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

Executive Summary **March 2011**

Interstate Data Review

Consultants: **Adebusoye Anifalaje**

.The interstate data review was used as an opportunity to evaluate the status of HMIS across the PRRINN states. As a means to establish continuity and strategic focus in HMIS support, the interstate data review workshop is generally designed to build on issues raised and recommendations made from preceding workshops. Consequently, emphasis was placed on cluster and priority facilities in terms of their reporting rates. In addition, the analysis (i.e. how to interpret and present data from the DHIS) of key service data, particularly MNCH, was also conducted. This performance audit was also intended to feed into a state-specific strategy/action plan for strengthening HMIS. The review also served as a platform for capacity building through advance technical support for HMIS consultants as well as “super-users” within the states. Moreover, HMIS representatives from the states were able share experiences on best practices and challenges. This essentially peer-review approach provided a critical but encouraging feedback to the participants.

Prior to the workshop, significant work was carried out on the maintenance of the DHIS database. This involved reviewing the harmonised data files which was developed on the template of the new HMIS001 form. It was imperative during this process to align data element names from the old form with the new forms. As such, an updated Nigerian Master data file was created which will be imported into individual state data files. The exercise was valuable in the sense that it was an opportunity to also appraise the state of the Nigerian Master data file. There were a number of inconsistencies discovered in the database, posing a significant threat to the integrity of the database in the mid-long term. However, as PRRINN support is limited at the Federal level, it was resolved to notify the NHMIS office of these concerns. It is recommended that a responsible officer should motivate for advance technical support to address the issues identified and draw up best practice policies for the maintenance of the database.

From an administrative and operational perspective, the introduction of the new NHMIS forms constitutes a challenge of duplication of efforts. This is especially the case with health workers having to fill in comparable data in both the IDSR and NHMIS. Having weighed the risks, the approach decided on was to keep the NHMIS and IDSR forms parallel. While the impact on the health worker would be negative, it was considered manageable. The assumption is that the health worker would be inclined to fill the IDSR as this is more established and monetised while the revised NHMIS form is still evolving. Although this has some bearing on the technical solution adopted, the impact is mostly on processes that primarily affect data quality, specifically consistency. It is recommended that HISP Nigeria and PRRINN programme managers engage the NHMIS office to discuss how the revised NHMIS form could be evolved to address and reduce duplication.

The data review workshop commenced with an opportunity given to participants to express their expectations. Some of the participants’ expectations of the data review included technical capacity building, taking stock of progress and challenges since the last interstate review and analysing how PRRINN states have performed in the last three years. Participants also wanted to examine issues surrounding the use of the new NHMIS forms and registers. They also expressed a need for feedback on how the information is (or will be) used, by whom and the problems faced so far (or anticipated). In general, there was an expectation that there would be knowledge and experience sharing between the states.

Presentations from the interstate data review focused on reporting rates and analysis of service data over a 2-year period i.e. from 2009 to 2010. Zamfara state reporting is disaggregated according to service delivery and programmes e.g. ANC, Immunisation and IDSR. The average submission rates for ANC data were 91% and 96% in 2009 and 2010 respectively. While on average, 79% of expected immunisation data was reported in 2009,

PRRINN-MNCH is funded and supported by UKaid (from the Department for International Development) and the State Department of the Norwegian Government

this increased to 94% in 2010. However, IDSR data reporting rate averaged only 10% in 2009 but significantly improved the following year to 64%. In Yobe state, the average reporting rates for Priority 1 facilities were approximately 40% and 55% in 2009 and 2010 respectively. In contrast, the reporting rate for cluster facilities was only about an average of 35% in 2009 but significantly improved in 2010 to an average of over 60%. Jigawa state reporting in 2009 averaged around 70% but increased consistently in 2010 to approximately 75% on average. In Katsina state, average reporting rate state-wide from 2009 to 2010 was around 8%. This was however about 40% for priority 1 facilities.

A number of state-specific issues came to the fore during the data review. For instance, in Katsina, data from January 2011 is being collected and captured using the new revised NHMIS form. Yobe conducted DHIS training in August 2010 using TOT trainers as co-facilitators. However, a more comprehensive training on the foundation course will be scheduled once the new NHMIS forms are available in the State. In Jigawa State, attention is now turned to the issue of sustainability. As such, from 2011 the government is introducing budgetary provisions for M&E.

