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PRRINN-MNCH Annual Review

Narrative Report

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Acronyms

ANC	Ante natal care
BCC	Behaviour change communication
CDF	Comprehensive Development Framework
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
DRF	Drug Revolving Fund
EC/EU	European Commission/Union
EOC	Emergency obstetric care
EDL	Essential Drug List
FMOH	Federal Ministry of Health
FP	Family Planning
GAVI	Global alliance for vaccines and immunization
GoN	Government of Nigeria
HERFON	Health reform foundation of Nigeria
HDSS	Health and Demographic Surveillance System
HMIS	Health management information system
HR	Human resources
IACC	Inter Agency Coordinating Committee
IMCI	Integrated management of childhood illnesses
IPDs	Immunisation plus days
ISS	Integrated supportive supervision
KAP	Knowledge, Attitude and Practice
KM	Knowledge management
LEC	Local engagement consultant / officer
LGA	Local government authority / area
LLGA	Learning local government authority
LSP	Lead State Programmes
LSS	Life saving skills
MCHIP	Maternal and Child Health Improvement Project (USAID)
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
MSP	Minimum Service Package
MSS	Midwife Service Scheme
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

OVI	Objectively verifiable indicators
PAC	Post-abortion care
PATHS2	Partnership for Transforming Health Systems 2
PEI	Polio Eradication Initiative
PHC	Primary health care
PHCDA	Primary health care development agency
PHCDB	Primary health care development board
PHCUOR	Primary health care under one roof
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 or attendance
SDSS	Sustainable Drug Supply System
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
SPHCMB	State Primary Health Care Management Board
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
V&A	Voice and Accountability
WHO	World Health Organisation

1. Executive Summary

1.1 Key Findings of the Review

This review is a DFID annual review of two projects that have been combined: the DFID-funded Programme for Reviving Routine Immunisation in Northern Nigeria (PRRINN) project (begun in 2006) and the Norwegian-funded Maternal, Neonatal, and Child Health (MNCH) project (begun in 2008). The four programme states in Northern Nigeria have a combined population of approximately 16 million—comparable to the populations of Sierra Leone and Zambia combined. The states were chosen for their exceedingly low health indicators (some of the highest maternal and infant mortality rates in the world) and the challenging environments (both physical and institutional). Still, the programme is making good progress against its outputs, even in this challenging environment.

This is an innovative programme as it combines health systems strengthening with maternal, neonatal, and child health interventions. This programme therefore combines a horizontal and vertical approach simultaneously—and could bring the best of both with proper attention given to strengthening the health system as well as extra attention to approaches demanded by a vertical programme. This is an approach that has not often been used before and may yield good results when outcomes can be measured some years in the future, especially in reducing maternal and child mortality. This programme is one to watch.

The project has made good progress in working with government at both state and federal levels, and in defining both human resource needs and the Minimum Service Package. Operations research has progressed and the stage is set with committees, research questions, protocols and some common OR tools. The HMIS component is showing signs of beginning to build a data culture in the states and the community engagement is showing good progress. The project's maternal health 'clusters' pull together groups of health facilities meant to respond to maternal health emergencies at the primary, secondary and tertiary levels. All service delivery work in each state will proceed in this cluster format.

The partnerships with stakeholders are strong on all levels and the team was clear that the PRRINN-MNCH team was improving the relationships between the government and the many UN and other donor players. A few partners said that they had never before seen such a good collaborator as PRRINN-MNCH. In addition, PRRINN (begun in 2006) and MNCH (begun in 2008) are truly integrated this year and MNCH is building on what PRRINN has learned. Finally, states are at varying levels of implementation and there is more scope for cross-state learning.

The programme's particular successes this year were:

- The basket fund in Zamfara state demonstrating that funds can be transparently managed there.
- The appreciation expressed by the state governments of Zamfara and Jigawa for capacity building elements of the project, demonstrating their willingness to participate in the process of transparent government.
- Human resource audits with fulltime HR units established within each SMOH, demonstrating real progress in HR planning in all states.
- Costing of the Minimum Service Package (MSP) in each state.
- Posting of 96 midwives per state through the Midwife Service Scheme (MSS).
- Increasing demand for routine immunisation (RI) and a programme survey indicates a doubling of routine immunisation rates for the four states (albeit from a very low base).

An implementer of a USAID-funded health project said rather wistfully that they wished that their project had a governance component—something that is built into the PRRINN-MNCH project already. This governance component allows the project to deal with the political realities and take the time to build government capacity. While it must be remembered that this project is primarily a health project and not a governance one, the integration of health and governance is looking like a more promising prospect for a lasting impact. Pressing for accountability and better performance from Government will continue to be priority. In Jigawa, the project can continue to work with Paths2 and SPARC.

The biggest problems remain:

- Tracking the release and expenditure performance of budgets at every level (federal to state to LGA);
- An overly complex health architecture across Nigeria; and
- A lack of trained health personnel, particularly midwives.

This programme remains High Risk as governance and institutional issues persist. While some indication of real government commitment to the programme is becoming apparent in some states, it cannot be guaranteed that this will continue. The team saw some improvements in commitment also at the federal level as well but it is too soon to say whether these will endure.

1.2 Scoring Assessment

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 so the work of the PRRINN programme is more advanced. Results of the PRRINN Annual Review are presented in Annex 1.

- (i) 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 – 1 (2 in 2009)*
Output 2 – Improved capacity at State and LGA levels for strategic analysis, policy development, planning and budgeting of routine immunisation: *Score – 2 (2 in 2009)*
Output 3 – Primary health care systems strengthened to support routine immunisation: *Score – 2 (3 in 2009)*
Output 4 – Increased demand for routine immunisation: *Score – 1 (2 in 2009)*
Output 5 – Improved capacity of Federal level to enable States' routine immunisation activities: *Score – 2 (3 in 2009)*.
- (ii) Overall Outputs Score for PRRINN remains '2'.
- (iii) For the PRRINN-MNCH outputs, the scoring is as follows:
Output 1 – Strengthened state and LGA governance of PHC systems geared to RI and MNCH: *Score – 2 (no scoring in 2009)*
Output 2 – Improved human resource policies and practices for PHC: *Score – 2 (no scoring in 2009)*
Output 3 – Improved delivery of MNCH services (including RI) via the PHC system: *Score – 3 (no scoring in 2009)*
Output 4 – Operations research providing evidence for PHC stewardship, RI and MNCH policy and planning, service delivery, and effective demand creation: *Score – 2 (no scoring in 2009)*
Output 5 – Improved information generation with knowledge being used in policy and practice: *Score 2 – (no scoring in 2009)*.
Output 6 – Increased demand for MNCH (including RI) services: *Score 2 – (no scoring in 2009)*
Output 7 – Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities: *Score 2 – (no scoring in 2009)*
- (iv) Overall Outputs Score is '2'.
- (v) Almost all PRRINN scores advanced by one mark as good progress has been made, especially in harmonisation and demand creation. PRRINN-MNCH scored lower as many outputs that are progressing well have not yet accomplished their objectives. Output 3 scored 3 again as service delivery is not yet fully functioning.

1.3 Risk Assessment

- (i) The risks originally identified and discussed in the 2009 Annual Review are still valid. The successful management of mitigation strategies is helping to reduce risks. See Annex 10 for an assessment of the risks.
- (ii) Overall rating of PRRINN-MNCH remains: High Risk.

1.4 Summary of Recommendations

General

For the programme

G.1. Continue stellar work with partners (UN and other health development projects as well as government stakeholders; the review team did not speak with local partners).

G.2. Increase collaboration with Paths2 (both in Jigawa and beyond)

- o Clarify workplans and responsibilities, especially at federal level
- o Serve on each others' review teams.

G.3 As procurement is slowing progress, the process should be examined more closely to see if there can't be improvements made by both Crown Agents and the PRRINN-MNCH programme.

For DFID

G. 4. A project complication is that the PRRINN funding will end before the MNCH funding does. This complicates matters as the projects cross-subsidise each other—particularly with the staffing. Extend DFID PRRINN funding for a sixth year, if possible, to coincide with the end of the MNCH funding as this would allow the project to consolidate all progress and complete its full range of activities by project's end.

G.5. DFID must continue to work with other donors by influencing them. DFID can use information fed from PRRINN-MNCH on potential opportunities, objectives and desired outcomes.

Output 1: State Governance: Strengthened state and LGA governance of PHC systems geared to RI and MNCH

For the programme

1.1 Maintain the momentum to gain the state political will, as in Zamfara.

1.2 Maintain emphasis on simplifying architecture for the health system (keep an eye on the drugs as an indicator of a functioning system).

1.3 Look at the political opportunities to ensure that budget and planning is transparent at all levels. (Follow the resources to ensure they are reaching the LGA level.) The programme needs to continue to provoke debate and encourage realistic health allocations that are implemented effectively.

1.4 Consider using the Zamfara basket fund approach in Yobe and Katsina as a temporary mechanism to demonstrate that funds can flow transparently.

1.5 The state governments need to be thinking for themselves and talking about change—PRRINN-MNCH should be aiding in this dialogue and eventually easing themselves out.

1.6 In Zamfara, with good performance, consider additional funds to build capacity in the area of budget, planning and implementation monitoring; also in expenditure tracking.

1.7 In Jigawa, the programme should continue to work closely with Paths2 and SPARC to feed RI into wider state planning and budgeting processes.

1.8 All state programmes should raise concerns, opportunities and options for DFID to advocate to the State Government to support the development. Use DFID as a tool.

For DFID

1.9 DFID should be supporting the momentum to gain the state political will and signing MOUs with states directly (especially in Yobe).

For the Government

1.10 As above, the state governments need to be thinking for themselves and talking about change

1.11 Maintain emphasis on simplifying architecture of the health system

1.12 Look at the political opportunities to ensure that budget and planning is transparent at all levels. (Follow the resources to ensure they are reaching the LGA level.)

Output 2: Human Resources: Improved human resource policies and practices for PHC

For the programme

2.1 Re-orienting managers to better post matching, qualification and performance based HR systems will be difficult, as well as maintaining an accurate HRIS, but it should remain a PRRINN-MNCH priority.

2.2 It would be a very positive step to publish HR data and periodic reports among the agencies and donors, disaggregated by gender to facilitate awareness of shortages, equity, and deployment issues.

2.3 PRRINN-MNCH may want to also look at innovative models for addressing chronic shortage of CHEWs and midwives:

- Explore alternative models for deploying and supporting CHEWS
 - Rotating female CHEWS for outreach services (Yobe)
 - Mobile services (Katsina)
 - CHEWS posted to hard-to-reach areas (Jigawa, Zamfara)
- Integrate village health volunteers (TBAs, CBDs, etc), CHEWS and midwives to support MNCH services
- Extend support around incentives to keep staff in place
- Support PHC management training for health personnel within the training institutions and as part of supportive supervision and in-service training.

2.4 There is an opportunity to think outside the box and address equity/social inclusion of women and girls within the context of the more socially acceptable need for health services such as:

- Determine reasons why so few women graduate from midwifery school and remedy; also look at CHEW curriculum.
- A health care worker 'feeder programme' focused on getting girls from primary through secondary using a basic life skills/health care track; or
- Increasing the acceptability of male CHEWs.

Output 3: Service Delivery: Improved delivery of MNCH services (including RI) via the primary health care system**For the programme**

- 3.1 Coordinate timelines for MNCH to offer the full package with all M, N, and CH elements
- 3.2 Promote complete delivery of the MH package
 - Accelerate work in family planning and communicate this to state teams
 - Ensure that family planning is included in the Minimum Service Package (MSP) as well as that contraceptives are on all state Essential Drug Lists (EDL) and coordinating with MCHIP.
- 3.3 Harmonise MNCH services with RI as quickly as possible so that they are both available in all facilities
 - Concentrate on the CEOC clusters in each state and coordinate timelines for MNCH to offer the full package.
 - Ensure that the MSP can be delivered, particularly at the primary level—and move to integrated services as quickly as possible.
 - Cooperating with WHO on IPDs is worth the good relationship (but phase out as soon as is politic).
- 3.4 Facilitate Sustainable Drug Supply Systems (SDSS) in each state as soon as possible as the current Drug Revolving Funds (DRFs) are being decapitalised.
- 3.5 Support the states to monitor and support the facilities within the CEOC clusters.

Output 4: Operations Research: Operational research providing evidence for PHC stewardship, RI and MNCH policy and planning, service delivery, and effective demand creation**For the programme**

- 4.1 Build state capacity and ensure a variety of research questions across the four states, but also seek and support studies that allow comparison and learning across states.
- 4.2 OR agenda in each state tests alternative service delivery models. Need to work closely with Outputs 3 and 6 to insure coordination of initiatives and learning across outputs.
- 4.3 Promotion of cross-state learning and OR “division of labour” can help all states launch studies, accelerate learning within and between states and allow cost-sharing for OR costs
 - OR training workshops with all states to develop common methodologies where possible
 - Quarterly cross-state OR meetings
- 4.4. Need to integrate PBF into the OR protocols
 - Demonstrate if Free MNCH is possible in Jigawa
 - Zamfara experimenting with women’s savings groups as form of PBF
- 4.5 OR outcomes measured include the logframe indicators, but many other intermediate outcomes needed to facilitate learning about what works.
- 4.6 Continue to ensure that the whole programme staff maintains a good understanding of the operations research component of the programme.

Output 5: HMIS/Information: Improved information generation with knowledge being used in policy and practice**For the programme**

- 5.1 Update and streamline national HMIS forms with state and national stakeholders
 - Need to cover MNCH services more completely (e.g. add FP, c-sections, more details on M,N, C services)
 - Ensure all partners can use and feed into the same system
 - Include way for register to be used to develop facility or community reports.
- 5.2 Analyse data at all levels and use it to genuinely inform decisions.
- 5.3 HMS 001 forms need to be in place and training given in their use, especially at facility level.
- 5.4 Use data to ensure that communities can eventually understand that conditions are improving (or worsening) in their areas (important for V&A)
- 5.5 Explore greater use of visual material for HMIS staff to both support them and the importance of their work and to remind them of their responsibilities.
- 5.6 Learn from other states: Feature best practice.
- 5.7 The programme needs to think through its strategy for the use of success stories and more visual information, including (perhaps) a website.

For the Government

- 5.8 MLG must provide more and adequate personnel to do the data management job at all levels.

Output 6: Demand Generation: Increased demand for MNCH (including RI) services**For the programme**

- 6.1 The team strongly recommends jointly developed demand generation, V&A, and any equity and social inclusion workplans across participating donor/agencies with clear roles and deliverables. V&A has a yet untapped potential to drive political change.
- 6.2 With demand generation and community engagement ahead of the supply of primary care, it is important to be careful to keep this work balanced in a stepped fashion.
- 6.3 The project may want to increase support of existing village/ward development committees as critical elements in creating demand and supply of services.
- 6.4 The demand generation should begin to supplement general awareness messaging with messaging around access – what services, where, and when.
- 6.5 Need for community health volunteers to be more mobile and recognized for contributions.
- 6.6 Include family planning. Child spacing and family planning conversations are going on within the communities. The FMOH/Reproductive Health Unit, project staff and health workers seem to think demand is there and communities are receptive. Begin to work on some family planning tools and messages.
- 6.7 There is a real V&A opportunity to focus on engaging State Ministry of Health and Ministry of Local Government on resource allocation and utilization and performance of health care delivery system using strong professional groups such as the Nigerian Medical Association and HERFON.

For DFID

6.8 Ensure demand creation coherence across Nigerian programmes

Output 7: Federal Governance: Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities**For the programme**

7.1 PRRINN-MNCH must continue its strategic approach at federal level and continue to work with other key players.

7.2 Assist the FMOH and the FPHCDA to continue to clarify their roles.

7.3 The PRRINN-MNCH programme can help NPHCDA by demonstrating that it is at the state level where the most difference will be made.

7.4 Look at incentives to obtain more and retain midwives.

7.5 Continue to look at solutions for the lack of midwives at the federal level. Are midwife standards too high? What are the intermediate cadre options?

For the Government

7.6 As above, the FMOH and the FPHCDA must continue to clarify their roles to avoid overlap and ensure coherent coordination.

7.7 The federal government must act decisively in considering alternative solutions to the shortage of midwives in the north.

2. Introduction

2.1 Background

The PRRINN-MNCH programme incorporates two projects from two funding sources which have been merged into one programme. The PRRINN project was a DFID-funded health system strengthening programme begun in 2006, particularly focused on routine immunisation. In 2007, the Norwegian government began discussions about an MNCH intervention in the PRRINN states and a tender was launched. In September 2008, the MNCH programme was awarded to the same consortia carrying out the PRRINN programme and the two are now fully merged administratively and programmatically. (The one exception to this is that the PRRINN project must still report to DFID using its original five outputs in order to account separately for the DFID funding.) The MNCH programme is taking advantage of the learning already carried out by the PRRINN one and the Norwegians are getting very good value for money. The logframes for both projects can be found in Annex 11.

As the PRRINN programme began first, the routine immunisation work is slightly ahead of the MNCH interventions. The review team has urged the project staff to harmonise the implementation of both as quickly as possible and the project is close to doing this. Within a year, it would be expected that the two programme components would be completely caught up.

The main body of the report consists of the findings of the review against the combined PRRINN-MNCH logframe. A separate assessment against the original PRRINN outputs can be found in Annex 1.

2.2 Methodology

The review team looked at key documents and reports and met with PRRINN-MNCH staff as well as key stakeholders at the federal, state and LGA levels. The team visited all four states and met with government staff and other partners as well as seeing community engagement activities and touring health facilities. At the beginning and end of each state visit, the visiting review team met with the state offices of the PRRINN-MNCH staff. The TORs for the Annual Review can be found in Annex 6.

The review team had fifteen participants, each with responsibility for one of the project's outputs. These included:

Review Teams

State Team 1 (Zamfara, Katsina)	State Team 2 (Yobe, Jigawa)
Carol Bradford, consultant & Team Leader (Leader Team 1) Solvi Taraldsen, DFID David Lloyd-Davies, DFID (Zamfara only) Jane Miller, DFID (Katsina only) Mr Frank Akpan, FMOH Andrew L Mbewe, WHO Dr Bulama Sulaiman, SMOH Yobe Pharm. Usman Tahir, SMOH Jigawa Dr Emmanuel Odu, NPHCDA	Jakesh Mahay, DFID (Leader Team 2) Maisha Strozier, consultant Lene Lothe, NORAD Carolyn Sunners, DFID (Yobe only) Halima Tajo, NPHCDA Taiwo Oyelade, WHO Dr Aliyu Ma'awiyya, SMOH Katsina Bala Aliyu, SMOBEP Zamfara

Each team member was responsible for various aspects of the report and these detailed responsibilities (as well as full titles for each team member) can be found in Annex 7. Of the 15 participants, six had also participated in the review last year so continuity was good. The multi-disciplinary team meant interesting and varied questions in the meetings with stakeholders. And the representatives from the state governments on the team switched teams so that they were visiting different states to their own—leading to some healthy rivalry and cross-state learning. All team members (with the exceptions noted above) participated in the entire week from the briefing on Monday morning to the wrap-up session back in Kano on Friday afternoon. The full itinerary for the Review can be found in Annex 8.

