This is a significant improvement over last year where there were none.

Zamfara has budgeted for an additional 5 solar refrigerators per LGA and PRRINN has supported sustainability by building the capacity of cold chain maintenance officers. However, cold chain equipment at facility level remains in poor condition. Zamfara has put money and infrastructure into improving transport of vaccines to facility level.

There is a lack of data on immunisation services, e.g. the number of sessions or children vaccinated. It is reported that there is immunisation provision by a large number of health facilities in Zamfara but that it is irregular. Zamfara is not limiting facilities to one per ward as recommended in the national strategy. Health facility and RI mapping has already been done and this will help strengthen service delivery.

All LGAs in Zamfara are reported to have quarterly plans for vaccine distribution, supervision etc. and LECS have proved effective in monitoring routine immunisation plans. There are, theoretically, free MCH services in Zamfara, and it is proposed to expand this from one hospital to all facilities. The site visit to Kotorkoshi Primary Health Centre in Bungudu LGA showed very poor infrastructure, no beds, no drugs, etc and, consequently, very limited services.

IPDs still pose a major constraint, with each campaign consuming two to three weeks of health workers' time. There is concern that immunisation is being viewed as a separate issue from PHC by the community because of campaigns. PRRINN provides consultants to support each campaign, predominantly with monitoring but also some planning and training.

12 Annex 6: TERMS OF REFERENCE

UK Norway MNCH Initiative

**Annual Review – Reviving Routine Immunisation in Northern Nigeria *and*
Inception Review – Maternal Newborn and Child Health Programme**

1. Objective
1.1 The aim is to do a combined review of DFID's routine immunisation programme, PRRINN (Partnership for Reviving Routine Immunisation in Northern Nigeria), and the Norway-funded Maternal, Newborn and Child Health programme (MNCH).

1.2 Specific outputs are:

i. Assessment of annual progress of PRRINN against logframe purpose, outputs and OVIs;
ii. Assessment of the early inception period of the new MNCH component against the logframe;
iii. Assessment of the appropriateness of the combined logframe and the planning and reporting framework for planning, monitoring and reporting;
iv. Assessment of management arrangements for the two components;
v. Monitoring and evaluation strategy for the two programmes including recommendations on revision or adjustment to the programme logframes, particularly objectively verifiable indicators;
vi. Completed standard DFID Annual Review for both components.

2. The Recipient
2.1 The Recipient of this work is DFID Nigeria.

3. Scope of Work
3.1 The Review Team will consider issues that include, but are not limited to, the following:

PRRINN
- Quantitative and qualitative progress against programme purpose and outputs;

MNCH
- Assessment of the work (appropriateness, quality, gaps) done during the Inception Phase including annual planning;

For Both
- Risk analysis and mitigation;
- Monitoring and evaluation strategy;
- Reporting arrangements, progress and financial;
- Budget performance;
- Management of UK Norway delegated cooperation;
- Linkages with Government of Nigeria institutions, policy, programmes.

3.2 The team should highlight any particular successes or challenges and identify lessons learnt.

3.3 The team should make specific recommendations in areas where they consider that change is necessary or desirable, and agree an action plan for implementation of changes.

4. Method

4.1 PRRINN-MNCH will provide necessary information and documentation prior to the review.

4.2 The Review Team will do preparatory reading in advance of the review.

4.3 The review will take place predominantly in Northern Nigeria. There will be meetings in Abuja and Kano, where the programme has its national office. The team will be divided into two, to visit the four States in which PRRINN-MNCH works - Jigawa, Katsina, Yobe, Zamfara.

4.4 Activities will include:

- Read and analyse background information on: Nigerian Federal and State policies and strategies particularly for MNCH and routine immunisation; the current status of MNCH in Nigeria; PRRINN-MNCH documentation including programme memoranda and reports;
- Agree on responsibilities for addressing particular aspects of the review;
- Hold discussions with DFID and members of the PRRINN-MNCH consortium;
- Hold discussions with Federal and State Government officials and other national and international partners active in immunisation e.g. EU, USAID, WHO, UNICEF in Abuja and Kano;
- Review the status of immunisation and primary health care services in one or two facilities and from state data;
- Each team member will complete their delegated part of the report;
- Hold a meeting after the field work is completed between team members, DFID and PRRINN-MNCH management to agree key findings and recommendations;
- Write a narrative report of the combined review;
- Ensure all documentation is available for UK Norway annual meeting.