In addition to the presentations made by the participants, they were set a task on calculating and presenting specific service data i.e. ANC coverage, comparing ANC 1st visit, Total Deliveries and BCG and TT2+. In Zamfara ANC coverage was approximately 15% and 25% in 2009 and 2010 respectively. The presentation of ANC 1st Visit before Deliveries and then subsequently showing BCG immunisation was explained to be a logical chronology. In Zamfara, the figures showed that only about half of those coming for ANC deliver their babies in the health facilities (around 10%). The team noted that some of the problems revolve around cost. They also mentioned that the cultural belief is that if people deliver in health facilities it means there is a problem. However, it was noteworthy to see higher rates of BCG immunisation (over 30% and 50% in 2009 and 2010). In 2009, the figures show almost half of the population is covered for DPT 1 but just under 40% in 2010. The NICs findings for Zamfara show DPT3 coverage at 54% in 2010 while the DHIS records 59%. This is usually expected, as methodology is different but figures sufficiently close to argue for the reliability of the DHIS figures.

Jigawa's ANC coverage rate in Dec 2010 was about 62% while TT2+ was about half of this rate. Although indicators in the master files and some states are incorrect, Jigawa has correctly defined indicators. DPT1 and DPT 3 coverage in 2009 were 61% and 48% respectively; in 2010 these were 90% and 72%. Despite the dropout rate being higher than the target of no more than 10%, it was noted that coverage takes precedence over dropout rate, as the latter is reflective of service quality.

In Yobe, there were questions regarding the source of immunisation data. This was because the State captures data in the DVD-MT. However this data is aggregated at the LGA and as such it was recommended that there was a need to get the LIOs who aggregate these data to provide the disaggregated health facility input. Also, naming of health facilities is not standardised therefore a meeting with the LIO, MCH Coordinators and M&E Officers will be necessary to align names used in the field and official names in the DHIS. Due to the extremely low reporting rate in Katsina, the coverage calculated was particularly unreliable e.g. average coverage in 2009 was about 5% and under 10% in 2010.

During the interstate review, there was an opportunity for the HIMA and the HISP consultants to discuss the current HMIS support arrangements and the mid-term review. The main issues included how to align state work plans with technical support provided; budgeting for and financing the printing of the new NHMIS forms and registers; progressing the mobile HMIS pilot; how to support the establishment of the summer school and the role of the study tour; support for the programme's M&E report; cascading of training and the possibility of drawing up an institutional contract for regional consultants akin to that which is in place for the national consultants. Feedback from the mid-term review flagged up the need for the HMIS support strategy to adopt a cluster approach; balance support between state and health facilities; provide information related to service delivery with verifiable evidence in the field. The review also recommended that a closer link be forged with Output 3 and 6, working on voice and accountability between health facilities and the community.

At the end of the review workshop, each state team had an exercise to identify their particular weaknesses, suggest intervention strategies to mitigate these and draw up a new work plan. These were to be followed up by national consultants responsible for respective states.

- The HMIS STA and a regional consultant involved in this review, further discussed the status of HMIS activities planned for the

PRRINN-MNCH is funded and supported by UKaid (from the Department for International Development) and the State Department of the Norwegian Government

year. Specifically, it was agreed that the various HMIS training manuals and programmes scheduled from 2010 should be taken forward. These include the DHIS Foundation, Intermediate and Advanced courses, the Use of Information for Programme Managers and the Basic Use of Information modules. The HMIS STA and the regional consultant at the end of the assignment debriefed the HIMA. The highlights of the issues noted were that, 1) special measures have to be taken in Katsina and Yobe. It was also a priority that data capture in Yobe for cluster facilities are complete; 2) arrangements to be made to coordinate NCs experience-sharing meetings and review work plans bimonthly; 3) there must be a renewed focus on cluster facilities (at least for Katsina and Yobe); 4) prioritise piloting the Use of Information training module in Zamfara and Jigawa. The following key recommendations were made:

- A member of the HISP team is to be designated to take leadership in the maintenance and management of the DHIS database.
- The State HMIS team in Zamfara should be deployed to help out in Katsina with backing of the STMs concerned.
- National Consultants should sample health facility records monthly or work with LEOs to get to one or two health facilities.
- Cluster health facilities should be models. NCs will be required to identify which health facilities they visited and which the LEOs visited.
- HIMA and the Regional Consultant involved in the HMIS trainings should arrange to convene a meeting for handing over the DHIS foundation training materials and select a few people for the advanced training in September 2011.
- National Consultants to support the HDCC quarterly meetings. Accompanying reports should not just identifying attendees but also detail the issues discussed.

Please email info@prrinn-mnch.org for the full report