In each state, the team met with the PRRINN-MNCH state team offices before meeting with other stakeholders, visiting health facilities or seeing any community engagement activities. In all states save Jigawa, the visiting teams were also able to meet with the state teams to brief them on their findings. The persons and organisations consulted can be found in Annex 9. This four-state visit made it possible for the team to grasp the complicated situation in each of the states in an efficient manner. See Annexes 2-5 for short reports for each state.

This multi-disciplinary team approach should be continued in future years; it would be hoped that Paths2 would attend next year. Planning in advance might allow for more efficient meeting set-up in the states in future; also ensure that team documents are available in advance, if possible.

3 Assessment against Logframe Outputs

3.1 General Progress

The Review Team saw again the difficulties of working in the Northern Nigerian environment where systems are entrenched and there is little incentive to change. The biggest problems remain:

- Tracking the release and expenditure performance of budgets at every level (federal to state to LGA);
- An overly complex health architecture across Nigeria; and
- A lack of trained health personnel, particularly midwives.

Despite these difficulties, the programme made real progress in the past year as revealed by improved scores for PRRINN for almost all outputs. PRRINN-MNCH marks also improved but to a lesser extent as the full programme is still relatively new and many components are not yet fully in place.

The programme's particular successes this year were:

- The basket fund in Zamfara state demonstrating that funds can be transparently managed there.
- The appreciation expressed by the state governments of Zamfara (see letter in Annex 12) and Jigawa for capacity building elements of the project demonstrating their willingness to participate in the process of transparent government.
- Human resource audit with fulltime HR units established within each SMOH, demonstrating real progress in HR planning in all states.
- Costing of the Minimum Service Package (MSP) in each state.
- Posting of 96 midwives per state through the Midwife Service Scheme (MSS).
- Increasing demand for RI and a programme survey indicates a doubling of routine immunisation rates for the four states (albeit from a very low base).

Recommendations from the 2009 Annual Review were taken seriously by the project and largely addressed. Linkages with the Government of Nigeria and its institutions as well as with other programmes are to be commended. Here is a programme that fully realises that it is impossible to carry out the programme without full partnership with government and other stakeholders.

The PRRINN-MNCH full logframe can be found in Annex 11 and baseline data is now complete. The original PRRINN logframe can also be found in Annex 11. Progress against outputs for both logframes can be found in Annex 1.

The Review report is structured using the combined PRRINN-MNCH logframe outputs. In addition, this report will include three elements of the project highlighted for this review: the three pillars of maternal health, routine immunisation and its progress (particularly as PRRINN is the longest running part of the programme); also, gender aspects of the programme were examined.

Output 1: State Governance: Strengthened state and LGA governance of PHC systems geared to RI and MNCH

The combined programme is being implemented in a challenging environment characterized by institutional constraints to improved primary health care (PHC) service delivery. Nevertheless, the structures, coalitions and partnerships being established in the states have the potential to have a large impact on Governance initiatives and issues that affect RI/MNCH and PHC.

Complex architecture As always, the complicated architecture for health confounds responsibilities and accountability throughout the system. The Primary Health Care Agency in Katsina is running model comprehensive primary health care clinics at the Local Government level and sees itself as overseeing PHC in Local Government – however the agency has neither responsibility for funding nor staffing of the local government PHC – therefore their ability to have a stewardship role is undermined. All states have some way to go before they have ‘PHC under one roof’ (see next and Output 7, Federal Governance). In addition, a look at the management of the drugs in all four states reveals that drugs are being bought by the state, local government, health facilities, the donors, and the MDG office, to name a few. These multiple procurement channels, meant that key drugs were found to be out of stock, including anti-malarial drugs, vaccines, and contraceptives.

PHC ‘under one roof’ (PHCUOR). Primary Health care ‘under one roof’ is an idea propagated by the programme to pull all those responsible for primary health care into one single government entity, which is not currently the case. At the moment, the State Ministry of Health, the Ministry of Local Government and the State Primary Health Care Development Agency (in Katsina only) all have some piece of responsibility for the delivery of PHC.

Budgeting and planning. These continue to challenge--specifically budget release and tracking at all levels, particularly in disbursement of non-salary recurrent costs. This is partly a structural issue as there doesn’t seem to be an established government system to produce summary LGA expenditure reports. There also appears to be little will in releasing what is perceived as ‘sensitive information’. Higher level political pressure will be required for this type of reform. That said, there is now some budget release for RI and MNCH and this demonstrates progress. In Jigawa, the Gundumas have well articulated operational plans for RI and MNCH and the communities are part of the process. PRRINN-MNCH has done well with supporting the state planning—including the State Strategic Plans. Operationalising these plans will be the next challenge for the programme. The LGAs in Yobe do not yet have operational plans for RI and MNCH and the communities where the facilities are situated are not yet part of the process. Zamfara has found some success in demonstrating transparency with its basket fund and, while the fund is relatively small, it proves that funds can flow.

State PHC Management Boards (SPHCMB). The programme has been providing technical assistance for the establishment of a SPHCMB in Yobe as well as Zamfara where these Boards could be approved imminently. There are high hopes for the SPHCMBs to configure the roles of the different tiers of Government to strengthen the delivery of PHC. The success of the SPHCMB will depend on leadership and the recruitment of key personnel able to manage the necessary realignment of roles and responsibilities. Incentives will need to be created to ensure those who currently control resources do not block the necessary change required to strengthen the system. The programme may be able to play a facilitative role to ensure that the legislation is understood by all stakeholders and implementation is open and transparent.

MSP and Free MNCH. The Minimum Service Package is now defined and costed in all states. The process of costing MNCH has begun and will be complete in early 2010.

'I was scared [when I heard about free MNCH] but we did the costing and it turned out to be less than I thought!'

Hamza Salihu, Director of Budget, Ministry of Budget and Economic Planning, Zamfara

Key Partners. The coordination with key partners is good, particularly with WHO. All partners reported that health development partners were meeting on a regular basis with MoH and that PRRINN-MNCH played a backseat (but important) coordinating role in seeing this happen. In Jigawa and Yobe, the MoEP is developing a development partner forum to strengthen coordination across all sectors. In Zamfara, the development partners stated that they had never seen a better partner than PRRINN-MNCH. Key development partners are:

- UN: WHO and UNICEF
- USAID: ACCESS and MCHIP
- EU: SRIP
- DFID: Paths2, SPARC (Jigawa and at federal level)
- Rotary International

GAVI funds. All four states managed to access GAVI funds. Using the Zamfara PHC Basket Fund as a home for GAVI funds deserves a good look as a replicable model to use in other states. Some GAVI funds have reached the PHCs in Yobe. (See Output 7 for more on GAVI funds.)

Health Sector Development Plan. All states established health milestones for inclusion in their plans.

Variance in political will at state level. There is evidence of good political will built in some states (Zamfara, Jigawa); political will needs further pushing in others (Yobe, Katsina). There was real enthusiasm on the part of the Ministry staff at the Director level for the work of PRRINN-MNCH in Zamfara. This was evidenced by a request for additional support from the programme for that 'magic capacity' the programme offers. It seemed that these government staff had realised that PRRINN-MNCH has actually made their work easier, more possible. (See Annex 12 for a letter from the Zamfara Health Commissioner.) Yobe, on the other hand, demonstrated a lack of discernable will on the part of the government. There is reported Governor commitment to strengthening the PHC system but this has yet to translate to visible interest at Director level where direction and decisions are required. In Katsina, the PHCA and LGA stated their commitment to MNCH and PHC. The SMOH, however, do not see PHC as their responsibility—but that of the SPHCDA. Who has the overall oversight for health there?

Advocacy. Active support by emirs and traditional leaders for RI and MNCH in Yobe and Jigawa was seen as remarkable by the Review Team. Work with HERFON across the four states continues to be in the right direction and HERFON's 2010 workplans look promising.

Recommendations on Output 1: State Governance: Strengthened state and LGA governance of PHC systems geared to RI and MNCH**For the programme**

- 1.1 Maintain the momentum to gain the state political will, as in Zamfara.
- 1.2 Maintain emphasis on simplifying architecture for the health system (keep an eye on the drugs as an indicator of a functioning system).
- 1.3 Look at the political opportunities to ensure that budget and planning is transparent at all levels. (Follow the resources to ensure they are reaching the LGA level.) The programme needs to continue to provoke debate and encourage realistic health allocations that are implemented effectively.
- 1.5 Consider using the Zamfara basket fund approach in Yobe and Katsina as a temporary mechanism to demonstrate that funds can flow transparently.
- 1.5 The state governments need to be thinking for themselves and talking about change—PRRINN-MNCH should be aiding in this dialogue and eventually easing themselves out.
- 1.6 In Zamfara, with good performance, consider additional funds to build capacity in the area of budget, planning and implementation monitoring; also in expenditure tracking.
- 1.7 In Jigawa, the programme should continue to work closely with Paths2 and SPARC to feed RI into wider state planning and budgeting processes.
- 1.8 All state programmes should raise concerns, opportunities and options for DFID to advocate to the State Government to support the development. Use DFID as a tool.

For DFID

- 1.9 DFID should be supporting the momentum to gain the state political will and signing MOUs with states directly (especially in Yobe).

For the Government

- 1.10 As above, the state governments need to be thinking for themselves and talking about change
- 1.11 Maintain emphasis on simplifying architecture of the health system
- 1.12 Look at the political opportunities to ensure that budget and planning is transparent at all levels. (Follow the resources to ensure they are reaching the LGA level.)

Output 2: Human Resources: Improved human resource policies and practices for PHC

Critical lack of staff. Human resources remain a major focus for PRRINN-MNCH. PRRINN-MNCH will need to examine the implications of staffing for service delivery and strengthening the capacity of a critical mass of health workers. Human resources, particularly a shortage of midwives, was cited as the biggest challenge by everyone to MNCH in Northern Nigeria. There is room for some original thinking and the programme may need to support the government on incentives to retain staff in project catchment areas if the expected results are to be delivered. As the health professions (programme officers, managers, policy staff) are in higher earning positions, their appointment and deployment is often very political and reflects strong patronage. Deployment and imbalance in the distribution of CHEWs and midwives between urban and rural areas will be a critical issue across the states. This is an area where PRRINN-MNCH has and can play a role. Recruitment and retention of CHEWs is a major challenge and has resulted in task shifting with CHEWs staffing clinics instead of doing more outreach work. There is no shortage of CHEWs in the country, just recruitment, deployment, and retention issues in the north.

HR audits. The programme is doing a good job with the human resource audits and the work is ongoing. All states seem to have progressed significantly with the completion of the audits, review and revision of HR policies and establishments of the HRIS. In Jigawa, the transition to the Gunduma system presents a further opportunity to ‘rationalize’ staffing – reposting and retraining health staff to better improve system-wide performance.

Midwife Service Scheme (MSS). This is an excellent performance in working together with all stakeholders to get nearly 96 national midwives posted in each of the four states. The MSS is a strong stop gap measure for addressing some of the supply issues for midwives. All four states are well on their way to receiving and deploying the staff strategy and states will top up the N30,000 provided by NPHCDA with incentives. These include additional state and LGA salary top ups, housing and amenities. The retention strategies in place and proposed are good steps, but are unlikely to overcome the main issues around retention approaches. Receiving salary was not an issue among the workers asked and this will remain an important incentive and motivational issue. It is not known why fewer midwives reported to Yobe but the Review Team did notice a lower uptake which will require exploration by the Yobe State Team.

Number of new midwives coming to PRRINN-MNCH states		
STATE	MIDWIVES COMMISSIONED in 2009	MIDWIVES REPORTING in 2010
Jigawa	96	94
Katsina	96	86
Yobe	96	61
Zamfara	96	91

A new cadre. There may be a need for a new cadre below a midwife but above a CHEW--what should she be called and how long should she be trained? The team heard of ‘community midwives’ and of CHEWS trained for either two or three years. This means that there are experiments being considered. The programmes in consultation with the Government must work out the most sensible solution and then build the political momentum behind it to see that the idea is accepted and implemented.

Key Human Resource Gender Issues. It is very difficult to separate the HR issues from gender issues. It is not just the number of CHEWs available but the need for female CHEWs in the communities and in the health centres to be culturally acceptable to women. There must be a longterm strategy has to deal with a number of issues:

- Not enough girls completing secondary schools to meet requirements for entrance into nursing, CHEW, midwifery programmes.
- Need for strategic approaches to deploying and utilizing a limited supply of female healthcare workers effectively across the PHCs and health facilities.
- Approach to using CHEWs as truly community-based health workers with access and capacity to meet the needs of women and children who cannot easily access clinic services for economic, financial, and cultural reasons.

- As increasing the number of female health workers is a long term issue, there is a need to look at improving the capacity of male workers to deliver services to women and increasing the receptiveness of communities to male extension workers.
- Why are so few women graduating from the midwifery schools in the north? (e.g. Katsina)

Recommendations on Output 2: Human Resources: Improved human resource policies and practices for PHC

For the programme

2.1 Re-orienting managers to better post matching, qualification and performance based HR systems will be difficult, as well as maintaining an accurate HRIS, but it should remain a PRRINN-MNCH priority.

2.2 It would be a very positive step to publish HR data and periodic reports among the agencies and donors, disaggregated by gender to facilitate awareness of shortages, equity, and deployment issues.

2.3 PRRINN-MNCH may want to also look at innovative models for addressing chronic shortage of CHEWs and midwives:

- Explore alternative models for deploying and supporting CHEWS
 - Rotating female CHEWS for outreach services (Yobe)
 - Mobile services (Katsina)
 - CHEWS posted to hard-to-reach areas (Jigawa, Zamfara)
- Integrate village health volunteers (TBAs, CBDs, etc), CHEWS and midwives to support MNCH services
- Extend support around incentives to keep staff in place
- Support PHC management training for health personnel within the training institutions and as part of supportive supervision and in-service training.

2.4 There is an opportunity to think outside the box and address equity/social inclusion of women and girls within the context of the more socially acceptable need for health services such as:

- Determine reasons so few women graduate from midwifery school and remedy; also look at CHEW curriculum.
- A health care worker 'feeder programme' focused on getting girls from primary through secondary using a basic life skills/health care track; or
- Increasing the acceptability of male CHEWs.

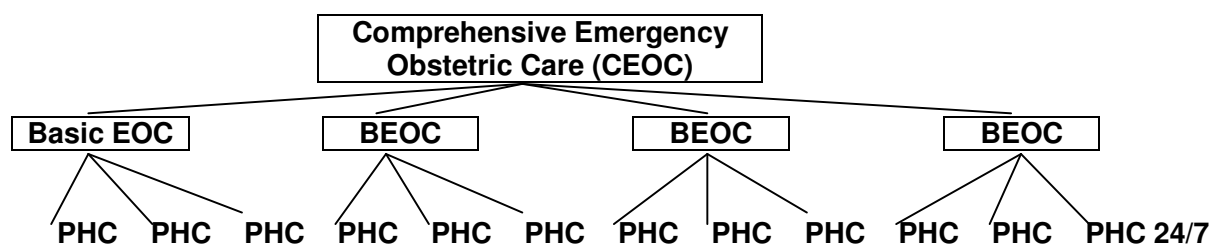
Output 3: Service Delivery: Improved delivery of MNCH services (including RI) via the primary health care system

Service delivery is still poor as improvements in the health system have not yet reached the service delivery level. The MNCH service delivery is still in the formative stages and the CEOC clusters are not yet ready to measure. On the positive side, RI is improving.

Demand outstripping supply. Facilities still face a shortage of trained staff, drugs and equipment. The programme must be careful to raise demand for services in pace with the service delivery improvements.

Services not integrated. Services are still not integrated, requiring clients to return to facilities for different services. By the end of the project, PHC services should be fully integrated so that they are more efficient for women (the client), especially those travelling long distances.

CEOC Clusters ready soon. MNCH services are currently being renovated and are not yet ready for service. The Review Team toured several facilities that are currently being refurbished—due to be finished by mid-March 2010. Until the CEOC clusters (illustrated here) are fully operational, it is unlikely that there will be any falls in maternal deaths. The plan is to develop the first cluster in 2010 and to expand to two more in each state before the project end.



An illustration of a CEOC cluster.

Inadequate supplies. Drugs and commodities are not available where required and logistics need strengthening. While the percentage of facilities with tracer drugs available was achieved, the system still needs further improvements. Sustainable drug supply systems are currently being designed in all states and are awaiting procurement of seed stocks of drugs. There is still much work to do here—particularly with the Free MNCH policy in the various states.

Training Midwives and CHEWs. The programme will need to focus on training the staff in the CEOC clusters and getting them functioning. This work will be continuous.

Little family planning. The three pillars of maternal health are lacking a pillar in this project: family planning and post-abortion complications. The third pillar of maternal health accounts for the final third of maternal deaths (after EMOC and SBA). The Review Team saw little evidence that family planning has been integrated into the project so far. While the low profile of family planning was sensible in the first year of the PRRINN-MNCH programme, it is now time to fully integrate family planning into all activities. The Review Team was consistently told that there was demand from women and acceptance by important stakeholders for child spacing. Family planning is only on Katsina's essential drug list and is not yet there for Zamfara and Yobe. State officials will need to be educated on the many health benefits to child spacing. In addition, post-abortion care must be available at all levels of the health system.

Disease incidence. There are indications that measles and polio cases have come down dramatically but it is not clear that the programme can take credit for these decreases or the fact that there were no disease outbreaks in the reporting period. It is possible that these decreases, particularly in measles, are a result of more children being immunised but it is too soon to say. The results of a PRRINN-MNCH rapid immunisation cluster survey just completed is showing some slow but encouraging rises in fully immunised children at one year of age. This would suggest that the number of children immunised in the PRRINN-MNCH states has doubled in the last three years (from a very low base). The number of facilities providing RI has increased from 89 to 236.

Fully immunised children (Percent of one-year-olds)

Survey	Jigawa	Yobe	Zamfara	Katsina
NICS 2006	4.4	5.7%	0	2.2
P-M survey, 2009	9.0%	7.2%	8.7	6.6

MNCH services. It is too soon to look at MNCH indicators yet and no new surveys have taken place since the baseline survey done in 2009. State HMIS data shows some small increases in ANC visits. These statistics should be more revealing in 2011. The 2010 NICS will also give data on whether there has been an increase in TT doses.

Recommendations on Output 3: Service Delivery: Improved delivery of MNCH services (including RI) via the primary health care system

For the programme

- 3.1 Coordinate timelines for MNCH to offer the full package with all M, N, and CH elements
- 3.2 Promote complete delivery of the MH package
 - Accelerate work in family planning and communicate this to state teams
 - Ensure that family planning is included in the Minimum Service Package (MSP) as well as that contraceptives are on all state Essential Drug Lists (EDL) and coordinating with MCHIP.
- 3.3 Harmonise MNCH services with RI as quickly as possible so that they are both available in all facilities
 - Concentrate on the CEOC clusters in each state and coordinate timelines for MNCH to offer the full package.
 - Ensure that the MSP can be delivered, particularly at the primary level—and move to integrated services as quickly as possible.
 - Cooperating with WHO on IPDs is worth the good relationship (but phase out as soon as is politic).
- 3.4 Facilitate Sustainable Drug Supply Systems (SDSS) in each state as soon as possible as the current Drug Revolving Funds (DRFs) are being decapitalised.
- 3.5 Support the states to monitor and support the facilities within the CEOC clusters.