5. Review Team

5.1 The proposed Review Team members are listed below. The topics/areas that they will specifically cover will be indicated in the draft report outline. They will lead discussions on and provide text for the reports in these areas and will report to the Team Leader.

Consultant Team Leader
Consultant on Monitoring and Evaluation
DFID Health adviser
DFID Governance adviser
DFID Social development adviser
DFID Regional coordinator
DFID Programme/Project officer
Norwegian representative
NPHCDA Abuja
FMoH, Abuja
WHO
EC
PATHS 2
SunMap
One representative from each of 4 state governments

5.2 The Review Team will be split into two teams when visiting the States.

5.3 Logistics and planning support will be provided by DFID Kano office manager with support by HD team in Abuja, and by PRRINN-MNCH offices in Kano, Abuja and the States.

6. Key Tasks (Consultants):

Description	Team Leader	M & E Consultant
Field work	1 .Participate in the design and planning of the review. 2 .Participate in the finalisation of composition, roles and responsibilities of review team. 3. Lead the review team in its meetings and field work. 4. Manage the team members. 5. Coordinate inputs of review team participants. 6. Write the draft and final narrative reports. 7. Assist in preparation of the UK Norway annual meeting.	Assess progress against the MNCH output on information generation and knowledge management; Write relevant portion of narrative report. Assess appropriateness and measurability of logframe indicators in the programme logframes; Assess completeness and monitoring of baseline indicators; Make recommendations on information (indicators and targets) needed for future monitoring and evaluation including: programme monitoring; measuring milestones; producing announceables etc.
Desk Work	8. The Team Leader will be responsible for writing the narrative report with specified inputs from other team members. 9. The DFID coordinator will be responsible for completing the internal DFID annual review. 10. A narrative report of the Review with key findings and recommendations will be completed within 2 weeks of the end of the review 11. Documents and presentations will be prepared for the UK Norway annual meeting	The Monitoring and Evaluation consultant will be responsible for writing the section in the narrative report on the MNCH Output on information generation and knowledge management. The consultant will also write recommendations on information (indicators and targets) needed for: programme monitoring; measuring milestones; announceables etc. The consultant will write recommendations for future monitoring and evaluation of the combined MNCH initiative. These will be discussed with DFID and PRRINN MNCH and presented to the Team Leader. The Consultant will submit her written report to the Team Leader by the end of February 2009.

7. Overall Reporting

7.1 The Team Leader will be responsible for writing the combined report with specified inputs from other team members.

7.2 The DFID coordinator will be responsible for completing the internal DFID annual review.

7.3 A narrative report of the Review with key findings and recommendations will be completed within 2 weeks of the end of the review.

7.4 The standard DFID Annual Reviews will be completed by mid-March.

7.5 Documents and presentations will be prepared for the UK Norway annual meeting.

8. Timeframe

8.1 Essential background reading for the review will be supplied to team members by the end of January and this reading should be undertaken before the start of the main review mission on 2nd February.

8.2 The team leader will provide inputs to the preparation of the review in January 2009 and to the UK Norway annual meeting in March 2009;
8.3 The review mission will be undertaken within approximately two weeks in early February 2009.

9. DFID Coordination

9.1 The overall coordinator will be Carolyn Sunners, Health Adviser in Kano.

10. Background

10.1 More background information is available in the recommended documents. Key issues are highlighted below.

10.2 *MNCH in Nigeria*
Nigeria is not on target to reach MDGs 4 and 5. Maternal, newborn and child health mortalities in northern Nigeria are amongst the highest in the world. Immunisation coverage in Nigeria has fallen since the 1990s to become one of the lowest in the world. The 2006 National Immunisation Coverage Survey suggested full immunisation coverage in the 4 PRRINN States to be less than 7%, with measles coverage between 15 and 25%. The data quality assessment done by PRRINN showed poor quality of data with both over (the majority) and under-reporting.

In 2007, the Nigerian National Programme of Immunisation merged with the National Primary Health Care Agency. A 'Reaching Every Ward' strategy was developed for immunisation. There is a Partnership for MNCH in Nigeria and a new Integrated Maternal, Newborn and Child Health strategy being rolled out into the states.

10.3 *PRRINN*
DFID is supporting the strengthening of routine immunisation through a 5-year programme, PRRINN. The programme's outputs include capacity building of governmental partners, increasing community demand for immunisation, and harmonisation of donors' inputs in order to revitalise routine immunisation. It has been operational in four states (Jigawa, Katsina, Yobe and Zamfara) in Northern Nigeria since early 2007. An annual review in February 2008 showed

good progress had been made in laying foundations for progress but that it is a high risk programme with challenges due to the poor status of primary health care in the country.