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

The 2009 Annual Review found that the programme was behind in its OR activities but the team this year was pleased to find that the project had caught up very well. Most states have formed committees, have protocols, space and priorities and are reflecting their experiences in Navrongo.

Health and Demographic Surveillance System (HDSS). The HDSS in Zamfara looks like it will be of great potential both to Zamfara and to Northern Nigeria. The emphasis on the centre

being government owned is excellent and likely to attract more donor funding. The facility is not operational yet but the infrastructure is taking shape and equipment has arrived.

Research questions community driven. The Review Team saw good evidence that research questions were state and community driven.

Understanding of OR. Discussions reflected that the 'thinking' around the OR agenda and how OR shall be used to test innovative interventions on the small scale with a view to subsequent state-wide rollout seemed quite mature. The one exception to this was Yobe's programme which is slightly behind the others but is just now developing a workable, small-scale project to assess CHEW outreach efforts.

Enthusiasm for the trip to Navrongo. How much everybody learned when they went to Ghana! All states came back eager to explore how a modified Community Health and Population Service Programme could work in their own state and how they could use OR to find the right model.

Operations Research Questions, by State	
<p>JIGAWA</p> <ul style="list-style-type: none"> • Feasibility of improving access to MNCH services through CHEWS posted to hard-to-reach areas (CHEW-Compound) • With the following elements: <ul style="list-style-type: none"> • Human resources (Incentive mechanism for staff retention, and pilot staff performance and rewards) • Drug subsidy to increase access • Increasing community awareness/removing cultural barriers affecting MNCH access (Community Engagement, Emergency Transport Schemes) 	<p>YOBE</p> <ul style="list-style-type: none"> • Piloting an MNCH outreach packet to be provided by CHEWS in the cluster • Related to this question: <ul style="list-style-type: none"> ○ The effects of the implementation of free MNCH in secondary health facilities and its implications on bypassing PHC units, costs and drug supply etc. ○ OR related to the ETS scheme to ensure sustainability
<p>KATSINA</p> <ul style="list-style-type: none"> • Assessment of the effectiveness of Mobile services (CHEW or nurse/midwife) to expand access and health care improvements for communities more than 10k from facilities • Related elements: looking at Community engagement and performance-based financing 	<p>ZAMFARA</p> <ul style="list-style-type: none"> • Assessment of alternative models for women’s savings clubs to mobilize funds and use of EOC as needed (includes performance based financing options) • Pilot of an alternative RI immunization register to improve tracking and assessment of ‘fully immunised’ child

Recommendations on Output 4: Operations Research

For the programme

- 4.1 Build state capacity and ensure a variety of research questions across the four states, but also seek and support studies that allow comparison and learning across states.
- 4.2 OR agenda in each state tests alternative service delivery models. Need to work closely with Outputs 3 and 6 to insure coordination of initiatives and learning across outputs.
- 4.3 Promotion of cross-state learning and OR “division of labour” can help all states launch studies, accelerate learning within and between states and allow cost-sharing for OR costs
 - OR training workshops with all states to develop common methodologies where possible
 - Quarterly cross-state OR meetings
- 4.4. Need to integrate PBF into the OR protocols

- Demonstrate if Free MNCH is possible in Jigawa
 - Zamfara experimenting with women's savings groups as form of PBF
- 4.5 OR outcomes measured include the logframe indicators, but many other intermediate outcomes needed to facilitate learning about what works.
- 4.6 Continue to ensure that the whole programme staff maintains a good understanding of the operations research component of the programme.

Output 5: HMIS/Information: Improved information generation with knowledge being used in policy and practice

Nigeria is not a data culture. In many ways, this output is one of the toughest as there is nothing glamorous about it and yet much knowledge of progress rests here. The team did see greater understanding of HMIS in some states than last year and noted steady improvement. Also, some states are stronger (Zamfara, Jigawa) than others (Katsina, Yobe). That said, there was little evidence of forms or complete reporting at facility level as they were all using a variety of record books; there was also little evidence that health staff had been trained in record keeping yet.

State plans reflect HMIS findings. The team found evidence that state plans reflect key HMIS findings and that there was increasing use of information from assessments, supervision and data quality audit findings in planning exercises.

Inadequate staff and equipment still limit improvements. While there were more better-housed staff than the previous year, the data infrastructure is still inadequate. A proper system will require more staff in adequate space with computers.

Mobile phone technology. Piloting the use of data collection via mobile phones seemed to be a good learning experience which also garnered enthusiasm for data collection. Expand this slowly, if possible, while monitoring correct use of equipment. The programme should be careful to wait for the right time and the right technology.

Sharing data with the community. There was no evidence that any data were being shared with the community or facility. As data collection improves and the data becomes more meaningful, this sharing with the PHCs and the community is going to be important. The community badly needs to see their efforts bearing fruit. Voice and accountability (V&A) efforts often hinge on seeing some improvement and demanding even more as the sense of hopelessness recedes. It becomes worth the trouble to complain!

USAID using different form. The current HMIS form does not allow the capture of all health interventions so, in at least one state, USAID had introduced a second form to capture their full service delivered. Introducing a parallel system and expecting an already stretched health facility to report twice is unrealistic. As the HMIS form 001 requires updating (e.g., current forms do not provide for c-sections nor family planning), surely the way ahead is to revise the form at the federal level so that everybody benefits. While understanding that this is more difficult than it sounds, this is something that PRRINN-MNCH and Paths2, as well as other stakeholders could do together in collaboration with the FMOH.

Preaching success. DFID expects projects to provide materials for demonstrating the success of the project and PRRINN-MNCH is some way behind some other DFID-funded programmes in Nigeria. PRRINN- MNCH should consider establishing a small and simple website to increase public awareness, along the lines of those now used by ESSPIN and SPARC; DFID and Norway could link to such a site from their own websites.

More success stories. During the review, the team heard about 11 case studies which can be made available. There is scope to improve the impact of these for a UK public audience by focussing on impact (achieved or expected) more than process. These would be human interest stories in simple English (500 words), making good use of photographs and other visual tools. In Zamfara State, the basket fund was identified as having potential as a case study.

Recommendations on Output 5: HMIS/Information

For the programme

- 5.1 Update and streamline national HMIS forms with state and national stakeholders
 - Need to cover MNCH services more completely (e.g. add FP, c-sections, more details on M,N, C services)
 - Ensure all partners can use and feed into the same system
 - Include way for register to be used to develop facility or community reports.
- 5.2 Analyse data at all levels and have it genuinely inform decisions.
- 5.3 HMS 001 forms need to be in place and training given in their use, especially at facility level.
- 5.4 Use data to ensure that communities can eventually understand that conditions are improving (or worsening) in their areas (important for V&A)
- 5.5 Explore greater use of visual material for HMIS staff to both support them and the importance of their work and to remind them of their responsibilities.
- 5.6 Learn from other states: Feature best practice.
- 5.7 The programme needs to think through its strategy for the use of success stories and more visual information, including (perhaps) a website.

For the Government

- 5.8 MLG must provide more and adequate personnel to do the data management job at all levels.

Output 6: Demand Generation: Increased demand for MNCH (including RI) services

All states are moving quickly on activities, particularly on community engagement (CE) within clusters: knowledge of maternal danger signs is impressive, especially as CE work is only 3 months old in MNCH. The team found common themes and messaging in RI and MNCH and only Yobe's messaging required adaptation for language (where languages other than Hausa are required). The Review Team heard a very moving testimony of a woman saved by the Emergency Transport Scheme (ETS) in Katsina. The ETS services observed in Kumaru are a good example of how awareness can lead to community action to meet demand generated for services.

Managing Free MNCH. There appears to be high awareness of free MNCH services at the general hospital level where some states already offer free services. There is clearly unmet

demand for free MNCH and RI services. There is a risk that the population and providers at PHC levels--which don't offer free MNCH yet-- may be overworked, under resourced and frustrated, undermining recent demand gains. There is also confusion about the services available at the PHC level which runs the risk of clogging the secondary facilities (where services are meant to be free) with patients who should be presenting at the primary level. This will have to be carefully managed.

Moving from awareness to access. So far, the demand creation is centring on raising awareness and has not yet moved to access and utilization. The demand creation seems to be more in the awareness stage, with community engagement, education and mass media. Turning the awareness into real demand – where awareness becomes access and utilization of service is the next step. Yobe noted that the new emphasis in messaging will be on the what, where, and when.

Leveraging resources. There is scope for leveraging resources such as in Yobe with the Ministry of Women's Affairs. Yobe has done a good job in leveraging their support around social mobilization and community engagement, with both financial commitments (N20 million for 2010) and staff time. Yobe has also been working effectively with the Women Development Officers at the LGAs. Zamfara and Katsina has been able to partner with UNICEF, WHO, USAID to scale up demand creation, particularly UNICEF.

Jigawa potential. Jigawa has much more support for demand creation and eventually V&A with Paths2, SPARC and SAVI programming in the state. There seems to be awareness on everyone's part that stronger coordination is needed for these activities.

Voice and Accountability. V&A work is set up and ready to progress in 2010. Jigawa noted some activities with SAVI and SPARC to support women's groups to organize and advocate for services, but V&A is in the early stages in all states. There is untapped scope here to drive political change.

Engaging community leadership. Sustaining the interest of the health community volunteers is key to the outcome of community engagement efforts for demand creation, particularly in an effort to improve RI. The 'village committees' in communities visited seemed active and linked to the facilities, but it is not clear if these were village development committees that often provide critical support to the PHCs around water, advocating for funds, drugs, and service delivery.

Recommendations on Output 6: Demand Generation

For the programme

6.1 The team strongly recommends jointly developed demand generation, V&A, and any equity and social inclusion workplans across participating donor/agencies with clear roles and deliverables. V&A has a yet untapped potential to drive political change.

6.2 With demand generation and community engagement ahead of the supply of primary care, it is important to be careful to keep this work balanced in a stepped fashion.

6.3 The project may want to increase support of existing village/ward development committees as critical elements in creating demand and supply of services.

6.4 The demand generation should begin to supplement general awareness messaging with messaging around access – what services, where, and when.

6.5 Need for community health volunteers to be more mobile and recognized for contributions.

6.6 Include family planning. Child spacing and family planning conversations are going on within the communities. The FMOH/Reproductive Health Unit, project staff and health workers seem to think demand is there and communities are receptive. Begin to work on some family planning tools and messages.

6.7 There is a real V&A opportunity to focus on engaging State Ministry of Health and Ministry of Local Government on resource allocation and utilization and performance of health care delivery system using strong professional groups such as the Nigerian Medical Association and HERFON.

For DFID

6.8 Ensure demand creation coherence across Nigerian programmes

Output 7: Federal Governance: Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities

The consultants spent a day in Abuja and met with the NPHCDA, the FMOH, Paths2, and with the PRRINN-MNCH National Advisor. The National Advisor plays an intermediate role between the programme at the state level and the various federal institutions including the NPHCDA, the FMOH, and other agencies and partners. The Federal Advisor concentrates his activities around routine immunisation and MNCH concerns at the Federal level. While this output is the smallest part of the programme's work, that one senior staff member has managed to maintain a significant presence in Abuja and make a difference even with scarce resources is impressive.

National Primary Health Care Development Agency (NPHCDA). The PRRINN-MNCH programme clearly had a good relationship and has developed considerable trust with the NPHCDA. (This was partly evidenced with a senior NPHCDA staff member joining the Review Team.) Executive Director Dr Muhammad Pate expressed his gratitude to the Review Team for the work of PRRINN-MNCH and cited their work on Agency institutional reform as being particularly helpful. It makes sense for PRRINN-MNCH to concentrate much of its energy here as RI and many MNCH interventions happen at the PHC level.

NPHCDA & the FMOH overlap. The FMOH appeared to be leaving PHC to NPHCDA BUT it is hard to draw the lines between. There is considerable overlap in policy, human resources, and responsibilities--only immunization has been left completely to NPHCDA. This is worrying as there is considerable scope for inertia, especially with human resources and supplies. There is scope for PRRINN-MNCH (as well as the SLPs) to make these blurry lines clearer.

Midwives Service Scheme (MSS). That the MSS produced 96 midwives for each of the four PRRINN-MNCH states is a real achievement. The team would wish the MSS would continue such good work but ended up sceptical that this might be a sustainable process.

PHC Under One Roof. PHC is currently managed in some part by at least three entities: the MLG, the SPHCDA, and the SMOH. The idea of pulling all responsible for PHC 'under one roof' is going to take a while to find its feet as current structures are entrenched. Stakeholders are beginning to understand why managing primary health care within one agency might be important but the political will is not yet in place. With a favourable policy environment, such a

change is perhaps possible within the next few years. PRRINN-MNCH ran a national workshop in Kaduna in 2009 with the NPHCDA.

GAVI funds. Excellent work by PRRINN-MNCH with helping with guidelines and tools for managing GAVI funds in Nigeria.

The Health Bill? The signing of the Health Bill will increase the capacity and the incentives for the states and the LGAs to plan and help them to mould the health architecture the way it should be. It will also increase the state leveraging power and there might be a constitutional amendment eventually. However, it is unclear if or when the bill will be signed. States should continue to set up institutional systems that will prepare them for the bill if they are worthwhile in themselves.

Paths2. The Lead State Programmes are beginning to make some progress but are concentrating more heavily on the FMOH. PRRINN-MNCH and Paths2 must continue to work together to exploit close relationships with all federal partners.

Recommendations on Output 7: Federal Governance

For the programme

7.1 PRRINN-MNCH must continue its strategic approach at federal level and continue to work with other key players.

7.2 Assist the FMOH and the FPHCDA to continue to clarify their roles.

7.3 The PRRINN-MNCH programme can help NPHCDA by demonstrating that it is at the state level where the most difference will be made.

7.4 Look at incentives to obtain more and retain midwives.

7.5 Continue to look at solutions for the lack of midwives at the federal level. Are midwife standards too high? What are the intermediate cadre options?

For the Government

7.6 As above, the FMOH and the FPHCDA must continue to clarify their roles to avoid overlap and ensure coherent coordination.

7.7 The federal government must act decisively in considering alternative solutions to the shortage of midwives in the north.

Maternal Health: The Three Delays

FIRST DELAY: The factors in the household and community that delay the decision to seek care.

→Programme response: Teach the community about the maternal danger signs; look at barriers such as lack of permission or financial.

The work of health educators, village development, village health committees under PRRINN-MNCH has demonstrated that strong awareness of the importance of maternal health at family and community level can increase demand and change behaviour in seeking services. Converting awareness into real demand is as much an economic issue as it is an awareness or cultural matter. Most families in the target states must make such decisions in the face of harsh, often insurmountable, economic realities.

The project has also begun to address the issue of how unmet demand for services at PHC level may place greater demands on general hospitals. The project may wish to promote antenatal care, and availability of women facilitators to encourage early family dialogue and preparation for possible service needs and promote approaches and disseminate models for mitigating costs for EOC through family and community support systems.

SECOND DELAY: Lack of transport to move woman from home to facility or from lower level to higher level facility.

→Programme response: Emergency Transport Scheme (ETS)

The project has begun to work with communities to help them work out appropriate ways to get women to health facilities in emergencies. Some communities use motorcycles to obtain skilled attendance; others have a community fund to pay a taxi or other ambulance services. Several communities have run training for drivers in safely moving a woman when in labour. The project may consider disseminating the early results of interventions such as use of community-based ETS and other innovations driven by increased community demand for services

THIRD DELAY: When the facility is unable to treat the woman (6 signal functions in BEOC and full 8 signal functions in CEOC).

→Programme response: CEOC clusters functioning at all levels with good referral systems

All four of the focus states have demonstrated some commitment to providing free maternal health services, including antenatal care and some EOC. The package of services available, at what levels, and how the states can sustain such services are important issues to address in the next phase of PRRINN-MNCH and the CEOC clusters. With MNCH activities not fully underway, there are opportunities to identify appropriate interventions and entry points in addressing the service delivery needs.

Special Focus Areas for this Annual Review

Three Pillars of Maternal Health

There are three pillars of maternal health—and each contributes approximately equally to a reduction in maternal deaths. These are:

- The availability of emergency obstetric care (EMOC) including the eight signal functions;
- Skilled attendance at birth (SBA); and
- Family planning and post-abortion care.

The three pillars must not be pitted against one another and must all be addressed in equal measure by the healthcare delivery system. EMOC must be available to take care of the 15% of women who have complications at birth (and most of these are not recognisable ahead of time). SBA is required so that small complications can be sorted at the primary level and more complicated problems referred to higher level health facilities. Family planning saves lives by preventing births in women who are too young (under 18) or too old and by helping women space births to two to three year intervals, enhancing the health of both the mother and the infant and older sibling. Access to post-abortion care (PAC) is required to prevent infections and is also a good opportunity to introduce family planning. Ipas Nigeria has found a 40% uptake in FP post-abortion in their work in Zamfara.

The PRRINN-MNCH programme is progressing well with their work in MNCH, particularly with the access to emergency obstetric care in their CEOC clusters. The increase in midwives as well as the training of CHEWs in life-saving skills is making a real difference to SBA in Northern Nigeria. The programme's attention to FP must now be addressed seriously.

Historically, the PRRINN programme began as one of routine immunisation. When the MNCH component was added, there was worry that offering RI and FP together might recall the recent scare in Northern Nigeria conflating injections with infertility. The programme made a deliberate strategy to offer FP if requested but to keep these activities quiet.

This policy is no longer necessary and FP must now be given the attention the other two maternal health pillars are receiving. There is considerable demand for FP by women in Northern Nigeria but most women require the permission of their husbands. Working with men to make them understand the healthy benefits for the whole family of child spacing will need to be worked into community engagement activities in the coming years.

Routine Immunisation

The main RI achievements of the PRRINN-MNCH programme are:

- Supporting and participating in the planning, implementation, monitoring and evaluation of Outreaches and Immunization Plus days during 2009.
- Funding the coordination and planning meetings for most immunization related meetings.
- Supporting the establishment of the Primary Health Care Delivery Fund in Zamfara, also referred to as "Basket Fund".
- Supporting the in-service training for MSS midwives in LSS and IMCI. Health Workers trained in IMCI are expected to ask every child visiting health facilities for their immunization status and provide vaccines for all those children that have not been vaccinated.
- Providing, installing and maintaining solar driven equipment at the State Cold Room for the different vaccines.

- Funding RI Outreach Services and participating in IPDs (both planning and implementation).
- Supporting states to improve information generation related to impact of outreach activities on immunization
- The establishing the community engagement approach to generate demand for MNCH services inclusive of immunization; it is in its early stages and the volunteers are eager to learn and do their tasks.

During 2009, a total of 386 Measles cases (milestone 16,687) and 84 polio cases (milestone 178) was reported in the programme states. There was no major reported measles outbreak across the states. The national polio eradication initiative targeted 0 polio incidence by the end of 2010. Distribution of measles and polio cases per state was: 142 measles cases and 18 polio cases in Jigawa, 56 measles cases and 15 polio cases in Zamfara, 41 measles cases and 15 polio cases in Yobe, and 127 measles cases and 36 polio cases in Katsina.

A total of 395,477 children under-one year were immunised against measles (milestone 204,711). The distribution per state was: 68,076 in Jigawa, 66,689 in Zamfara, 109,971 in Yobe, and 150,761 in Katsina.

Data from state HMIS indicated that a total of 251,167 under one-year-old children received OPV3 (milestone 188,865), while 282,505 children under one received DPT3 (milestone 188,865). Distribution of OPV3 and DPT3 immunisation per state was 67,947 OPV3 and 64,976 DPT3 in Jigawa, 41,930 OPV3 and 49,449 DPT3 in Zamfara, 52,857 OPV3 and 60,518 DPT3 in Yobe, and 88,433 OPV3 and 107,742 DPT3 in Katsina.

A total of 225,197 one-year old children were fully immunised in all states (milestone 126,540). Distribution of fully immunised per state was: 51,116 in Jigawa, 49,449 in Zamfara, 32,131 in Yobe, and 88,433 in Katsina.

The Review Team observed the following challenges:

- Sustaining the interest of the health community volunteers is key to the outcome of community engagement efforts for demand creation, particularly in an effort to improve RI.
- Are outreach activities and IPDs Campaigns killing the generation of demand for health services and utilization of the health facilities?
- There is currently “Primary Health Care Under Many Roofs” (rather than under one roof) and this will continue to have many implications in the implementation of PHC activities.

Gender Aspects

The PRRINN-MNCH project has demonstrated significant progress in addressing gender-related opportunities and challenges to improving effective MNCH health services in Northern Nigeria. These achievements are facilitated by women and children being the primary beneficiaries of the health services provided, including services at health facilities and demand generation through community engagement.

Increasing the voice of women at household level in accessing MNCH and RI services.

The northern context for health services delivery is a rich environment for assumptions around religious and cultural barriers. Many of the barriers and thus interventions play to the belief that women are powerless and men are fast to exercise their authority in ways that prevent their wives and children from leading healthy, productive lives. The project's community engagement approach and achievements around increased EOC access in several communities visited demonstrate effective ways to identify real barriers and use family and community level solutions to address these challenges.

The recently completed KAP surveys provide a wealth of information around household and community dynamics that need to be further explored through operations research. The OR to be done around financial barriers to accessing services (Katsina) and cultural barriers to accessing MNCH (Jigawa) will be particularly important. Many studies show that much of what is considered cultural, gender-laden barriers to accessing maternal and reproductive health services may actually be financial constraints and can be addressed through more effective family communication. It will be important to promote more community engagement, awareness and media messaging that emphasize family and community decision-making in accessing health services, including ways to mitigate costs through family and community support. And do not wait until the end of the project to disseminate the early results of interventions that address the changing role men and the importance of male and community involvement in accessing RI and MNCH service settings.

Increasing the voice of women at community and LGA levels to address issues of availability and quality of services at PHCs. The project is doing very good work in ensuring that women are represented on village health committees. There are also plans in Jigawa and other states to establish facilities committees using the PATHS model. These structures can be leveraged to improve MNCH services at PHC level. The review did not, however, show much work on increasing women's representation at higher organizational levels such a village development committees or ward development committees. These already-established mechanisms play important roles in decision-making, accessing health and other resources, and communicating needs and demands up to LGA and state levels.

Addressing the shortage of female health practitioners for MNCH. PRRINN-MNCH's role in understanding and addressing shortages and deployment issues for midwives and CHEWs in the focus states should be acknowledged as both an achievement and a continuing challenge. However, the shortage of midwives and the low prevalence of female CHEWs, estimated at only about 20 percent in most northern states, add a strong gender dimension to this human resource and service delivery issue. Midwives provide MNCH knowledge, access to services, and improved quality of services at clinic and community levels. Female CHEWS have greater ease and access to women often confined to their communities or villages. The dynamics of this problem may seem obvious and well documented -- few females qualified to enter midwife training; few capable of completing demanding midwife programmes for academic or cultural reason; midwives and CHEWs are not interested in serving in rural areas of the north -- but the solution is more complex and will involve working across sectors and states to begin to address. A question for PRRINN-MNCH is what innovations can the project model in focal states to scale up MNCH services given that current challenges will take many years to overcome? A second question is how can the project assist government and communities in developing long term, research-based solutions to shortages of midwife and other female practitioners, particularly in rural areas? It would be helpful to facilitate dialogue among the key stakeholder groups across the focus states on a coordinated approach to addressing the shortage of midwives and female CHEWS in rural facilities and communities.

Increasing awareness of the importance of women's perspective and roles in health policy and service delivery. One of the strongest observations around the gender dimensions to improving access to MNCH services in the north is the low number of women in key decision-making positions in the SMOHs, or servicing as LGA Primary Health Care Coordinators in the focus states. The Review Team was not able to access the HR audit data during the field visits, but from interviews, the numbers are very low relative to other regions of the country, with Katsina having perhaps the strongest representation. Even more significant for PRRINN-MNCH programming is limited understanding of the importance that women's experience and perspectives bring to decision-making. Several government officials, PRRINN-MNCH staff and review team members acknowledged the low numbers but did not see a strong connection between responsiveness and effectiveness of the service delivery system and having women in service delivery, policy and management positions. As part of the HR systems strengthening, the programme could increase monitoring of hiring and deployment for appropriate gender balance at the PHC Coordinator level and in other decision-making roles at SMOH.

Strengthen the participation of professional health associations and women's groups in advocating for improved MNCH services. A strong observation from the review is that there is a level of frustration at both the project level and DFID level about the lack of progress in improving the environment for true reforms, performance and accountability around resources and services.

While the support from PRRINN-MNCH to ministries around budget and planning, HMIS and strengthening service delivery are critical elements of improved supply of MNCH services, a coherent approach to voice and accountability and social inclusion has yet to emerge. The advocacy through respected members of HERFON and other eminent persons has shown some promise; however it is citizens through citizen groups and recipients of services who must ultimately hold government and elected officials accountable. And for MNCH services, these are largely women and their families, and professional groups with large women's membership.

The religious and cultural context for civic engagement of government in the northern states presents many challenges for PRRINN-MNCH efforts to move beyond community engagement on PHC provided MNCH services to engaging the political processes at LGA and state levels that determine policies and resource allocation. However, there are opportunities to integrate social mobilization at community and LGA with higher level advocacy at LGA and state levels. This has been a particularly effective model for women and professional organizations in other parts of the country and also in the more urban areas in Kano, Kaduna, and other northern states. While it is appropriate from an equity and social inclusion standpoint to promote direct engagement of rural women on issues that affect their lives, the immediate reality of the north is that rural women must take advantage of the position of women's and professional groups operating at higher level of society to give voice to the health care needs. The programme should engage with the SAVI and Paths2 project to develop appropriate models of voice and accountability for MNCH service delivery.

4. Amendments to the logframe

The Review Team has made no changes to the combined PRRINN-MNCH logframe which can be found in Annex 11.

5. Risk Assessment

The risks in the combined PRRINN-MNCH remain valid. The overall rating of PRRINN-MNCH remains: High Risk. The PRRINN-MNCH Risk Assessment (unchanged from last year) can be found in Annex 10.

6. Project Management

6.1 Management

The Review Team examined management structures within PRRINN-MNCH as well as the DFID management of the programme. In general, the management procedures were sound and no major problems were identified. The administrative and financial relationships between the Kano central office and the state team offices were functioning well.

As Northern Nigeria is a setting with many gender challenges, the team leader discussed with the Deputy Director of the programme the scope for some in-office gender exercises with the state team as well as the Kano office. The men in the office, particularly, need to understand how much harder it is for women to work in the environment of Northern Nigeria. Such gender exercises were already on the agenda and will be scheduled in 2010.

Each State team leader has an opportunity to meet with senior management in Kano as well as with the other state team leaders on a monthly basis and this is seen as valuable. There was a request from at least one of the state offices for more frequent visits from the national office to the states.

6.2 Reporting to DFID

PRRINN-MNCH provides quarterly reports to DFID with the December report encapsulating the activities of the entire year. These documents report against logframe outputs and are clear and in a suitable format. The Review Team found the format of the December 2009 report with its short Executive Summary, more extensive Main Report, and then detailed annexes to be an extremely helpful one. These reports should arrive in the second week of the month following the end of the quarter (to fit in with DFID reporting).

6.3 Financial Reporting and Budget Performance

Financial reporting to DFID in Abuja remains appropriate and good financial management procedures are in place. PRRINN-MNCH is able to break down expenditure by output or by states without difficulty and this is excellent. A full routine external audit of PRRINN-MNCH will be conducted by the end of March 2010 by an international auditing company. The audit report will assess procedures and practices, and make recommendations; the next Annual Review of the project should ensure all recommendations have been completed.

DFID staff should continue its good working relationships with the Government of Norway, although Norway has delegated routine project management responsibility to DFID. The presence of two Norwegians on the Review Team was excellent.

A spot check of the Zamfara State project team revealed that it is following good project and financial management practices. An informal discussion with accounts staff did not raise any concerns. Good systems are in place in terms of separation of duties (three signatures required for payments); regular internal spot checks on cash; occasional comprehensive checks and reviews of procedures, vouchers and cash by national office.

6.4 Communications

The project makes good use of communications for development at the implementation level. In Zamfara, UNICEF staff spoke of using a DVD developed by PRRINN-MNCH.

There is scope for improved communications about the project itself; DFID is keen to publicise successful projects such as PRRINN- MNCH, to demonstrate impact to the public in the UK and in Nigeria. See the further discussion in the main body of the report, Output 5.

PRRINN-MNCH has developed a logo, which should be used on all communication products as well as, where appropriate, at the activity level. Whenever the project logo is used, DFID and Government of Norway logos should also be displayed, making clear the nature of the engagement (ie 'project funded by...'); these logos should also be used on office signage. However, DFID will soon be revising its logo, and work in this area should be delayed until revised guidance is distributed to project managers. The project should continue to take a sensible approach to branding, to avoid detracting from government ownership, which, as seen in Zamfara, is strong.

6.5 Transition to PRRINN-MNCH

The Review Team saw a very good blending of the two projects and had no concerns.

6.6 Procurement

The length of time it takes for the procurement process with Crown Agents came up in several contexts. Programme staff cited the increased programme flexibility achieved when DFID relaxed the procurement conditions so that programmes could procure up to £5000 without using Crown Agents. The programme staff also thought that, in many cases, they could procure items more cheaply without using Crown Agents. When using Crown Agents, the programme reports that there are often delays, poor quality assurance, piece-meal delivery, higher prices and last minute changes. The Review Team did not speak with Crown Agents so do not know their version of events.

Recommendation:

G.3 As procurement is slowing progress, the process should be examined more closely to see if there can't be improvements made by both Crown Agents and the PRRINN-MNCH programme.

6.7 Management by DFID

The relationship between the PRRINN-MNCH office and the DFID Kano office was functioning well. Having a DFID office actually in Kano makes a material difference in this relationship. Also, the addition of a secondee from the Norwegian government to the DFID Kano office has further improved project management.

DFID should not let their emphasis on the State Lead programmes distract them from an excellent and not-unrelated programme: PRRINN-MNCH. Paths2 could and should learn all they can from PRRINN-MNCH approaches, especially as many staff from Paths1 are part of the

PRRINN-MNCH team. And PRRINN-MNCH must benefit from Paths2 and its extended resources and the staff they can bring to bear on similar problems in all the northern states. This is true at both the federal and state level. Path2 really should have been a member of this Annual Review and must not miss the opportunity next year—especially as the MNCH interventions will begin to be evident. Small rivalries should be forgotten in the face of the enormous challenges in maternal and child health in Northern Nigeria.

DFID should also beware of overloading a small programme with changing and competing priorities. This successful programme is accomplishing much in a challenging environment.

Annex 1: Annual review against a) PRRINN-MNCH outputs and b) PRRINN outputs

a) Progress against outputs: PRRINN-MNCH (begun in 2008)

During the reporting period, the programme completed MNCH baseline surveys and finalised both PRRINN and MNCH logframes. A programme and state specific M&E framework, with milestones and targets for the lifespan of the combined programme has been developed. The Annual Plan for 2010 was developed based on the M&E framework and 2010 programme and state specific milestones. Definitions for the indicators have been drafted, and data capturing templates designed.

Goal: To improve maternal, newborn and child health in Northern Nigeria

Purpose: To improve effective access to MNCH (including RI) services in four states

Goal Indicators

MDG4, Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate. % of births attended by a skilled birth attendant.

Purpose Indicators

% of infants fully immunised by first birthday.
 % of women aged 15-49 have appropriate TT doses.
 Caesarean section rates in targeted CEOC clusters.
 % of women receiving ANC.
 Measles incidence reduced by 80%.
 Polio incidence reduced to near zero.

Baseline data on immunisation coverage indicators (for PRRINN) came from the National Immunisation Coverage Survey (NICS) undertaken in 2006. Baseline data for MNCH indicators came from baseline surveys conducted in the first quarter of 2009. No new survey data was available on any of the purpose level indicators by the end of 2009. Follow-up MNCH surveys are planned for the second half of 2010. The NICS planned for 2009 did not materialise. To provide some interim assessment of progress in immunisation coverage, PRRINN-MNCH has planned a rapid immunisation cluster survey for January 2010. More detailed information is available in Annex 6 M&E Dec 09 report.

The total number of reported cases of measles in 2009 in all four states was 355. This is a huge reduction from the total number reported in 2008, which was 22,250. However, the number of children immunised against measles has also increased enormously in 2009. Basically it is too early to establish that the reduction is due to improved immunisation.

Similarly, the total number of reported cases of polio has decreased significantly from 237 cases in 2008 to 178 in 2009.

Output 1 Strengthened State and LGA governance of PHC systems geared to RI and MNCH

Output 1 Logframe Indicators

State government staff lead annual review and health planning process in all states.
 Number of states with their State Health Plan incorporated into their State Development Plan.
 State health plans reflect project data from 2010.
 Number of donor PHC programmes reflected in State and LGA annual health plans.
 SIACCs support for RI through PHC system in all states.
 No donor field missions and reviews done jointly.
 All states successfully access new Federally managed health funds.
 Availability of PHC budget and expenditure reports for LGAs/Gundumas.

Support state Planning and policy development

State government staff led annual reviews and health planning processes in all states with technical and financial support from the programme. The Programme states were supported to revise State Strategic Health Plans (based on Federal planning framework) and develop Annual Operational Plans for 2010. States and LGAs/Gunduma plan costed and incorporated in 2010 budgets.

All states established health milestones for inclusion in their State Development Plan. These were developed as part of their revised health sector strategic plans. Each state has a different timeframe for revision of SEEDs and development of new State Development Plan (SDP).

In all the states *the Minimum Service package (MSP) was developed and costed.* In Jigawa the package MSP is reflected in the annual operational plan and State comprehensive development framework (SEEDS II). The other three states, focussed on developing MSP document and costing it. Once approved, the costed MSP will be incorporated into the new SDP.

Costing of the free MNCH service and incorporation in to the state development plan is partially achieved. In Jigawa, the costed free service is partially reflected in the operational plan and state comprehensive development plan while in the other three states; committees have been established to cost the free service.

Each state has 2 or more examples of evidence based planning that is reflected in their 2010 plans. States were encouraged to develop an evidence based plan for 2010 based on project data. Information from programme supported integrated supportive supervisions, annual PPRHAA exercises, and community engagement activities helped the states reflect a few examples of evidence based planning. In Jigawa, cold chain equipment and solar maintenance and roll-out community engagement plans were incorporated based on quarterly cold chain audit, ISS and health partnership interventions. In Zamfara. The Programme supported the Introduction of Mgso4, mesoprostol, and antishock garments and budgeting for 2010. In Yobe, Cold chain planned preventive maintenance training for PHC health workers budgeted based on programme technical support. In Katsina, introduction of Mgso4, mesoprostol, and antishock garments; procurement and installation of solar refrigerators were based on project data.

Facilitate coordination and harmonisation of stakeholders and partners at state and LGA level

All states have 1-2 donor PHC programmes reflected in their State and LGA annual health plans. The number of donors reflected in state health plans depends on availability of decentralised donor programmes per state. In all the states, the PRRINN-MNCH programme plan for 2010 reflected in the state and LGA/Gunduma plans. In Jigawa and Katsina, PATHS2 and SUNMAP programmes plan also reflected in the 2010 plan respectively.

In all the states, *SIACC or equivalent coordination committees have provided some support to RI through the PHC system.* In Jigawa, SIACC approved the release of quarterly state RI fund and GAVI fund. In all states, the coordination committees met at least once every quarter to address RI and IPDs.

The *programme participated in the inception review of PATHS2 and SuNMaP* but was not part of the formal review team. The number of donor field missions and reviews done jointly are subject to frequency of donor field missions and reviews. In Jigawa, the programme participated in PATHS2 inception review, while in Katsina, the programme participated in SUNMAP programme review.

Promote coordinated advocacy, institutional change and change management

All States developed advocacy plans with HERFON facilitation. State HERFON teams re-activated around facilitation of state advocacy plans and plans for capacity building are being developed.

During the reporting period, *a number of advocacy visits targeting high political leaders, traditional and religious leaders have been organised.* In Jigawa, advocacy visit paid to the SSG, traditional and religious leaders to promote RI. In Yobe, advocacy visit paid to the Governor to promote MNCH and establish state primary health care board. In Katsina, the first ladies of LGA chairmen and traditional leaders promoted community engagement interventions. In Zamfara, LGA chairmen and chairman of the health committee of the state assembly visited to promote establishment of PHC board.

Support health financing, budgeting and public financial management for PHC

All states have made considerable progress in accessing new federally managed health funds in 2009. The milestone of two successive years' access for new federally managed health funds in two states was partially achieved. In Jigawa, the state accessed MDG fund for two successive years. In the other three states, they accessed GAVI fund for one year.

The milestone for *accessing of two federally managed funds in two states* has been achieved. All states accessed GAVI and MDG funds. Jigawa, Katsina and Yobe states have also accessed NHIS fund. The Programme supported development of financial guidelines for NPHCDA and PRRINN-MNCH states. No financial reports required yet, as the fund was released in the second half of the year.

In all the states, annual PHC budgets were available both at state and LGAs/Gunduma levels, as the programme was also actively supported the development of costed plan for the year 2009 at state and LGA level. Release of funds for PHC activities has

increased in all states. In Zamfara, the PHC service delivery fund is operational, with 14 LGAs contributing monthly to the fund (over N18M for June to November 2009). The Executive Governor has also approved the State's contribution of about 10.5 million to the fund (late December 2009) although this is yet to be released. In Jigawa, the state also released a total of N15.3 million in 2009 to the Gunduma Councils for RI services. PRRINN-MNCH supported the Gunduma Health system Board to monitor the disbursement and utilization of the fund. In Katsina, LGAs now release N50,000 monthly for PHC activities. GAVI Funds are also accessed and disbursed to LGAs. In Yobe, N4.6 million was received in the fourth quarter from GAVI. (On 13 January 10, the State Governor also pledged the release of N25,000 per month for each midwife that came to Yobe as part of the MSS scheme.)

Output 2 Improved human resource policies and practices for PHC

Output 2 Logframe Indicators

Status of HR policies and plans in each state.

Number of health professionals trained annually.

% of professional staff given in-service training in MNCH in targeted PHC facilities.