10.4 Norway Global Campaign for the Health MDGs
The Norwegian Global Campaign for the Health MDGs was launched in September 2007. Its principles are that aid agencies align with country priorities and national plans; aid agencies should strengthen health systems as a whole with flexible and long-term, predictable funding; and all partners should work in a transparent, accountable way. The Government of Norway agreed to finance a Maternal, Newborn and Child Health programme in the States in Northern Nigeria where PRRINN works. The programme was designed to augment and strengthen PRRINN by deepening the governance components of PRRINN, strengthening support to the broader PHC system, and creating a larger operational research component. DFID is managing the programme on behalf of the Norwegians through a delegated cooperation arrangement. The consortium managing PRRINN won the tender for this new component, which started in September 2008.

11. Relevant Documentation

11.1 The following documents will be available to the review team by the end of January and should be read before commencement of the field work.

PRRINN programme memorandum
PRRINN revised logframe
PRRINN quarterly and annual reports
Outline of Joint Programme
PRRINN-MNCH planning framework
MNCH programme memorandum including logframe
PRRINN-MNCH quarterly report
MNCH baseline reports
Relevant consultant reports

Additional relevant material includes:
FMoH policies/strategies relevant to MNCH
State MoH strategic health plans
UK Norway delegated cooperation arrangement.

13 Annex 7: Itinerary

Date	Activities	
Sunday February 1	Jack Eldon arrives Kano. Preliminary meetings with Carolyn Sunners and David Ukagwu.	
Monday, February 2	Jack Eldon meets Carolyn Sunners and other DFID officials. Initial briefings and finalisation of review design. Meeting with overall Review Team to agree roles and responsibilities. PRRINN self-evaluation: Meeting with PRRINN Team for presentation of progress to date. Review Team meeting to consider PRRINN's self-evaluation.	
	TEAM 1	**TEAM 2**
Tuesday, February 3	Travel to Gusau, **Zamfara State** Meetings with: PRRINN/MNCH team. Visit to Kotorkoshi PHC	Travel to Dutse, **Jigawa State**. Meetings with: PRRINN/MNCH team, State Ministry of Health and Gunduma Board, WHO, EU-PRIME, Ministry of Planning, Ministry of Budget and Planning (Governance Adviser), Ministry of Women's Affairs
Wednesday, February 4	Meetings with: State Ministry of Local Government UNICEF, WHO, COMPASS, ACCESS, EU-PRIME, State Ministry of Health Ministry of Budget and Economic Planning, Local Government Inspectorate. Debriefing with PRRINN/MNCH team Depart for **Katsina State** .	Debrief with PRRINN/MNCH team, Visit to Shuwarin PHC facility and Kiyawa LGA cold store, Depart for Damaturu, **Yobe State**.
Thursday, February 5	Meetings with: PRRINN/MNCH State Team State Ministry of Health SPHCDA Hospital Services Management Board ACCESS, COMPASS, WHO, EU Prime, Rotary, UNICEF,	Meetings with: PRRINN/MNCH State Team State Ministry of Health State Ministry Of Local Government Visit to Ngelzarma MCH SRIP, WHO and EU-PRIME Visit to Ngelzarma MCH
Friday, February 6	Local Government Inspectorate State ministry Women's Affairs Visit to Mashi PHC. Depart for Kano	Debriefing with PRRINN/MNCH team Depart for Kano
	Review Teams meet in Kano, discuss and integrate findings. J. Eldon meets with representative of FMoH and NPHCDA to discuss progress at Federal level.	

Saturday, February 7	Consultants write reports
Sunday, February 8	Report writing continues. Meetings with PRRINN Kano.
Monday – Wednesday, February 9 - 11	Report writing continues. Telephone consultation with PRRINN Abuja to discuss progress at Federal level.
Thursday, February 12	Stakeholders' workshop in Kano. Findings presented to by the consultants. Plenary discussion of findings and recommendations. Carol Bradford departs Kano for Abuja
Friday, February 13	Report writing Jack Eldon departs Kano for Abuja. Discussion with SPARC Abuja to discuss developments in state and local governments. Carol Bradford departs for London.
Saturday, February 14	Jack Eldon departs for London.

14 Annex 8: Persons / organisations consulted

Abuja

- Ben Anyene, PRRINN-MNCH Federal level.
- Dr Joy Efere, FMoH.
- Binta Ismail, NPHCDA.