% of targeted facilities with at least one health worker trained in LSS.

Facilitate strengthening of human resource policy development and management

Significant improvement has been achieved in the status of HR policies and plans in all states. Improving human resources for health is one of the strategic objectives in the revised states development health plans. In all the states, the programme provided technical support ensuring that findings from HR audit informed the development of HR plan. In Jigawa, the programme supported the state to adopt the national HR policy. HR units established all states' ministries of health and guidelines for HR coordination committee agreed with states.

HR forum held in all states to review HR audit data. In Jigawa, HR committee established and inaugurated. In the other three states, consensus was reached on establishment of HR committees and broad membership agreed. Transition from the Forum to an established HR committee is taking place at different rates.

States and LGAs were supported to address shortages, maldistribution and attrition of skilled birth attendants and other MNCH staff by exposure to HR audit data that evoked lively debate in Health Forums that had broad representation from various interest groups. Most states lifted their embargo on employment of certain categories of SBAs, especially for doctors and midwives, who were recruited during the last quarter following concerted advocacy with key stakeholders

Strengthen work force planning for health services

HR Planner used in 4 PRRINN-MNCH states to improve quality of HR data (HR audit and employee profiles; introduce software for management of HR data and built HR management capacity).

HRIS has been developed for 2 states (Jigawa and Zamfara) and it has been installed in the Kano office and Zamfara office and key staff have received initial training. HRIS is being piloted in 2 LGA/Gundumas: in Zamfara in the LLGA and in Jigawa in the Learning Gunduma.

HR managers have received basic exposure to HR data from HRIS that has initiated learning and increased level of competency in collection and use of key HR information. The HRIS is being used in Jigawa to manage transfer of staff to Gundumas.

Support the training of MNCH workers

Total number of health professionals graduated (including mid level health workers) in 2009 from state health training institutions in three states was 1273. In Yobe, 119 (62 males and 57 females). In Jigawa, 282 (disaggregated data is not available). In Zamfara, 184(113 male and 93 female). In Katsina 666, (disaggregated data is not available).

16% of professional staff was given in-service training in MNCH in targeted facilities in 2009 (milestone 10%) i.e. 84 out of 540 staff received in-service training. Distribution in the three states was: 24% in Zamfara, 10% in Yobe, and 13% in Katsina.

21% of targeted facilities have at least one health worker trained in LSS (milestone 10%). Distribution in the three states indicates 18% in Zamfara, 21% in Yobe, and 23% in Katsina.

Number of health facilities with at least one health worker trained in IMCI was 34 in three states against the milestone of 35.

A total of 55 new trainers on RI/MNCH trained (milestone=40); 19 on IMCI, 24 on KMC, and 12 on LSS competency based.

A total of 13 driver trainers trained (milestone=6).

A total of 9 practical sites established for RI/MNCH in-service training (milestone=9)

A total of 3 training institutes partially accredited (milestone=3); in Katsina 2 and in Zamfara 1.

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

Output 3 Logframe Indicators

% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%.

Systems for effective supervision in each state.

Number of PHC facilities providing BEOC.

% of PHC facilities with tracer drugs available.

Number of 1-year-old children immunised against measles.

% of health facilities providing RI experiencing vaccine stock-outs of TT.

Facilitate PHC system development and capacity building

21% of LGAs reached performance ranking tool (PPRHAA) scores over 75% (milestone 29%). In Jigawa, 44% of the Gunduma councils and in Katsina, 38% of the LGAs reached scores over 75%. None of the LGAs in Zamfara or Yobe reached scores over 75%. However, 86% of LGAs in Zamfara and 71% of LGAs in Yobe scored between 50% and 74%.

In all the states, *supervision teams visited LGAs/Gunduma with technical and financial support from programme*. A total of 12 supervision visits conducted in targeted LGAs/Gunduma councils (milestone 9). The supervision visits per state: 4 in Jigawa, 4 in Zamfara, 2 in Yobe, and 2 in Katsina.

None of the targeted facilities achieved the minimum building standards or equipped with minimum equipment model lists. Bill of quantities took longer than expected due to huge price variations. Tenders issued and rehabilitation is ongoing. Equipment for 3 CEOC, 12 BEOC, and 24 PHC ordered in September 09. Assessment of minimum building standards and equipment will take place from the second half of 2010 once refurbishment and equipping of the first cluster of facilities has been completed.

Strengthen maternal care

Although no formal surveys have been undertaken to assess any change in maternal care indicators since the baseline surveys in the first half of 2009, considerable efforts have been made to improve availability and quality of maternal care data provided by the routine HMIS in each state. Where the routine HMIS system does not provide data on programme specific indicators alternative systems are being designed to collect data on an intermittent basis. We expect to report on a number of primary indicators in addition to logframe indicators from mid 2010.

13% of deliveries attended by SBAs. Distribution per state was 15% Zamfara, 16% Katsina and 4% in Yobe.

Caesarean section rate was 1.04%. The distribution per state was 0.15% Yobe, 0.6% Katsina and 2% Zamfara.

Data on % of women aged 15-49 have appropriate TT doses awaiting next NICS survey 2010. The programme will also conduct Mini Household survey end 2010.

State HMIS data indicated that 21% of women received ANC (milestone= 25%). ANC distribution in the states indicates that 29% in Jigawa, 10% in Zamfara, 23% in Yobe and 20% in Katsina. A total of 14,790 first visits ANC (milestone 15,734) and a total of 8,480 deliveries (milestone 8,853) reported from 3 states targeted facilities. Distribution of ANC and deliveries per state indicates that 8,493 ANC and 3,642 deliveries in Zamfara, and 2,347 ANC and 625 deliveries in Yobe. Data from Katsina is outstanding.

None of the targeted facilities provide all signals of CEOC, BEOC or 24/7 EOC. Among the targeted facilities, 52 CEOC have at least 6 midwives (1 in Zamfara and 1 in Katsina), 5 BEOC have at least 2 midwives (3 in Zamfara and 2 in Katsina), and 3 PHC facilities in Zamfara have at least 1 midwife.

Strengthen neonatal and child health

Most neonatal and child health interventions focussed on establishing an appropriate working environment (refurbishment and equipment) and training trainers for IMCI and KMC.

No milestones were set for signal functions or trained staffing levels for 2009. The programme will commence reporting against milestones in 2010.

A total of 5 targeted BEOC and CEOC facilities have at least 2 health workers trained in IMCI. This is 11% of end of programme target of 45 facilities. No milestone set for 2009.

A total of 5 targeted CEOC facilities have at least 4 health workers trained in competency-based LSS-EONC. Distribution per state indicates: 3 in Katsina, 1 in Yobe, and 1 in Zamfara.

A total of 7 targeted BEOC facilities have at least 2 health workers trained in competency-based LSS-EONC. Distribution per state indicates: 3 in Katsina, 2 in Yobe, and 2 in Zamfara.

Community based management of acute malnutrition (CMAM) pilots designed for Katsina and Zamfara.

Strengthen sustainable drug supply

Annual PPRHAA exercise indicated that *tracer drugs were available in 68% of PHC facilities* (milestone 54%). Distribution per state indicated that 93% in Jigawa, 78% in Katsina, 54% in Yobe, and 48% in Zamfara.

A system for sustainable drug designed for Zamfara, Yobe, and Katsina states and ready to pilot in 13 facilities per state (cluster) once drugs ordered have been delivered.

Strengthen immunisation systems

% of infants fully immunised by first birthday is not captured by the HMIS data. The average coverage for the programme states from NICS 2006 (PRRINN baseline) was 3% while the baseline MNCH survey 2009 was 16%. The next NICS expected to be conducted in 2010 (supposed to be 2009). The programme will conduct rapid EPI cluster Survey in few LGAs of the four states in Jan 10.

During the reporting period, *a total of 386 Measles cases* (milestone 16,687) and *84 polio cases* (milestone 178) reported in the programme states. There was no major reported measles outbreak across the states. The national polio eradication initiative targeted 0 polio incidence by the end of 2010. Distribution of measles and polio cases per state was: 142 measles cases and 18 polio cases in Jigawa, 56 measles cases and 15 polio cases in Zamfara, 41 measles cases and 15 polio cases in Yobe, and 127 measles cases and 36 polio cases in Katsina.

Annual PPRHAA exercise indicated that *62% of health facilities providing RI experiencing vaccine stock-outs of TT* (milestone 34%). The range varies from 50% in Jigawa, to 81% in Zamfara, 58% in Yobe and 57% in Katsina.

Data from quarterly cold chain audit indicated that *49% of LGAs had one month stock of all antigens for previous 3 months* (milestone 59%). Range of one month stock per state was: 65% in Jigawa, 75% in Zamfara, 0% in Yobe, and 57% in Katsina.

A total of *395,477 children < 1yr were immunised against measles* (milestone 204,711). Distribution per state was: 68,076 in Jigawa, 66,689 in Zamfara, 109,971 in Yobe, and 150,761 in Katsina.

Data from state annual PPRHAA exercises indicated that *78 % of health facilities had up to date microplan for RI* (milestone 30%). Distribution per state was: 88% in Jigawa, 75% in Zamfara, 76% in Yobe, and 71% in Katsina.

Among all health facilities appraised by PPRHAA, *41% had up to date immunisation monitoring charts* (milestone 40%). Distribution per state was: 32% in Jigawa, 50% in Zamfara, 60% in Yobe, and 20% in Katsina.

59% of health facilities appraised by PPRHAA in 2009 provide RI on weekly basis. Distribution of weekly RI services per state was: 85% in Jigawa, 70% in Zamfara, 70% in Yobe, and 70 % in Katsina.

Tracer medical supplies were available at 70% of PHC facilities (milestone 52%). Availability of tracer drugs per state was: 96% in Jigawa, 46% in Zamfara, 54% in Yobe, and 85% in Katsina.

Data from state HMIS indicated *that a total of 251,167 < one year old children received OPV3* (milestone 188,865), *while 282,505 children < 1 yr received DPT3* (milestone 188,865). Distribution of OPV3 and DPT3 immunisation per state was 67,947 OPV3 and 64,976 DPT3 in Jigawa, 41,930 OPV3 and 49,449 DPT3 in Zamfara, 52,857 OPV3 and 60,518 DPT3 in Yobe, and 88,433 OPV3 and 107,742 DPT3 in Katsina.

DPT3 drop-out rate was 21%(milestone 40%) in all states. Drop-out rate in the states were between 20% and 23%.

A total of 225,197 one year old children were fully immunised in all states (milestone 126,540). Distribution of fully immunised per state was: 51,116 in Jigawa, 49,449 in Zamfara, 32,131 in Yobe, and 88,433 in Katsina.

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

Output 4 Logframe Indicators

State plans reflect OR results.

Number of pieces of OR into supply & demand aspects of MNCH which feed into programme.

Reporting on state plans reflecting OR results will commence second half of 2010.

Establish institutional arrangements for operations research

In all programme states *Stakeholders were engaged in establishing institutional arrangements for operational research.* State OR agenda set and OR Advisory Groups constituted through engagement of stakeholders. Research Ethics review committees constituted and training for the committees will be organised in 2010.

INDEPTH network engaged in design, setup and training personnel for HDSS in Zamfara.

Conduct implementation research

Establishment of operational learning LGA sites and HDSS site was partially achieved. 3 LLGA sites (in Jigawa, Yobe and Katsina) and HDSS site in Zamfara have been identified and state partners have made buildings available. Key technical staff have been appointed and are currently functioning with support from the State programme offices until equipment arrives to set up decentralised offices in LLGAs. State priority OR protocols developed for implementation. Delays in delivery of OR equipment and logistics in procurement plan have compromised HDSS set up plans.

Disseminate and utilise OR findings

Baseline survey report disseminated to stakeholders. Findings of the survey used for programme planning and development of monitoring and evaluation framework.

Output 5 Improved information generation with knowledge being used in policy and practice*Output 5 Logframe Indicators*

State plans increasingly built on evidence from HMIS.

Demonstrated level of understanding in use of information by trained HMIS officers in each state.

% of LGAs with HMIS MNCH data collated at state level on a monthly basis.

Strengthen information use across all states

All states' plans reflect use of some HMIS data collected from ISS and PPRHAA. Some progress is demonstrated in utilisation of routine HMIS data and information collected through ISS and PPRHAA for state plans. *All programme states established Health Data Consultative Committees* and organised quarterly review meetings. In Jigawa RI data quality audit was conducted. In Zamfara State HMIS staff conducted self-data quality assessment on quarterly basis.

Support capacity building of a sustainable HMIS system

HMIS officers in each state demonstrated some skills in the use of the DHIS and analysis of data for review purposes. Area of capacity building includes training on the use of DHIS. TOT for 25 masters trainers was conducted, with emphasis on DHIS software application and data analysis. In Jigawa, Katsina and Zamfara M&E coordinators were trained on IDSR. Data collection tools have been procured and handed over to SMOH.

% of LGAs with HMIS MNCH data collated at state level on a monthly basis varies from 35% to 100% (milestone 20%). In Jigawa, the average monthly return was 54% while in Zamfara for RI (99%), for IDSR (100%) and for MNCH data (85%). In Yobe, the average was 35% while in Katsina for RI (100%), for IDSR (100%) and for MNCH (70%).

59% of PHC facilities submitted monthly HMIS for RI within the designated period (milestone 20%). Monthly HMIS returns from PHC, both for RI and MNCH, were lower than LGAs. Distribution per state was: Jigawa 54%, Zamfara 80%, Yobe 80% and Katsina 21%.

38% of PHC facilities submitted monthly HMIS returns for MNCH, within the designated period (milestone 20%). Distribution per state was: Jigawa 54%, Zamfara 64%, Yobe 24% and Katsina 20%.

40% of PHC facilities submitted monthly HMIS returns for IDSR within the designated period (milestone 20%). Distribution per state was: Jigawa 54%, Zamfara 21%, Yobe 66% and Katsina 20%.

45% of PMS sites had an accuracy ratio of between 0.85-1.15 for specified data elements: OPV3, DPT3, ANC four visits, SBA (milestone 30%)

Establish knowledge management for PRRINN-MNCH

One article was published in a peer review journal (milestone 0). Based on PRRINN household survey, the article discussed factors predicting BCG immunisation status in Northern Nigeria: behavioural and ecological perspective was included. (Stella Bababla and Umar Lawan. Journal of Child Health Care 2009, vol 13, No 46).

A total of 13 success stories were written for different audiences including DfID, media and website (milestone 4). Distribution of written success stories per state was: 4 in Jigawa, 2 in Zamfara, 5 in Yobe, and 2 in Katsina.

Programme website was designed and documentation completed and will be live in February 2010.

An annual report for 2008 was published.

Establish monitoring and evaluation for PRRINN-MNCH

During the reporting period, the national office and state programmes produced 4 quarterly progress reports. Draft annual report was produced for the whole programme. Two quarterly M&E reports were produced at state and national level.

Output 6 Increased demand for RI and MNCH services

Output 6 Logframe Indicators

% of women in targeted areas who have standing permission to take their child to a health facility.
% of never immunised children < 2 in targeted areas.
% of women in targeted areas who know at least 4 of the maternal danger signs.
% of mothers of children < 2 in targeted areas who know the childhood vaccination schedule.
Increased political support for MNCH (including RI) evidenced by high level public events.
% of wards with a development committee and/or health partnership implementing a community action plan.
% of facility health committees for intervention facilities in targeted areas actively monitoring drugs.

Monitoring data for the first 4 of these logframe indicators (on standing permission, never immunised children, maternal danger signs and childhood vaccination schedule) was collected during the MNCH baseline surveys undertaken in the first half of 2009. It is

therefore not possible to provide any further survey-based data by the end of 2009. A mini household survey will be undertaken in the second half of 2010 to monitor progress on these indicators. However, during the last quarter of 2009 pilot KAP studies were conducted to monitor changes in communities where community engagement initiatives for RI and MNCH are being implemented. In 2010 the programme will report on indicators based on biannual KAP studies. In Jigawa, follow-up RI KAP survey conducted in Mid-December 2009 indicated that 94 % of women in community engagement intervention areas had standing permission to take their child to a health facility while 53 % of mothers of children < 2 knew the childhood vaccination schedule.

There was an *increase in political support for MNCH (including RI)* evidenced by high level public events in all programme states. All states achieved at least one high level public event at state level and one at LGA level.

Facilitate the establishment of a community engagement approach to promote healthy MNCH behaviours and generate demand for RI and other MNCH services

13% of wards had a development committee and/or health partnership implementing a community action plan by the end of 2009 (milestone 7%). Distribution per state was: 19% in Jigawa, 14% in Zamfara, 15% in Yobe and 5% in Katsina.

A total of 101 community engagement intervention sites were established active community response systems to MNCH barriers (milestone 75). Distribution per state indicated 54 sites in Jigawa, 12 sites in Zamfara, 17 sites in Yobe and 18 sites in Katsina.

A total of 146 maternal complications were transferred to health facility via emergency safe motherhood transport scheme in the second half of the year (milestone 45). This was a remarkable achievement ahead of the milestone set for the year. Distribution of the referral per state indicated 51 in Zamfara, 37 in Yobe and 58 in Katsina.

The number of State ministries/ departments/ agencies (MDAs) that include funds for MNCH demand-side issues in their budgets has increased in all states. The programme has pursued a forceful course to broaden commitment to MNCH demand side issues beyond the SMOH. Ministries of Women Affairs have budgeted for MNCH demand side issues in 3 states.

State ministries/ departments/ agencies (MDAs) lead community engagement activities with technical and financial support from the programme. Active engagement of State Ministries of Women Affairs in leading CE in all states has been achieved.

A total of 6 LGAs/Gundumas are leading community engagement activities in 3 states (milestone 4). LGA leadership is essential to establishing a sustainable CE process.

Enhance the profile of health promotion/communication at State and LGA levels

12% of PHC HFs had immunisation IEC products including Job Aids (milestone 8%). PRRINN-MNCH has printed and distributed vaccination hand poster and flyers to PHC facilities. Distribution per state indicated 17% in Jigawa, 11% in Zamfara, 14% in Yobe and 5% in Katsina.

A total of 8 tutors from 8 training institutions were trained as trainers in appropriate interpersonal communication and counselling (IPCC). State distribution was: 2 from each Jigawa and Zamfara, 3 from Katsina, and 1 from Yobe).

Between 2 to 4 jingles aired at least for 13 weeks in all programme states.

All states have commenced airing jingle series that are partially sponsored by government/private radio. Preparation is in progress to start airing MNCH spots.

Facilitate the creation of an enabling environment for Voice & Accountability initiatives to increase demand for RI and other MNCH services

Strategies for establishment of facility health committees and monitoring of drugs for intervention facilities have been developed. A series of trainings for the FHC at the PHC and Secondary facility levels have been planned for the 1st quarter of 2010.

Promote mainstreaming of equity and social inclusion in policy and programmes

A report on HMIS from equity perspective has been produced. The state HMIS units will be included in the training on the mainstreaming equity and social inclusion issues in the second quarter of 2010.

A clustering study of households with MNCH problems was completed in Katsina. Stakeholder engagement on results was planned for January 2010 and this will hopefully inform the development of appropriate safety nets in Katsina and roll out approach in other states in 2010.

Output 7 Improved capacity of Federal Ministry level to enable States' routine immunisation activities

Output 7 Logframe Indicators

Formal systems for leveraging, accessing and utilising additional PHC funding.
 Agreed strategies to improve efficiency of RI.
 Federal level delivers X% vaccines and supplies to states on time.
 Number of state cold stores with adequate safe vaccines.

Support co-ordination and harmonisation at federal level

GAVI Financial Management System guidelines and tools were developed. PRRINN states & NPHCDA focal persons were trained on the tools' application.

The programme provided technical support for the development of Country Multi-year Immunization Plan and strategies for New Vaccine Initiative.

A total of 96 Midwives were deployed to each program state in Q4 09 as part of the MSS scheme.

Contribute to securing Dependable RI Supplies and Leveraging Extra Resources

Federal level delivery of vaccines and supplies to states on time during 2009 was 100%. All State stores were well stocked when visited during the Rapid Assessment of Immunisation in the last quarter of 2009. However, some stockouts of BCG and TT had occurred in the Yobe state store in the previous 3 months. A system has been established to monitor deliveries of vaccines and supplies at zonal and states stores on quarterly basis in 2010.

b) PRRINN project (begun in 2006)

General Progress against outputs

PRRINN has made very good progress against outputs at state as well as at federal level. During the reporting period, the programme revised its logframe into the new DfID format. A programme and state specific M&E framework, with milestones and targets for the remaining lifespan of the programme was developed. The Annual Plan for 2010 was developed based on the M&E framework and 2010 programme and state specific milestones. The full PRRINN logframe can be found in Annex 11.

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

Output 1 Logframe Indicators

No donor field missions and reviews done jointly.

Number of donor PHC programmes reflected in State and LGA annual health plans.

SIACCs support for RI through PHC system in all states.

Facilitate coordination and harmonisation of stakeholders and partners at state and LGA level

The programme participated in the inception review of PATHS2 and SuNMaP but was not part of the formal review team. The number of donor field missions and reviews done jointly are subject to frequency of donor field missions and reviews. In Jigawa, the programme participated in PATHS2 inception review, while in Katsina, the programme participated in SUNMAP programme review.

All states have 1-2 donor PHC programmes reflected in their State and LGA annual health plans. The number of donors reflected in state health plans depends on availability of decentralised donor programmes per state. In all the states, the PRRINN-MNCH programme plan for 2010 was reflected in the state and LGA/Gunduma plans. In Jigawa and Katsina, PATHS2 and SUNMAP programmes plan were also reflected in the 2010 plan respectively.

In all the states, SIACC or equivalent coordination committees have provided some support to RI through the PHC system. In Jigawa, SIACC approved the release of quarterly state RI fund and GAVI fund. In all states, the coordination committees met at least once every quarter to address RI and IPDs.

Promote coordinated advocacy, institutional change and change management

All States developed advocacy plans with HERFON facilitation. State HERFON teams re-activated around facilitation of state advocacy plans and plans for capacity building are being developed.

During the reporting period, a number of advocacy visits targeting high political leaders, traditional and religious leaders has been organised. In Jigawa, advocacy visit was paid

to the SSG, traditional and religious leaders to promote RI. In Yobe, advocacy visit was paid to the Governor to promote MNCH and establish state primary health care board. In Katsina, the first ladies of LGA chairmen and traditional leaders promoted community engagement interventions. In Zamfara, LGA chairmen and chairman of the health committee of the state assembly visited to promote establishment of PHC board.

Weighting: 15%
Scoring: 1

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

Output 2 Logframe Indicators

State government staff lead annual review and health planning process in all states.

State health plans reflect project data from 2010.

All states successfully access new Federally managed health funds.

Availability of PHC budget and expenditure reports for LGAs/Gundumas. Number of states with Demonstrated level of understanding in use of information by trained HMIS officers in each state.

% of LGAs with HMIS MNCH data collated at state level on a monthly basis.

Support state Planning and policy development

State government staff led annual reviews and health planning processes in all states with technical and financial support from the programme. The Programme states were supported to revise State Strategic Health Plans (based on Federal planning framework) and develop Annual Operational Plans for 2010. States and LGAs/Gunduma plans were costed and incorporated in 2010 budgets.

Each state has 2 or more examples of evidence based planning that is reflected in their 2010 plans. States were encouraged to develop an evidence based plan for 2010 based on project data. Information from programme supporting integrated supportive supervisions, annual PPRHAA exercises, and community engagement activities helped the states to reflect on a few examples of evidence based planning. In Jigawa, cold chain equipment and solar maintenance and roll-out community engagement plans were incorporated based on quarterly cold chain audit, ISS and health partnership interventions. In Zamfara, the Programme supported the Introduction of Mgso4, misoprostol, and antishock garments and budgeting for 2010. In Yobe, Cold chain planned preventive maintenance training for PHC health workers with the budget based on programme technical support. In Katsina, introduction of Mgso4, misoprostol, and antishock garments; procurement and installation of solar refrigerators were based on project data.

All states established health milestones for inclusion in their State Development Plan. These were developed as part of their revised health sector strategic plans. Each state has a different timeframe for revision of SEEDs and development of new State Development Plan (SDP).

Support health financing, budgeting and public financial management for PHC

All states have made considerable progress in accessing new federally managed health funds in 2009. The milestone of two successive years' access for new federally managed health funds in two states was partially achieved. In Jigawa, the state accessed MDG fund for two successive years. In the other three states, they accessed GAVI fund for one year.

The milestone for accessing of two federally managed funds in two states has been achieved. All states accessed GAVI and MDG funds. Jigawa, Katsina and Yobe states have also accessed NHIS fund. The Programme supported development of financial guidelines for NPHCDA and PRRINN-MNCH states. No financial reports have yet been required, as the fund was released in the second half of the year.

In all the states, annual PHC budgets were available both at state and LGAs/Gunduma levels, as the programme also actively supported the development of costed plan for the year 2009 at state and LGA level. Release of funds for PHC activities has increased in all states. In Zamfara, the PHC service delivery fund is operational, with 14 LGAs contributing monthly to the fund (over N18M for June to November 2009). The Executive Governor has also approved the State's contribution of about 10.5 million to the fund (late December 2009) although this is yet to be released. In Jigawa, the state also released a total of N15.3 million in 2009 to the Gunduma Councils for RI services. PRRINN-MNCH supported the Gunduma Health system Board to monitor the disbursement and utilization of the fund. In Katsina, LGAs now release N50,000 monthly for PHC activities. GAVI Funds are also accessed and disbursed to LGAs. In Yobe, N4.6 million was received in the fourth quarter from GAVI. (On 13 January 10, the State Governor also pledged the release of N25,000 per month for each midwife that came to Yobe as part of the MSS scheme.)

Strengthen information use across all states and support capacity building of a sustainable HMIS system

All state plans reflect use of some HMIS data collected from ISS and PPRHAA. Some progress has been demonstrated in utilisation of routine HMIS data and information collected through ISS and PPRHAA for state plans. All programme states established Health Data Consultative Committees and organised quarterly review meetings. In Jigawa RI data quality audit was conducted. In Zamfara State HMIS staff conducted self-data quality assessment on quarterly basis.

% of LGAs with HMIS MNCH data collated at state level on a monthly basis varies from 35% to 100% (milestone20%). In Jigawa, the average monthly return was 54% while in Zamfara for RI (99%), for IDSR (100%) and for MNCH data (85%). In Yobe, the average was 35% while in Katsina for RI(100%), for IDSR(100%) and for MNCH(70%).

Weighting: 20%

Scoring: 2

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

Output 3 Logframe Indicators

% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%.

% of PHC facilities with tracer drugs available.

Number of 1-year-old children immunised against measles.

% of health facilities providing RI experiencing vaccine stock-outs of TT.

Number of health professionals trained annually.

Facilitate PHC system development and capacity building

21% of LGAs reached performance ranking tool (PPRHAA) scores over 75% (milestone 29%). In Jigawa, 44% of the Gunduma councils and in Katsina, 38% of the LGAs reached scores over 75%. None of the LGAs in Zamfara or Yobe reached scores over 75%. However, 86% of LGAs in Zamfara and 71% of LGAs in Yobe scored between 50% and 74%.

In all the states, supervision teams visited LGAs/Gunduma with technical and financial support from the programme. A total of 12 supervision visits were conducted in targeted LGAs/Gunduma councils (milestone 9). The supervision visits per state were as follows: 4 in Jigawa, 4 in Zamfara, 2 in Yobe, and 2 in Katsina.

Strengthen maternal care

Although no formal surveys have been undertaken to assess any change in maternal care indicators since the baseline surveys in the first half of 2009, considerable efforts have been made to improve availability and quality of maternal care data provided by the routine HMIS in each state.

Data on % of women aged 15-49 have appropriate TT doses is awaiting next NICS survey 2010. The programme will also conduct Mini Household survey end 2010.

State HMIS data indicated that 21% of women received ANC (milestone= 25%). ANC distribution in the states is registered at 29% in Jigawa, 10% in Zamfara, 23% in Yobe and 20% in Katsina. A total of 14,790 first visits ANC (milestone 15,734) and a total of 8,480 deliveries (milestone 8,853) were reported from 3 states targeted facilities. Distribution of ANC and deliveries per state has reached 8,493 ANC and 3,642 deliveries in Zamfara, and 2,347 ANC and 625 deliveries in Yobe. Data from Katsina is outstanding.

Strengthen sustainable drug supply

Annual PPRHAA exercise indicated that tracer drugs were available in 68% of PHC facilities (milestone 54%). Distribution per state indicated the figures of 93% in Jigawa, 78% in Katsina, 54% in Yobe, and 48% in Zamfara.

Strengthen immunisation systems

% of infants fully immunised by first birthday is not captured by the HMIS data. The average coverage for the programme states from NICS 2006 (PRRINN baseline) was 3% while the baseline MNCH survey 2009 was 16%. The next NICS is expected to be conducted in 2010 (supposed to be 2009). The programme planned to conduct rapid EPI cluster Survey in few LGAs of the four states in Jan 2010.

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Data from quarterly cold chain audit indicated that 49% of LGAs had one month stock of all antigens for previous 3 months (milestone 59%). The range of one month stock per state was as follows; 65% in Jigawa, 75% in Zamfara, 0% in Yobe, and 57% in Katsina.

A total of 395,477 children under 1 year old were immunised against measles (milestone 204,711). The distribution per state was: 68,076 in Jigawa, 66,689 in Zamfara, 109,971 in Yobe, and 150,761 in Katsina.

Data from state annual PPRHAA exercises indicated that 78 % of health facilities had up to date microplan for RI (milestone 30%). The distribution per state was: 88% in Jigawa, 75% in Zamfara, 76% in Yobe, and 71% in Katsina.

Among all health facilities appraised by PPRHAA, 41% had up to date immunisation monitoring charts (milestone 40%). The distribution per state was: 32% in Jigawa, 50% in Zamfara, 60% in Yobe, and 20% in Katsina.

59% of health facilities appraised by PPRHAA in 2009 provide RI on weekly basis. The distribution of weekly RI services per state was: 85% in Jigawa, 70% in Zamfara, 70% in Yobe, and 70 % in Katsina.

Tracer medical supplies were available at 70% of PHC facilities (milestone 52%). The availability of tracer drugs per state was: 96% in Jigawa, 46% in Zamfara, 54% in Yobe, and 85% in Katsina.

Data from state HMIS indicated that a total of 251,167 under one year old children received OPV3 (milestone 188,865), while 282,505 children under 1 year received DPT3 (milestone 188,865). The distribution of OPV3 and DPT3 immunisation per state was 67,947 OPV3 and 64,976 DPT3 in Jigawa, 41,930 OPV3 and 49,449 DPT3 in Zamfara, 52,857 OPV3 and 60,518 DPT3 in Yobe, and 88,433 OPV3 and 107,742 DPT3 in Katsina.

DPT3 drop-out rate was 21% (milestone 40%) in all states. The drop-out rates in the states were between 20% and 23%.

A total of 225,197 one year old children were fully immunised in all states (milestone 126,540). The distribution of fully immunised per state was: 51,116 in Jigawa, 49,449 in Zamfara, 32,131 in Yobe, and 88,433 in Katsina.

Strengthen HR planning and development

Total number of health professionals graduated (including mid level health workers) in 2009 from state health training institutions in three states was 1273. In Yobe, 119 (62 males and 57 females). In Jigawa, 282 (disaggregated data is not available). In Zamfara, 184 (113 male and 93 female). In Katsina 666, (disaggregated data is not available).

A total of 55 new trainers on RI/MNCH were trained (milestone=40); 19 on IMCI, 24 on KMC, 12 on LSS competency based.

A total of 13 driver trainers were trained (milestone=6).

MLM immunisation training of state and LGA managers was supported by the programme in all states.

Human Resource Information System (HRIS) has been developed for 2 states (Jigawa and Zamfara) and it has been installed in the Kano office and Zamfara office and key staff have received initial training. HRIS has been piloted in 2 LGA/Gundumas: in Zamfara in the LLGA and in Jigawa in the Learning Gunduma.

HR managers have received basic exposure to HR data from HRIS that has initiated learning and increased level of competency in collection and use of key HR information. The HRIS is being used in Jigawa to manage transfer of staff to Gundumas.

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

Reporting on state plans reflecting OR results will commence second half of 2010.

In all programme states Stakeholders were engaged in establishing institutional arrangements for operational research. State OR agenda was set and OR Advisory Groups has been constituted through engagement of stakeholders. Research Ethics review committees have been constituted and training for the committees will be organised in 2010.

Establishment of operational learning LGA sites and HDSS site was partially achieved. 3 LLGA sites (in Jigawa, Yobe and Katsina) and HDSS site in Zamfara have been identified and state partners have made buildings available.

Support capacity building of a sustainable HMIS system

HMIS officers in each state demonstrated some skills in the use of the DHIS and analysis of data for review purposes. Area of capacity building includes training on the use of DHIS. TOT for 25 masters trainers have been conducted, with emphasis on DHIS

software application and data analysis. In Jigawa, Katsina and Zamfara M&E coordinators have been trained on IDSR. Data collection tools have been procured and handed over to SMOH.

59% of PHC facilities submitted monthly HMIS for RI within the designated period (milestone 20%). Monthly HMIS returns from PHC, both for RI and MNCH, were lower than LGAs. Distribution per state was: Jigawa 54%, Zamfara 80%, Yobe 80% and Katsina 21%.

38% of PHC facilities submitted monthly HMIS returns for MNCH, within the designated period (milestone 20%). Distribution per state was: Jigawa 54%, Zamfara 64%, Yobe 24% and Katsina 20%.

40% of PHC facilities submitted monthly HMIS returns for IDSR within the designated period (milestone 20%). Distribution per state was: Jigawa 54%, Zamfara 21%, Yobe 66% and Katsina 20%.

45% of PMS sites had an accuracy ratio of between 0.85-1.15 for specified data elements: OPV3, DPT3, ANC four visits, SBA (milestone 30%)

Establish knowledge management for PRRINN

One article was published in a peer review journal (milestone 0). It was based on PRRINN household survey, the article discussed factors predicting BCG immunisation status in Northern Nigeria: behavioural and ecological perspective was included. (Stella Bababla and Umar Lawan. Journal of Child Health Care 2009, vol 13, No 46).

A total of 13 success stories were written for different audiences including DfID, media and website (milestone 4). Distribution of written success stories per state was: 4 in Jigawa, 2 in Zamfara, 5 in Yobe, and 2 in Katsina.

Programme website has been designed and documentation completed and it will be live in February 2010.

An annual report for 2008 was published.

Establish monitoring and evaluation for PRRINN-MNCH

During the reporting period, the national office and state programmes produced 4 quarterly progress reports. Two quarterly M&E reports have been produced at state and national level.

Weighting: 30%

Scoring: 2

Output 4 Increased demand for routine immunisation

Output 4 Logframe Indicators

Increased political support for MNCH (including RI) evidenced by high level public events.

% of mothers of children < 2 in targeted areas who know the childhood vaccination schedule.
 % of never immunised children < 2 in targeted areas.
 % of wards with a development committee and/or health partnership implementing a community action plan.

Monitoring data for 2 of these logframe indicators (never immunised children, and childhood vaccination schedule) was collected during the MNCH baseline surveys undertaken in the first half of 2009. It is therefore not possible to provide any further survey-based data by the end of 2009. A mini household survey will be undertaken in the second half of 2010 to monitor progress on these indicators. However, during the last quarter of 2009 the programme did pilot KAP studies to monitor changes in communities where community engagement initiatives for RI and MNCH are being implemented. In 2010 the programme will report on indicators based on biannual KAP studies. In Jigawa, follow-up RI KAP survey conducted in Mid-December 2009 indicated that 94 % of women in community engagement intervention areas had standing permission to take their child to a health facility while 53 % of mothers of children < 2 knew the childhood vaccination schedule.

There was an increase in political support for MNCH (including RI) evidenced by high level public events in all programme states. All states achieved at least one high level public event at state level and one at LGA level.

Facilitate the establishment of a community engagement approach to promote healthy MNCH behaviours and generate demand for RI and other MNCH services

13% of wards had a development committee and/or health partnership implementing a community action plan by the end of 2009 (milestone 7%). Distribution per state was: 19% in Jigawa, 14% in Zamfara, 15% in Yobe and 5% in Katsina.

A total of 101 community engagement intervention sites established active community response systems to MNCH barriers (milestone 75). Distribution per state indicated 54 sites in Jigawa, 12 sites in Zamfara, 17 sites in Yobe and 18 sites in Katsina.

The number of State ministries/ departments/ agencies (MDAs) that include funds for MNCH demand-side issues in their budgets has increased in all states. The programme has pursued an active course to broaden commitment to MNCH demand side issues beyond the SMOH. Ministries of Women Affairs have budgeted for MNCH demand side issues in 3 states.

State ministries/ departments/ agencies (MDAs) lead community engagement activities with technical and financial support from the programme. Active engagement of State Ministries of Women Affairs in leading CE in all states has been achieved.

A total of 6 LGAs/Gundumas are leading community engagement activities in 3 states (milestone 4). LGA leadership is essential to establishing a sustainable CE process.

Enhance the profile of health promotion/communication at State and LGA levels

12% of PHC HFs had immunisation IEC products including Job Aids (milestone 8%). PRRINN-MNCH has printed and distributed vaccination hand poster and flyers to PHC facilities. Distribution per state indicated 17% in Jigawa, 11% in Zamfara, 14% in Yobe and 5% in Katsina.

A total of 8 tutors from 8 training institutions were trained as trainers in appropriate interpersonal communication and counselling (IPCC). State distribution was: 2 from each Jigawa and Zamfara, 3 from Katsina, and 1 from Yobe).

Between 2 to 4 jingles were aired daily at least for 13 weeks in all programme states.

All states have commenced airing jingle series that are partially sponsored by government/private radio. Preparation is in progress to start airing MNCH spots.

Actions are being taken to facilitate the creation of an enabling environment for Voice & Accountability initiatives to increase demand for RI and other MNCH services

Strategies for establishment of facility health committees and monitoring of drugs for intervention facilities have been developed. A series of trainings for the FHC at the PHC and Secondary facility levels planned for the 1st quarter of 2010.