Kano

- WHO
- UNICEF
- PRRINN national management team and Project Management Board.
- Haliru Musa, SuNMap.

Jigawa

- PRRINN Team.
- State Ministry of Health - PS, Directors and staff.
- Gunduma – Director General and staff; Director Hospital Services.
- Director Planning and Research; HSB Pharmacist; Director Planning and staff.
- State Ministry of Budget and Planning - Director Planning and staff.
- State Ministry of Women's Affairs – Permanent Secretary.
- PATHS 2.
- WHO, EU PRIME, Rotary and Immunisation Basics.
- Visit to Shuwarin PHC facility and Kiyawa LGA cold store.

Katsina

- PRRINN team.
- State Ministry of Health – PS and Directors.
- State PHCDA Executive Chairman and Director.
- Hospital Services Management Board.
- State Ministry of Health PS and deputy PS.
- State Ministry of Women Affairs, PS and Directors.
- Local Government Inspectorate and Chieftancy Affairs – Special Adviser and Directors.
- WHO, UNICEF, COMPASS, EU PRIME, PATHFINDER, ACCESS, ROTARY.
- Mashi PHC Facility - PHC Coordinator and team.

Yobe

- PRRINN Team.
- State Ministry of Health, DPM, Director Planning and staff.
- State Ministry of local government, Director PHC and staff.
- Special Advisor to the Governor
- PS Local Government
- Director Primary Health Care - Local Government
- UNICEF, SRIP, EU PRIME, and WHO
- Ngelzarma MCH: CHO, nurses, CHEWS, and other officials.

Zamfara

- PRRINN team
- State Ministry of Health Honourable Commissioner, PS, Directors and staff,
- State Ministry of Local Government and Chieftancy Affairs, L.G. Inspectorate
- Ministry of Budget and Economic Planning PS and team
- UNICEF, COMPASS, ACCESS, EU PRIME
- Visiy to Kotorkoshi PHC, Bungudu LGA: Officer in Charge and staff, PHC Chairman.

15 Annex 9. Updated Risk Assessment February 2009

RISK	CATEGORY	COMMENTS AND MITIGATION STRATEGY
a) Federal Govt does not supply to States all required vaccines, syringes and safety boxes.	Impact High, Probability medium Unchanged	Presidential and Ministerial commitment to RI at Federal level and a sound UNICEF managed procurement mechanism were deemed sufficient to mitigate this risk at approval. The Programme Memorandum committed PRRINN to undertake operational research with UNICEF on the acquisition, supply and reporting mechanisms. The system appears to be working And there have been improvements in vaccine availability in the states compared with last year. Unfortunately the Government has precipitously introduced a policy on using auto-destruct syringes which are not yet fully available which may add another risk. ***Mitigation*** PRRINN (and donor group) should to advocate at Federal level for bundling of needles and syringes, and for emergency supplies to be additional. Donors to advocate for UNICEF to retain procurement responsibility. Donors to advocate for a delay in implementation of the policy on auto-destruct syringes.
b) PHC services do not get delivered.	Impact High, Probability High Unchanged	Uptake or RI constrained by the absence or poor quality of services available from PHC facilities. There has been little improvement since last year although some evidence of progress e.g. the use of mobile clinics in Katsina, and some increase in resources being put to PHC by the States and LGAs ***Mitigation*** The UK Norway MNCH programme will provide additional support to strengthen PHC
c) Negative impact of PEI and measles campaigns	Impact High, Probability High Unchanged	The distortionary effect of IPDs is acknowledged by all (including WHO and UNICEF) to be preventing improvement of RI and wider PHC reform. It sucks in excessive resources and the monetisation of incentives, for patients and Government/donor IPD staff, has meant little pressure for change. The Federally initiated Task Force established to look at ways of transiting to a more sustainable RI programme delivered through the PHC system has not delivered.