Promote mainstreaming of equity and social inclusion in policy and programmes

A report on HMIS from equity perspective has been produced. The state HMIS units will be included in the training on the mainstreaming equity and social inclusion issues in the second quarter of 2010.

A clustering study of households with MNCH problems was completed in Katsina. Stakeholder engagement on results will take place in January 10 and this will inform development of appropriate safety nets in Katsina and roll out approach in other states in 2010.

Weighting: 25 %

Scoring: 1

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

Output 5 Logframe Indicators

Formal systems for leveraging, accessing and utilising additional PHC funding.

Agreed strategies to improve efficiency of RI.

Federal level delivers X% vaccines and supplies to states on time.

Support co-ordination and harmonisation at federal level

GAVI Financial Management System guidelines and tools have been developed. PRRINN states & NPHCDA focal persons have been trained on the tools' application.

The programme provided technical support for the development of Country Multi-year Immunization Plan and strategies for the New Vaccine Initiative.

Contribute to securing Dependable RI Supplies and Leveraging Extra Resources

Federal level delivery of vaccines and supplies to states on time during 2009 was 100%. All State stores were well stocked when visited during the Rapid Assessment of Immunisation in the last quarter of 2009. However, some stockouts of BCG and TT had occurred in the Yobe state store in the previous 3 months. A system has been established to monitor deliveries of vaccines and supplies at zonal and states stores on quarterly basis in 2010.

Weighting: 10 %

Scoring: 2

Annex 2: Jigawa State Report

The review team met with the Commissioner of Health, DG Gunduma and a number of director level officials. There is clearly political will to strengthen PHC. The Gunduma structure appears to be supporting this political will and delivering results. The governance aspects of the programme have benefited from DFID's other programmes in Jigawa, particularly SPARC and Paths2 to strengthen planning and finance.

Health Planning. The programme has rightly focussed on supporting Gunduma councils in their planning and finance activities and supporting input into wider planning processes e.g. the Health Sector Plan and Jigawa State Comprehensive Development Framework (CDF). The programme raised a number of questions for clarification on RI and the Jigawa State CDF. The programme will support Government to lead a review of the RI components of its Health Sector Plan.

GAVI funds. The programme has supported the State to retire and access GAVI funds. The State however was unable to spend all of its last allocation from GAVI because planned activities fell outside of GAVI guidelines. The programme is supporting the State to ensure that funds can be reassigned to GAVI approved activities.

Routine Immunisation. Immunization service delivery support seems stronger around IPDs/PEIs, while RI activities seem to be more on advocacy for resources, identifying barriers, planning to address barriers, training on vaccine management, including solar equipment. Considerable support is needed around addressing the issue of availability of vaccines during RI events. Motorcycles procurement, integration of motorcycle training into health worker curriculum has been cited as an achievement in this area.

Funding RI. There was some concern that no money was made available for RI in the 2010 budget. The explanation was that LGA budgets capture money for RI. The programme will need to ensure that finance from LGA and GAVI are fully captured in 2010 budget and plans. There was a large disparity in 2009 funds available for Polio Eradication and Routine Immunisation (N336m and N26m respectively). The programme needs to clearly communicate targets and costs and lobby on this basis.

Partnership. Coordination with other health development partners has come a long way since last year with regular meetings now being held. Health development partners are meeting on a regular basis with MoH and working from the operational plan derived from the Health Sector Plan. The MoEP is developing a development partner forum to strengthen coordination across all sectors. The programme's support to Gunduma Councils to strengthen HMIS, ISS and PPRHAA data collection has resulted in data being used to feed into Gunduma council plans. There seems to be much technical and geographic overlap between partners, making unclear arrangements about coordination, duplication and complementarity.

Gunduma System. The Gunduma System is quite bold and innovative, providing a number of opportunities for PRRINN for modeling and operations research, particularly. The Gunduma systems key features – moving health service delivery staff/resources/deliverables from the LGA to the health ministry and integration of primary and health care delivery provides interesting model of OR and modeling. It will

be important to develop a framework for assessing changes in performance early in the implementation.

Human Resources. PRRINN's work in support of the HR audit, post matching, piloting of the HRIS and proposed support around OR related to recruitment and retention of service delivery staff was noted and has helped clarify and shape priorities. Paths2 noted that the audit, HRIS software and training will enable them to use resources more strategically. Perhaps they can provide more support around incentives, maintaining the database.

Recommendations

For the programme

- The programme should continue to work closely with Paths2 and SPARC to feed RI into wider state planning and budgeting processes. Increase collaboration with Paths2 (both in Jigawa and beyond). Clarify workplans and responsibilities.
- The state governments need to be thinking for themselves and talking about change— PRRINN-MNCH should be aiding in this dialogue and eventually easing themselves out.

Annex 3: Katsina State Report

General Observations

The team met with various stakeholders and visited the Daura MNCH cluster where refurbishment of the Daura Hospital labour ward is taking place. The team also visited community engagement activities and spoke to both men's and women's groups. The PRRINN-MNCH offices are in the same complex as the SMOH, making contact and partnership easier. A recent change in leadership of the PRRINN-MNCH meant that there have been three STLs since the PRRINN project began, which was causing a break in continuity. Dr Sani had been in post less than a month but was quickly gaining knowledge of the state programme.

Project Progress

Health Architecture. Nigeria has very complex health architecture and this is illustrated in Katrina. The Primary Health Care Agency is well established but the issue of fragmentation is yet to be addressed. The Agency is running model comprehensive primary health care clinics at the Local Government level and sees itself as overseeing PHC in Local Government – however the agency is neither responsible for funding nor staffing the local government PHC; therefore, their ability to have a stewardship role is undermined.

Free MNCH and Referral. Referral is being adequately taken care of in Katsina by establishing one state-owned PHC in each LGA to mentor the LGA ward level PHCs. MNCH services are said to be free in all Secondary Health Care facilities in Katsina, but at the LGA level PHCs some components are free while some are not. This will lead to patient confusion as well as clogging up secondary facilities with clients who should be presenting at the primary level.

PHC Under One Roof. Katsina seems to have some way to go before they have 'PHC under one roof'. The Primary Health Care Agency and Local Government Ministry stated their commitment to maternal and child health and primary health care. The State Ministry of Health however do not see primary health care as their responsibility – but that of the PHC Agency in the State. If this is the case, it is unclear who has overall oversight for health in the state. Despite stated strong commitment from the local government and PHC Agency for primary health care, it is unclear how this commitment is translated into financial commitment, particularly at the local government level. MOU signing may be a mechanism for additional advocacy and monitoring by DFID on these issues.

HERFON. PRRINN has done some good advocacy in the state – including the involvement of traditional leaders. HERFON has made a 2010 work-plan to increase advocacy around maternal and child health issues. It has high level membership in the state and is chaired by the head of the primary health care agency. It also has membership in other ministries (including education) and this presents some good opportunities for PRRINN-MNCH.

MNCH. Katsina hosted the Training of Trainers courses for Life Saving Skills for CHEWs. CEOC rehabilitation is also underway including facilities for visiting families. This progress should begin to bear fruit this year.

SDSS. The system for procurement of drugs and consumables is not yet clearly defined and established. There is currently a perceived shortcoming in vaccine distribution due to fragmentation of PHCs service delivery. Also, there are multiple stakeholders buying drugs and the mechanisms for their management varies. In a single facility there can be DRF drugs and free drugs. Drugs are being bought by the state, local government, health facilities, donors, and the MDG office. In the midst of these multiple procurement channels, key drugs were seen during this review to be out of stock – including anti-malarial drugs and contraceptives. Overall the situation is complex and confusing – and in this environment there are opportunities for duplication of effort, confusion of responsibility and a lack of accountability.

Health Bill. Katsina referred a number of times to waiting for the Health Bill to be passed – and say its passage will resolve some of the primary health care issues in the state. It would probably be better for PRRINN-MNCH to put less emphasis on the Bill's passage and rather look for solutions that can be implemented immediately.

Budget and Planning. PRRINN-MNCH has done well with supporting the state in planning – including the State Strategic Plan. Emphasis is appropriately being now put on operational plans. However budgeting and budget execution remains a challenge – particularly in terms of disbursement of non-salary recurrent costs. It would be worth investing time in exploring this further – particularly around local government budget disbursement.

Coordination. PRRINN-MNCH has done some excellent work in bringing partners together. This should continue – together with exploration of mechanisms for deepening this coordination – such as joint reviews, and ensuring partners effort is mapped out and captured clearly in state health plans.

Human Resources. Generally there is a dearth of professional staff in all the states in number and mix, but the situation in Katsina seemed a bit better than in Zamfara, for example. The distribution of staff in all States visited is skewed towards urban centers as opposed to rural areas where they are most needed. It will be interesting to see the difference that the HR audit recommendations will make this year, particularly in the area of SBA. The challenge will be to see that the HR Coordinating Committee takes a driving role in implementing the recommendations.

Community engagement. The Review Team was impressed with the community engagement activities in the field. It is early days but if this progress is built on in future, great work can develop here.

Government complaisance. There is a level of government complaisance as the president's home state is used to a level of privilege other states might not enjoy. Some gentle rivalry between states should be encouraged and can remind Katsina that it will lag behind if its real problems are not addressed.

Recommendations

- Consider using the Zamfara basket fund approach in Katsina as a temporary mechanism to demonstrate that funds can flow transparently.
- The state governments need to be thinking for themselves and talking about change

Annex 4: Yobe State Report

The review team met officials from State Ministry of Health (SMoH), State Ministry of Local Government (MLGA), State Ministry of Budget and Planning (SMBP), State Ministry of Women's Affairs (MWA) and Geidam Local Government PHC department, as well as development partners: WHO, UNICEF and WB. Field visits were done to Geidam general hospital, MCH clinic, Kurnawa, Bursarwa LGA and a community in Bursarwa LGA.

Good relations. PRRINN-MNCH is greatly appreciated by all people met – it is seen as a great facilitator as well as supporter. Programme team was more optimistic than previous years: improved relations with the new Governor and Health Commissioner help.

Huge challenges remain. Good progress in almost all aspects of the programme and the right approach being used, however review showed huge challenges remain with health services still at very basic level and low capacity at Local Government and State levels. Work on community demand side is outstripping the supply side. Although the Governor is reportedly focussed on health, there is limited budgetary evidence of this or pressure on LGAs to perform. The review got the sense that responsibility, ownership, engagement and commitment to reduce child and maternal mortality from government officials are not very strong. Despite the excellent work of the programme, there is a high risk that programme will be at a similar level in 12 months time.

Free MNCH. A Free Maternal and Child Health policy was introduced by the Governor in mid-2009. Facilities don't charge for services and drugs are supplied free by the state: however, no drugs were received since the end of 2009 so were out of stock in facilities we visited. People are aware of free MNCH although there is no visible publicity about it.

SPHCB. There has been approval by EXCO for the establishment of a State Primary Health Care Board and a transitional committee is functioning. Work is already being done on mapping facilities and the human resources situation at LGA level. PRRINN-MNCH has provided technical assistance throughout the process. LGA health department, MLGA and SMoH are all aware of the fact and anticipating it is going to resolve all the problems. It certainly has potential for transforming the sector but this will totally depend on who is put in charge as the same people or same attitudes in a different institution will not change things. A lot is riding on the effectiveness of the new State PHC board. Incentives will need to be created to ensure those who currently control resources do not block the necessary change required to strengthen the system. The programme may be able to play a facilitative role to ensure that the legislation is understood by all stakeholders and implementation is open and transparent.

Management. Programme moved to new office space last year. Nearby old office now converted to guest house. STM goes to Kano (and now planned for other states) for monthly meeting.

Recommendations

For the programme

- Continue to focus efforts on development partner (both health and non-health) coordination and provide support to Government to provide oversight. Providing a pilot secretariat function should be explored.
- Build a stronger relationship with the MoEP. Build a strategy around known movers and shakers and make more integrated use of existing political economy work.
- Continue to strengthen coordination between the governance aspects of PRRINN-MNCH and EU SRIP with a particular focus on the multi-year budgeting framework.
- Continue support to establish the SPHCMB, specifically supporting the dissemination of legislation, clarifying roles and responsibilities and implementation structures. The programme will need to be sensitive about how it positions itself so as not to alienate other development partners.
- Explore the option of strengthening a relationship with an elected LGA Chairman with a view to increasing transparency of budget performance. Some background Political Economy work may be required. An assessment of existing resources and LGA capacity will be required.
- The programme should raise concerns, opportunities and options for DFID to advocate to Yobe State Government to support the development.
- Consider using the Zamfara basket fund approach in Yobe as a temporary mechanism to demonstrate that funds can flow transparently.
- The state governments need to be thinking for themselves and talking about change

For DFID

- DFID (not the programme) should sign the proposed MoU with Yobe State Government. The MoU will allow them to monitor progress on reform and provide a platform to raise concerns based on a mutually agreed Results Framework.
- DFID should formally meet with the political leadership on an annual basis to review progress. Opportunities to strengthen relationships with key Commissioners should be created.
- DFID should advocate with development partners at HQ level (Abuja) to support coordination at State level.

Annex 5: Zamfara State Report

The Review Team left Zamfara filled with optimism that change was possible even in a difficult setting. Stakeholders including development partners and government officials were generous with their praise for the PRRINN-MNCH team and the differences they had made. In all the meetings we held with stakeholders, there was the genuine sense of working on a difficult task together and that the facilitation of PRRINN-MNCH had made all the work easier. There was evidence that funds could flow in a transparent manner and that could be replicated in other areas of the health system.

The programme is being implemented in a challenging environment characterized by institutional constraints to improved PHC service delivery. Nevertheless, the structures, coalitions and partnerships being established in the state have the potential to impact on Governance initiatives and issues that affect RI and PHC in general, in the state.

Key Partners. The key programme partners in Zamfara state are the UN (UNICEF and WHO), USAID (MCHIP and ZAIHAP). They all gave PRRINN-MNCH high marks and said that the collaboration was among the best they had seen in Nigeria.

State and LGA planning and policy development. The state programme supported the state annual Review and Planning Meeting in Kaduna, to review the implementation of 2009 plans articulation of 2010 Plans/Budget. The process was lead by State officers and supported by PRRINN-MNCH. The programme further provided support to the development of State Strategic health Plan and Operational Plan for 2010.

Free MNCH. The Proposal by the state Government to implement 'Free Maternal and Child Health Care was costed with support by the programme, though this is undergoing further revision before inclusion in the 2010 plan, based on the advice of PRRINN-MNCH Governance Adviser.

Establishment of State Primary Health Care Management Board. This is imminent in Zamfara state. The draft document and a State Executive Council Memo have been submitted for approval by Government. The permanent secretary feels the approval could happen in a matter of "days".

State level structures. The programme has managed to establish and strengthen the following state level structures:

- State Inter-Agency Coordinating Committee
- State partners' Forum
- State Primary Health Care Fund Committee.

Human Resources. National Human Resource Policy and Strategic Plan have not yet been adopted or a new one developed in both States, but Zamfara has gone a step forward in establishing a Human Resource unit under the planning department.

PHC Basket Fund. Establishment of an effective and transparent PHC Fund has been achieved. It is a common basket fund into which all LGAs, State MOH and Gavl contribute funds that are used to address non-salary recurrent PHC activities in the areas which include vaccine supply chain and logistics, Integrated Monitoring and Supervision (ISS), and RI. The fund disbursement is managed through a chain of

approvals by the Permanent secretaries of Ministry of Health and Ministry of Local Government while signatories are the two permanent Secretaries and a representative of Development partners (WHO). Impressed by this arrangement, the State government decided to include IPDs funds in to the fund. It is generally believed that the PHC Fund will be absorbed into the SPHCB, when the later is approved, and will be sustained by the PHC fund as provided in the Health Bill.

Recommendations

For the programme

- Existing structures and partnerships present opportunities that can be maximally utilized as pressure sources to further strengthen existing state institutions & unlock the performance potentials around governance issues.
- Caution in responding to the clamour by other partners' for PRRINN-MNCH to do more in the area of Polio IPDs. PRRINN-MNCH emphasis need to remain focused on strengthening routine immunization as a component of Polio Eradication.
- With good performance, consider additional funds to build capacity in the area of budget, planning and implementation monitoring; also in expenditure tracking.

For DFID

- Need to move quickly on signing of MOU/Change Matrix Agreement with States and LGAs.

Annex 6: Terms of Reference

Annual Review

15 – 25 February 2010

Partnership for Reviving Routine Immunisation in Northern Nigeria - Maternal Newborn and Child Health Initiative; PRRINN – MNCH

1. Objective

1.1 The aim is to do an annual review of DFID's routine immunisation programme, PRRINN, and the Norway-funded Maternal, Newborn and Child Health programme, MNCH, which are being implemented as one combined programme.

1.2 Specific outputs are:

Assessment of annual progress of PRRINN MNCH against the combined logframe purpose, outputs and OVIs;

Completed standard DFID Annual Review template for PRRINN alone.

2. The Recipient

2.1 The Recipient of this work is DFID Nigeria.

3. Scope of Work

The Review Team will consider issues that include, but are not limited to, the following:

Quantitative and qualitative progress against programme purpose and outputs;

Progress on Output 2 (human resources) and Output 3 (service delivery including routine immunisation) in particular;

How the programme has been addressing gender so far and identify additional strategies;

Whether necessary baseline information is in place;

Follow-up on recommendations in the 2009 annual review report;

Risk analysis and mitigation;

Management (within programme, DFID - programme, DFID - Norway) and reporting arrangements, progress and financial;

Linkages with Government of Nigeria institutions, policy, other programmes.

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

The Team should make specific recommendations in areas where they consider that change is necessary or desirable.

4. Method

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

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

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 to visit the four States in which PRRINN-MNCH works - Jigawa, Katsina, Yobe, Zamfara.

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;

Meet with the Norwegian Embassy

Hold discussions with Federal and State Government officials and other national and international partners active in immunisation e.g. USAID, WHO, UNICEF.

Review the status of immunisation and primary health care services in the field in at least 1 health facility per state;

Hold a wrap-up meeting with key stakeholders to discuss key findings and recommendations;

Write a narrative report of the combined review and separate DFID Annual Review template for PRRINN alone;

5. Reporting

The Team Leader will be responsible for writing the combined report with specified inputs from some other team members, and for completing the internal DFID annual reviews template for PRRINN.

A draft narrative report of the Review with key findings and recommendations will be completed by Thursday 4th March. Comments will be provided by DFID by Friday 12th March. The final report should be submitted by Thursday 18th March.

The standard DFID Annual Review will be completed for PRRINN by the same schedule as the main report.

6. Timeframe

6.1 Essential background reading for the review will be supplied to team members by end of January and this reading should be undertaken before the start of the main review mission on 15th February.

6.2 The team leader will provide inputs to the preparation of the review in January 2010.

6.3 The review mission will be undertaken from 15th to 25th February 2010 with finalisation of the reports by 18th March.

7. DFID Coordination

7.1 The overall coordinator will be Solvi Taraldsen, Health Adviser in Kano.

8. Review Team

8.1 The proposed Review Team members are listed below. .

Consultant Team Leader

Consultant on Gender and Community Work

DFID Health advisers

DFID Governance adviser
DFID Programme/Project officers
Health Adviser from Norway
NPHCDA, Abuja
FMoH, Abuja
WHO
USAID
PATHS 2
One representative from each of 4 state governments

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

8.3 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.