		Mitigation The issue cannot be tackled by PRRINN alone: there are high level political and international dimensions. DFID HQ and DFIDN will continue to work with PRRINN, PATHS2 and donors to gather strong evidence on the strengths, impact and opportunity cost of IPDs. A review is being carried out now in order to guide a new strategy for polio eradication. PRRINN/MNCH Yobe will simultaneously work with WHO and the SMoH to develop a proposal for focusing IPD activities in Polio hotspots only, whilst strengthening PHC and RI in other LGAs.
d) Incorrect storage and use of vaccines	Impact High, Probability Medium Probability reduced to: Low	There have been improvements in the storage and use of vaccines. Cold chain has improved at State level although there is more work to be done at LGA level. Training has been given to all cold chain managers in the States. A solar fridge engineer was trained by PRRINN and went to install solar fridges purchased by the State. There has been more money put into transport of vaccines by some LGAs. ***Mitigation*** PRRINN will continue to focus on rehabilitation of solar fridges and maintenance at LGA level.
e) Communities and households do not take up RI	Impact High, Probability Medium Unchanged	There are a range of demand side factors affecting communities' ability and willingness to utilise services, including culture, mistrust, lack of knowledge and information, cost etc. Work this year has shown a significant increase in uptake of first vaccinations in pilot communities. ***Mitigation*** PRRINN will work with MNCH and other partners to scale up proved strategies and will continue to collect evidence of what works.
f) Lack of State and LGA commitment to RI and subsequent inadequate or mismanaged financial allocations.	Impact High, Probability Medium Unchanged	There has been small-scale but significant increases in commitments by both States and LGAs to RI and PHC. ***Mitigation*** PRRINN will continue to work with Ministries of Budget and Planning as well as line Ministries to increase budgetary allocations. DFID will continue advocacy at a higher level.
g) Failure to develop and	Impact Medium,	Lack of data is a key issue in analysing and monitoring the programme although it is

sustain effective data management systems	Probability Medium Unchanged	still possible to revive routine immunisation without it. HMIS data remains of dubious quality in all States. Collection is inconsistent, in part due to poor management at the facility level and the low priority SMoHs appear to give data. SMoHs and SMoLGs do not appear to appreciate the value of good data or know how it can be utilised for both planning and impact monitoring ***Mitigation*** Development of sound, shared data is a priority within PRRINN/MNCH's workplan. PRRINN/MNCH will work with other donors to establish more effective HMIS systems that provide district level data that can be used by all stakeholders. The programme will support capacity building within State Governments for analysis and planning.
h) Lack of reform at the strategic level isolates and marginalises RI.	Impact Medium, Probability Medium This risk should be deleted as it is adequately covered by (i) below.	Broader strategic health sector reform initiatives have been started in the States but the quality and commitment is variable. Addressing RI, or even PHC, on its own will not produce sustainable change. ***Mitigation*** Under the UK Norway MNCH and PRRINN work, State Teams should build upon the wider networks being established by governance reform programmes (eg SRIP, SLGP, SPARC) to engage with SEEDS and central ministries to generate broader coalitions for PHC reform. There needs to be assessment of structural and organisational constraints e.g. the unclear lines of responsibility between MOH, LGAs and parastatals and constraints to management, supervision and M&E this causes. PRRINN will need to ensure that it does not champion specific organisational models (e.g. Gunduma system in Jigawa) but neutrally contributes to decision-making and implementation.
i) Lack of PRRINN linkages to central strategic planning and resource allocation initiatives (SEEDS, PMF etc).	Impact High, Probability Medium Impact changed to: Medium	Inclusion of PHC reform and RI in SEEDS 2 is critical to securing political commitment, budget allocations and effective M&E. Links are not effectively made at present, except in Jigawa & Zamfara where they could be deepened. ***Mitigation*** PRRINN/MNCH will continue its broader engagement, as it has done in Zamfara. However there will be other networks, including civil society and private sector that should be investigated. PRRINN needs to cast its net widely.
j) Gunduma system in	Impact Medium,	The Gunduma system in Jigawa and the proposed PHCDA on Yobe have enormous

Jigawa fails. PHCDA system in Yobe fails.	Probability Medium Unchanged	potential to secure adequate funding, effective delivery and effective supervision at health facilities. However they will be contested by stakeholders whose power and influence will be eroded under the new system. They are likely to be compromised if insufficient staff are available at facility level to make the systems work. ***Mitigation*** PRRINN/MNCH and PATHS2 (in Jigawa) will work with other donors to support the implementation of Gunduma and PHCDA, and to help Jigawa and Yobe State Governments measure and communicate its positive impact.
k) Ineffective Federal MoH	Impact Medium, Probability Medium Unchanged	Relationships and lines of responsibility across the Federal MoH and parastatals (e.g. NPHCDA) have been unclear. The lack of a substantive Minister of Health and a new task force on polio exacerbated this. However there is a new Minister and a new head of the National Primary Health Care Agency who are working well together and bring new possibilities. ***Mitigation*** PRRINN, PATHS 2 and DFID, will continue to work to support the new leaders in order address these structural and organisational issues. The new Health Bill will help when passed.
l) Political and civil instability	Impact High, Probability Low	Remains a risk outside of PRRINN's control. Mitigation includes building capacity to sustain workplans without close PRRINN presence or oversight.
m) Local Government elections and challenges to 2007 electoral process disrupt programmes	Impact Medium, Probability Medium This risk should be deleted as there are no elections in the near future and other civil disturbances are covered elsewhere.	PRRINN started only a couple of months before the elections. There were delays but no substantive disruption**.** There are still some risks due to appeals being heard against election results. Careful planning ndn awareness of timings of aspects of the electoral process will help PRRINN plan as effectively as possible.
n) Insufficient or inadequately trained staff at PHC facilities	Impact high Probability medium	PHC are often inadequately staffed, or staffed by health workers with insufficient training to safely perform the range of functions that facilities should provide. There are particular shortages of trained midwives and unrealistic qualifications are demanded for entry into health training institutions. An embargo on health personnel recruitment in

New risk		Yobe further complicates the issue. ***Mitigation*** PRRINN/MNCH are undertaking HR Audits and will support the development of practical HR policies and strategies. This will include recommendations on training and HR development requirements.
o) Ineffective donor coordination **New risk**	Impact Medium Probability Medium	Donor coordination structures, especially in Yobe where there is no SIACC, remain sub-optimal. The inability of donors to present a united front to Government lessons traction and influence. WHO and donors involved in IPDs continue to give insufficient priority to coordination. ***Mitigation*** PRRINN/MNCH will continue to prioritise this and seek to secure effective partner coordination and engagement. In Yobe, working with other donors, the programme will advocate with the new Governor for an SIACC, with a broad (ie not just IPD) remit. DFID will work at Federal levels to ensure central directives don't undermine coordination at State level

16 Annex 10: DRAFT PRRINN-MNCH Combined Logframe 2009-2012

PROJECT NAME	PRRINN-MNCH in Northern Nigeria, 2009-2012					
GOAL	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
To improve maternal, newborn and child health in Northern Nigeria	MDG4, Target 5					
		Source				
		DHS, HDI (UNDP)				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	MDG5, Target 6					
		Source				
		DHS, HDI (UNDP)				

PURPOSE	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumptions**
To improve effective access to MNCH (including RI) services in four states	Percentage of births attended by a skilled birth attendant (SBA) to increase by x%, from baseline	Year 2	?%	?%	?%	Maintenance of Federal allocations to State and LGA health budgets Continued political stability and absence of civil strife
		Source				
		HMIS, Sentinal sites				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (1012)**	
	Percentage of infants fully immunised by first birthday increases by x%, from baseline	Fill in now: X%	?%	?%	?%	
		Source				
		NICS 2006, 2009, 2012				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	PROXY EMOC Indicator: Caesarean section rates rising over life of project and should be above 2% by EOP	?%	Increase from baseline	At least 2%	Above 2%	
		Source				

		HMIS, Sentinal sites			
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**
	Percentage of women receiving ANC increase by x%, from baseline	X%	?%	?%	?%
		Source			
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**
	Measles incidence reduced by 80% [AMENDED PRRINN]				
		Source			
		NICS 2006, 2009, 2012			
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**
	Polio incidence reduced to near zero [AMENDED PRRINN]				
		Source			
		NICS 2006, 2009, 2012			
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**
INPUTS (HR)	**DFID (FTEs)**				

Sentinel site data Jigawa[1]

[1] 36 health facilities were included in the sentinel site monitoring system in Jigawa. The data was captured using the DHIS. By early December (the time of the visit), four months data from July was available.

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

Thus from the purpose indicators, the ANC attendance has gone up and as a proxy the under 1 attendance and the immunisation attendance and the number of children with RTHCs have all increased.

OUTPUT 1	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumption**
Strengthened state and LGA governance of PHC systems geared to RI and MNCH	State government staff lead annual review and health planning process in all states	Collaborating	Lead with support	Lead with less support	Lead with no support	Federal, State and LGAs willing open up planning, budgeting and financial records to public scrutiny
		Source				
		State health policies, plans and budgets				

<table>
<tr>
<td rowspan="15">[Includes PRRINN outputs: 1) Effective harmonization and alignment of all agencies' support for routine immunisation at State and LGA levels; & 2) Improved capacity at State and LGA levels for strategic analysis, policy development, planning and budgeting of RI</td>
<td>Indicator</td><td>Baseline</td><td>Milestone 1</td><td>Milestone 2</td><td>Target (2012)</td>
<td rowspan="15">Draft Health Bill enacted and effectively applied at Federal, State and LGA level

Federal funds are released to States for PHC services

Donors want to harmonise and align with state priorities</td>
</tr>
<tr>
<td rowspan="2">All states successfully access new Federal health funds two consecutive years</td><td>None</td><td>Federal funds?</td><td>Federal funds?</td><td>Two years of Federal funds</td>
</tr>
<tr>
<td colspan="4">Source
State financial statements or federal level statements (e.g. NPHCDA for GAVI and possibly the PHC fund)</td>
</tr>
<tr>
<td>Indicator</td><td>Baseline</td><td>Milestone 1</td><td>Milestone 2</td><td>Target (2012)</td>
</tr>
<tr>
<td rowspan="2">Increased budget allocated to PHC and expenditure on PHC increasing at least 5% annually, from baseline</td><td>Fill in</td><td>?%</td><td>?%</td><td>?%</td>
</tr>
<tr>
<td colspan="4">Source
State budgets and expenditure reports</td>
</tr>
<tr>
<td>Indicator</td><td>Baseline</td><td>Milestone 1</td><td>Milestone 2</td><td>Target (2012)</td>
</tr>
<tr>
<td rowspan="2">Agreed health plan is incorporated into state development plan</td><td>Little</td><td>Some</td><td>More</td><td>Integrated</td>
</tr>
<tr>
<td colspan="4">Source
State development plan document</td>
</tr>
<tr>
<td>Indicator</td><td>Baseline</td><td>Milestone 1</td><td>Milestone 2</td><td>Target (2012)</td>
</tr>
<tr>
<td rowspan="2">State health plans reflect project data from 2010</td><td>None</td><td>Some</td><td>More</td><td>Fully</td>
</tr>
<tr>
<td colspan="4">Source
State health plans</td>
</tr>
<tr>
<td>Indicator</td><td>Baseline</td><td>Milestone 1</td><td>Milestone 2</td><td>Target (2012)</td>
</tr>
<tr>
<td rowspan="2">Steady improvement in donor PHC programmes reflected in State and LGA annual health plans</td><td>Little</td><td>Some</td><td>More</td><td>All</td>
</tr>
<tr>
<td colspan="4">Source
State and LGA health plans</td>
</tr>
<tr>
<td>Indicator</td><td>Baseline</td><td>Milestone 1</td><td>Milestone 2</td><td>Target (2010?)</td>
</tr>
<tr>
<td rowspan="2">SIACCs show steady improvement in their support for RI through PHC system in all states, from baseline</td><td>Little</td><td>Some</td><td>More</td><td>RI fully integrated</td>
</tr>
<tr>
<td colspan="4">Source
Meeting records</td>
</tr>
<tr>
<td>Indicator</td><td>Baseline</td><td>Milestone 1</td><td>Milestone 2</td><td>Target (2010?)</td>
</tr>
</table>

	Percentage of donor field missions, analytic work and reviews done jointly by 2011 increase from baseline	What is current number?				
		Source				
IMPACT WEIGHTING						**RISK RATING**
15						
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 2	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumptions**
Improved human resource policies and practices for PHC	Percentage of functional facilities with at least one health worker trained in LSS increases by x% annually, from baseline [Back-up Alternative: Distribution of health workers, by profession, urban/rural]	10% ??	20%	30%	40%	Increased commitment to PHC at State and LGA level
		Source				
		Facility and staff monitoring reports, Sentinal sites (not going to be rigorous data but should be able to establish trends), HR system linked to DHS				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	HR policies and plans developed, operationalised, and implemented in each state	Some	Developed	Operationalised	Implemented	
		Source				
		State Human Resource policy documents				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Number of health professionals trained	Number	Number	Number	Number	
		Source				

	annually [NEW DFID INDICATOR]	Project records				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
15	Percentage of staff with in-service training in MNCH services in PHC facilities increased by x% annually, from baseline	X%	?%	?%	?%	
		Source				**RISK RATING**
		In service training schedules				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 3	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumptions**
Improved delivery of MNCH services (including RI) via the PHC system [Includes PRRINN output: PHC systems strengthened to support RI]	Percentage of LGAs reaching performance ranking tool (PPRHAA) scores over 75%, from baseline	Fill in from PPRHAA	?%	?%	?%	Global and national initiatives do not disrupt planning and implementation of PHC, MNCH and RI at State and LGA levels States continues to provide drugs on a sustainable basis
		Source				
		PPRHAA reports				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	PHC facilities providing BEOCN increased by x% annually, from baseline	X%	?%	?%	?%	
		Source				
		Coverage surveys				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Systems for effective supervision established in each State by 2010, owned by 2011, and sustainable by 2012	Few	Established	Owned	Sustainable	
		Source				
		Facility and staff monitoring reports				

	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
	[NEW DFID INDICATOR] Number of 1-year-old children immunised against measles	Fill in	?%	?%	?%	
		Source				
		NICS 2009, 2012				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2010?)**	
	[ADDITIONAL FROM PRRINN:] Health facilities providing RI experiencing vaccine stock-outs of TT reduced annually, from baseline	Fill in from before	2008:	2009:		
		Source				
		Stock records or PPRHAA				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Percentage of people using MNCH services are satisfied in project areas, from baseline	Fill in	?%	?%	?%	
		Source				
		Rolling cluster surveys				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
25	Percentage of tracer drugs available increases x% per year, from baseline	X%	?%	?%	?%	
		Source				**RISK RATING**
		Stock records or PPRHAA				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 4	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumptions**
Operational research providing evidence for PHC stewardship, RI and MNCH policy and planning, service delivery, and effective demand creation	At least six pieces of OR into supply & demand aspects of MNCH feed into programme, 2 per year from 2010	None	2	2	2 (6 in total)	Results of operational research acceptable to government
		Source				
		Project reports				

IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
10	State plans reflect OR results, one example per year, by state, from 2010	None	1 per state	1 per state	1 per state (12 in total)	
		Source				
		State plans				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 5	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumptions**
Improved information generation with knowledge being used in policy and practice	All states have trained HMIS officers who demonstrate increasing understanding in the use of information, from baseline	Little	Basic	Moderate	Comprehension	States begin to build a data culture
		Source				
		HMIS data and reports				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	State plans increasingly built on evidence from HMIS	None	?	?	?	
		Source				
		State plans				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
10	HMIS MNCH data collated at State level from 100% of LGAs on a monthly basis by end of project	X%	?	?	100%	
		Source				**RISK RATING**
		HMIS				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	

INPUTS (HR)	DFID (FTEs)	

OUTPUT 6	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Assumptions
Increased demand for MNCH (including RI) services [Includes PRRINN output: Increased demand for RI]	Increased political support for MNCH (including RI) evidenced by high level public events: one per state and 2 at LGA level per year	None	1 at state level; 2 at LGA level	1 at state level; 2 at LGA level	1 at state level; 2 at LGA level	
		Source				
		Media reports; project reports				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Wards with a development committee and/or health partnership implementing a community action plan increased from 0 to 30% by end of project	0	10%	20%	30%	
		Source				
		Community monitoring process				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
20	Increased consensual agreement on use of MNCH services within families, from baseline	X%	?%	?%	?%	
		Source				**RISK RATING**
		Household survey				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Percentage of women who know the maternal danger signs increased by x%, from baseline	Fill in	?%	?%	?%	
		Source				
		HMIS, Household survey 2007, 2009, 2011				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Each state has at least one established and					
		Source				

	functioning system for defining and enforcing health rights and entitlements, with demonstrated access for women					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Mothers of children <2 who know the childhood vaccination schedule increase from 10 to 50%	10%	25%	40%	50%	
		Source				
		Household survey 2007, 2009, 2011				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Never immunised children reduced by 50%, from baseline					
		Source				
		Household survey 2007, 2009, 2011				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 7	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumptions**
Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities	Formal system established for leveraging, accessing and utilising additional PHC funding	None	Project facilitates	System developed	System functioning	All donors and partners provide common support and advocate for common strategy
		Source				
		Minutes of committee meetings				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	Sufficient funds allocated and released at Federal level for national immunisation supplies
	Federal level delivers X% vaccines and supplies to states on time, from baseline	Current % delivered on time	?	?	?	
		Source				
		Stock records of zonal and state stores				Federal government willing and have capacity to do
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	

5	Agreed strategies [developed, owned, and implemented] to improve efficiency of RI	None	Strategies developed	Strategies owned	Strategies implemented	
		Source				**RISK RATING**
		State reports				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
INPUTS (HR)	**DFID (FTEs)**					

** Indicators, baselines and targets should be disaggregated by sex, age etc. wherever relevant*