9. Background

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

9.2 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.

While the national under-five mortality is 157 per 1000 live births in the 2008 DHS the figures for the North West and North East zones are 217 and 222 respectively. Immunisation coverage in Nigeria has fallen since the 1990s to become one of the lowest in the world. The 2008 DHS suggests full immunisation coverage in the 4 PRRINN States to be between 0 and 5%, with measles coverage between 8 and 25%.

In 2007, the 'Reaching Every Ward' strategy was developed for immunisation. An Integrated Maternal, Newborn and Child Health strategy and a Midwifery Service Scheme are being rolled out

9.3 PRRINN- MNCH

DFID-funded PRRINN is a 5-year programme supporting the strengthening of routine immunisation. 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. In 2008 the Norwegian-funded MNCH programme was added, designed to augment and strengthen PRRINN by deepening the governance components of PRRINN, strengthen the broader PHC system with focus on maternal and child health and creating a larger operational research component. DFID is managing the programme on behalf of Norway through a delegated cooperation arrangement.

The consortium managing PRRINN won the tender for this new component, which started in September 2008, and the two components are now being implemented in an integrated way with a combined logframe, monitoring and evaluation framework and combined workplan. However, annual reporting requirements are still separate. The

narrative report of the annual review of the combined logframe and workplan is required for the Norwegians. DFID requires a separate assessment of progress against the purpose and outputs of the PRRINN logframe, with the information being derived from the combined review.

The combined annual review of PRRINN and Inception Review of MNCH in February 2009 showed that PRRINN was making good progress against most outputs at state level but that it remains high risk with continued concerns around the poor status of primary health care and broader governance and institutional issues. New risks identified were insufficient or inadequately trained staff at PHC facilities and ineffective donor coordination.

10. Relevant Documentation

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

- PRRINN programme memorandum
- MNCH programme memorandum
- PRRINN-MNCH combined logframe
- PRRINN logframe
- PRRINN- MNCH quarterly reports
- PRRINN-MNCH annual report 2009
- PRRINN- MNCH monitoring and evaluation framework
- PRRINN-MNCH workplan and budgets for 2009 and 2010
- Relevant consultants' reports

Additional relevant material includes:

- FMoH policies/strategies relevant to MNCH
- State MoH strategic health plans

Annex 7: Team Assignments for PRRINN-MNCH Annual Review February 2010

Assignment	Team 1		Team2	
	Katsina	Zamfara	Jigawa	Yobe
Output1: State Governance	Jane	Emmanuel	Jakesh (lead writer 2pp)/Bala	
Output2: Human Resources	Jane/Emmanuel /Frank/Sulaiman /Tahir	Solvi	Maisha/ Ma'awiyya	
Output3: Service Delivery	Solvi	Solvi	Taiwo	Carolyn
Output4: Operations Research	Carol (lead writer)		Lene/Bala	
Output5: Info Generation	Frank		Lene	
Output6: Demand Generation	Andrew		Maisha (lead writer 2pp)	
Output7: Federal Governance	Carol: lead writer with additional questions from Jane and Emmanuel			
Maternal Health 1st Delay*	Carol		Maisha (lead writer 1p)	
Maternal Health 2nd Delay*	Carol (lead writer 1p)		Maisha	
MH Third Delay* (clinical look at primary, secondary and tertiary health centres)	Solvi		Taiwo	
Immunisation	Andrew		Halima	
Management	David (institutional mngt arrangements) with Carol		Carolyn	
Gender	Carol		Maisha	
Risks	Carol			
Overall State write-ups (2pp of overall impression)	Carol	Carol	Maisha	Carolyn

Output Leaders' responsibilities:

14 February: Determine key questions for output

19 February: Key findings & Recommendations (1 page of bullet points max per output)

Review Teams

State Team 1 (Zamfara, Katsina)	State Team 2 (Yobe, Jigawa)
Carol Bradford, Team Leader (Leader Team 1) Solvi Taraldsen, NORAD/DFID David Lloyd-Davies, DFID (Zamfara only) Jane Miller, DFID (Katsina only) Mr Frank Akpan, FMOH Andrew L Mbewe, WHO Dr Bulama Sulaiman, SMOH Yobe Pharm. Usman Tahir, SMOGHB Jigawa Emmanuel Odu, NPHCDA	Jakesh Mahay, DFID (Leader Team 2) Maisha Strozier Lene Lothe, NORAD Carolyn Sunners, DFID (Yobe only) Halima Tajo, NPHCDA Taiwo Oyelade, WHO Dr Aliyu Mu'awiyya, SPHCDA Katsina Bala Aliyu, SMOPB Zamfara

Full names and titles:

Carol Bradford, DFID Consultant (Team Leader)
 Solvi Taraldsen, Health Advisor, DFID (seconded from NORAD), Kano office
 David Lloyd-Davies, DFID Abuja office
 Jane Miller, Team Leader, Human Development, DFID Abuja office
 Mr Frank Akpan, FMOH
 Andrew L Mbewe, Immunisation and Adolescent Health, WHO
 Dr Bulama Sulaiman, SMOH, Yobe
 Pharm. Usman Tahir, SMOGHB, Jigawa
 Emmanuel Odu, Deputy Director PRS, NPHCDA
 Jakesh Mahay, Governance Advisor, DFID (Leader Team 2)
 Maisha Strozier, Gender consultant
 Lene Lothe, NORAD
 Carolyn Sunners, Health Advisor, DFID (Yobe only)
 Halima Tajo, NPHCDA
 Taiwo Oyelade, WHO
 Dr Aliyu Mu'awiyya, SPHCDA, Katsina
 Bala Aliyu, SMOPB, Zamfara

Annex 8: Team Itinerary

13-25 February 2010

Date	Activities
Saturday February 13	Carol Bradford arrives Kano.
Sunday February 14	Maisha Strozier arrives Kano. Carol Bradford and Maisha Strozier meets Solvi Tareldsen and Carolyn Sunners and other DFID officials. Initial briefings and finalisation of review design.
Monday, February 15	Meeting with overall Review Team to agree roles and responsibilities. Meeting with PRRINN-MNCH Team for presentation of progress to date. Review Team departs for the field. TEAM 1: Travel to Gusau, Zamfara State and, on arrival, has a meeting with the PRRINN-MNCH state team. TEAM 2: Travel to Damaturu, Yobe State .
	TEAM 1
	TEAM 2
Tuesday, February 16	<p>AM Meetings with: UNICEF, WHO, COMPASS, ACCESS, EU-PRIME, State Ministry of Health Ministry of Budget and Economic Planning and State Ministry of Local Government PM Field visit: PHC and BEOC DHSS Community engagement</p> <p>Yobe State Meetings with: State Ministry of Local Government (MLGA); Geidam Local Government PHC Department; PRRINN/MNCH State Team Field visits: Geidam General Hospital; Kelliru MCH; Kurnawa PHC and community engagement, (Bursari LGA)</p>
Wednesday, February 17	<p>Visit to cold store Debriefing with PRRINN/MNCH team Depart for Katsina State and, on arrival: Meeting with the PRRINN- MNCH state team.</p> <p>Meetings with: State Ministry of Budget and Planning (SMBP); State Ministry of Health (SMoH); State Ministry of Women's Affairs (MWA); Donors (WHO, UNICEF, HSDP and World Bank); Return to Kano</p>
Thursday, February 18	<p>AM Visit to General Hospital, Daura Dan Nakola Community</p> <p>PM Meetings with Partners: WHO, Rotary, and UNICEF</p> <p>Travel to Dutse, Jigawa State. Meetings with: State Ministry of Health; Gunduma Board; WHO; PATHS 2: PRRINN-MNCH State Team Return to Kano Field Visit to: Talahiya East PHC (Miga LGA);</p>
Friday, February 19	<p>Meetings with: ACCESS-MCHIPS HERFON Ministry of Local Government SMOH Debriefing with PRRINN/MNCH team</p> <p>In Kano, no meetings</p>

	Depart for Kano
	Review Teams meet in Kano, Carol Bradford facilitates discussion of findings and teams compile.
Saturday, February 20	Consultants fly to Abuja
Sunday, February 21	Report writing.
Monday, February 22	Meetings in Abuja with the NPHCDA, Paths2, the FMOH-Family Health Department and with the PRRINN-MNCH National Advisor. Carol Bradford departs Abuja for Kano.
Tuesday February 23	Maisha Strozier departs Abuja for Kano. Report writing continues in Kano.
Wednesday February 24	Consultants meet with PRRINN-MNCH staff for final questions.
Thursday, February 25	Stakeholders' workshop in Kano. Findings presented to by the consultants. Plenary discussion of findings and recommendations. Carol Bradford departs Kano for London; Maisha Strozier departs Kano for Abuja.

Annex 9: Persons and Organisations Consulted

ABUJA

National Primary Health Care Development Agency, NPHCDA

22 February 2010

Dr Muhammad Pate, Executive Director, CEO, NPHCDA

Dr Emmanuel Abanida, Director of Immunisation

Dr Emmanuel Odu, Deputy Director PRS, SA to Executive Director

Dr Adamu Nuhu, Deputy Director of Routine Immunisation

Dr Oteh Daniel, Assistant Director of Health Systems Development

Prof Okey Akpala, Director of health System Development

FMOH, Family Health Department

22 February 2010

Helen Akhigbe, Programme Officer, Reproductive Health Unit

Jane Ajoko, Programme Officer, Child Health Unit

PRRINN-MNCH Federal Office: 22 February 2010

Dr Ben Anyene, National Policy Advisor

PATHS2: 22 February 2010

Mike Egboh, Director, PATHS2

Garba Safiyanu, States Programme Coordinator

Benson Obonyo, Technical Programme Coordinator

Kano

PRRINN-MNCH project staff

ZAMFARA

PRRINN-MNCH team

Partners Meeting: 16 February 2010

Aliyu Adamu Tsafe, Jhpiego, Johns Hopkins University

Salamatu Bako, Clinical Officer, ZAIHAP

Alpha Njie, WHO

Sana Suleiman, WHO

Annie Bala, MCHIP, JHPIEGO

Naureen Naqui, UNICEF

Zamrab Nyano, MCHIPS, JHPIEGO

Abdulganiyu Gina, UNICEF

Ismaila Mohammad, WHO

SMOH: 16 February 2010

Halilu Aliyu Anka, Permanent Secretary, MOH

Ahmadu Kelu, DPHS, MOH

Ibrahim Abu Mary, DNS

Bello Yusuf Galada, DA

Lawal Umar Bangudu, DPH

(Commissioner for Health phoned during meeting and spoke to the Team Leader)

Ministry of Budget and Ministry of LGA: 16 February 2010

Bala Wakili Gusau, Permanent Secretary, MLGCA
Kabiru Mohammed, Permanent Secretary, Ministry of Budget
Halilu Hassan Bakung, Director for Primary Healthcare, MLG
Hamza Salihu, Director of Budget, MBEP
Lerwauli Umer Bangulu, DHS, SMOH
Yusuf A Muso, SLO, SMOH

KATSINA**PRRINN-MNCH team****Ministry of Local Government: 19 February 2010**

Nalifi M. Idms
Aliyu G Girka, DAS
Ibrahim Mayunguwa, Director of Finance

State Ministry of Health: 19 February 2010

A G Tanimu, Permanent Secretary, SMOH
Dr Hadra Idris, Director of Public Health
Sanjawa , Director of Planning and Research
Halilu Idris, Director of Finance
Salisu Abuca, Director of Eng Ser
Rabi Sanusi, Director of Pharmacy, SMOH

Partners Meeting: 18 February 2010

Hafsat Yusif, SM Consultant, UNICEF
Fatimah B Mustafa, SM Consultant, UNICEF
Aishat Indo Lawa, State Coordinator, Rotary
Onilafe Michael, International Consultant, Communication, EPI, WHO
Dr Ado Bwaka, WHO State Coordinator
Dr Amina Shehu Sule, ACCESS, MCHIP (separate meeting 19 February 2010)

HERFON: 19 February 2010

Ibrahim Yusuf Kurfi, Vice Chariman
Adama Sule Bakori, Treasurer
Garba Lawar Abukur

YOBE**State Ministry of Local Government (MLGA), 16 February 2010**

Mustapha M. Bura, Deputy Primary Health Care Coordinator
Umar Ibrahim Geidam, LGA Immunisation Officer
Amina Zanna, MHC Coordinator
Mohammed Lutti, Disease Surveillance and Notification Officer/M&E Officer
Bukura Lawan, Cold Chain Officer

Geidam Local Government PHC Department, 16 February 2010

Primary Health Care Coordinator

Geidam General Hospital/Keliru MCH Clinic: 16 February 2010

Chief Nursing Officer
Ward I/C, Maternity Ward
Ward I/C, KMC Ward
Kurnawa PHC, (Bursari LGA); 16 February 2010
Hassan Abu Environmental Health Officer
Ruth Yohama, Senior Community Health Extension Worker
Pandama Mari, Health Assistant

PRRINN/MNCH State Team: 16 February 2010

Dr. Eric Amuah, State Team Leader
Zainab Abdul, State Program Officer (Demand Side)
Dr. Ashiru, Operations Research

Donors: 17 February 2010

Sera Jatau, UNICEF Social Mobilization Officer
Sambo Gabriel, WHO Consultants
Hamidu M. Alhaji – WHO Consultant
Dr. Jucy, WHO Consultant
David Mishelbwala,, UNCEF Logistics
Dr. Adamu Issa Mohammed, WHO State Coordinator
Health Systems Development Programme Representative

State Ministry of Health (SMoH): 17 February 2010

Alhaji Idrissa Mai Bukar Machinama, State Commissioner for Health

State Ministry of Budget and Planning (SMBP), 17 February 2010

Alhaji Amshi, Permanent Secretary

Ministry of Women Affairs: 17 February 2010

Rifkatu, O. Audu, Director of Women Affairs
Halima Salisu, Deputy Director of Women Affairs
Hauwa Suleiman, Dir Planning, Research and Statistics
Alhaji Bossoma, Director of Finance
Maryam Bomai, Deputy Director Child Welfare
Mohammed Z. Jakusko, Director of Personnel Management

JIGAWA

PRRINN-MNCH Team: 18 February 2010

Yusuf Yusufari, State Team Manager

State Ministry of Health: 18 February 2010

Dr. Ibrahim M. Nashabaru, Commissioner
Alhaji Ibrahim Adamu, Permanent Secretary
Dr. Hassana H. Adamu, Director General, Gunduma HSB
Alhaji Mustapha Abdu, Director of Human Resources
Dr. Umar Bulangu, Director of Budget and Planning
Alhaji Usman Abdu, Director of Finance, Gunduma HSB
Pharmacist Lawan Bala Kazaure, Director Pharmacy, Gunduma HSB

Visit to Talahiya East PHC (Miga LGA) 18 February 2010

Alhaji Aminu DanMallam, Director Primary Health Care, Gunduma Health Systems Board
Officer in Charge (OIC), Talahiya East PHC

WHO 18 February 2010

Dr. A. Maiwada, State Coordinator

Annex 10: Updated Risk Assessment February 2009 (no changes made in 2010)

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	<p>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.</p> <p>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.</p> <p>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.</p>
b) PHC services do not get delivered.	Impact High, Probability High Unchanged	<p>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</p> <p>Mitigation The UK Norway MNCH programme will provide additional support to strengthen PHC</p>
c) Negative impact of PEI and measles campaigns	Impact High, Probability High Unchanged	<p>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.</p>

		<p>Mitigation</p> <p>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.</p>
d) Incorrect storage and use of vaccines	<p>Impact High, Probability Medium</p> <p>Probability reduced to: Low</p>	<p>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.</p> <p>Mitigation</p> <p>PRRINN will continue to focus on rehabilitation of solar fridges and maintenance at LGA level.</p>
e) Communities and households do not take up RI	<p>Impact High, Probability Medium</p> <p>Unchanged</p>	<p>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.</p> <p>Mitigation</p> <p>PRRINN will work with MNCH and other partners to scale up proved strategies and will continue to collect evidence of what works.</p>
f) Lack of State and LGA commitment to RI and subsequent inadequate or mismanaged financial allocations.	<p>Impact High, Probability Medium</p> <p>Unchanged</p>	<p>There has been small-scale but significant increases in commitments by both States and LGAs to RI and PHC.</p> <p>Mitigation</p> <p>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.</p>
g) Failure to develop and sustain effective data management systems	<p>Impact Medium, Probability Medium</p> <p>Unchanged</p>	<p>Lack of data is a key issue in analysing and monitoring the programme although it is 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</p>

		<p>of good data or know how it can be utilised for both planning and impact monitoring</p> <p>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.</p>
<p>h) Lack of reform at the strategic level isolates and marginalises RI.</p>	<p>Impact Medium, Probability Medium</p> <p>This risk should be deleted as it is adequately covered by (i) below.</p>	<p>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.</p> <p>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.</p>
<p>i) Lack of PRRINN linkages to central strategic planning and resource allocation initiatives (SEEDS, PMF etc).</p>	<p>Impact High, Probability Medium</p> <p>Impact changed to: Medium</p>	<p>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.</p> <p>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.</p>
<p>j) Gunduma system in Jigawa fails. PHCDA system in Yobe fails.</p>	<p>Impact Medium, Probability Medium</p> <p>Unchanged</p>	<p>The Gunduma system in Jigawa and the proposed PHCDA on Yobe have enormous 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.</p>

		<p>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.</p>
k) Ineffective Federal MoH	<p>Impact Medium, Probability Medium</p> <p>Unchanged</p>	<p>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.</p> <p>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.</p>
l) Political and civil instability	<p>Impact High, Probability Low</p>	<p>Remains a risk outside of PRRINN's control. Mitigation includes building capacity to sustain workplans without close PRRINN presence or oversight.</p>
m) Local Government elections and challenges to 2007 electoral process disrupt programmes	<p>Impact Medium, Probability Medium</p> <p>This risk should be deleted as there are no elections in the near future and other civil disturbances are covered elsewhere.</p>	<p>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 and awareness of timings of aspects of the electoral process will help PRRINN plan as effectively as possible.</p>
n) Insufficient or inadequately trained staff at PHC facilities New risk	<p>Impact high Probability medium</p>	<p>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.</p> <p>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.</p>
o) Ineffective donor	<p>Impact Medium</p>	<p>Donor coordination structures, especially in Yobe where there is no SIACC, remain sub-optimal.</p>

<p>coordination</p> <p>New risk</p>	<p>Probability Medium</p>	<p>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.</p> <p>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.</p>
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Annex 11: PRRINN Logframe 2007-2011

PROJECT NAME	PRRINN in Northern Nigeria, 2009-2011				
GOAL	Indicator	Baseline (2007)	Milestone 1 (2009)	Milestone 2 (2010)	Target (2011)
Progress towards achievement of MDGs 4 & 5 in Nigeria	MDG4, Target 5	161 ¹	153	149	144
	Reduce by two thirds, between 1990 and 2015, the under five mortality rate	Source National figures based on Demographic Health Survey (DHS) 2008, MNCH Household Survey 2009 established <5 mortality in MNCH States (Yobe, Zamfara and Katsina) as 246.			

PURPOSE	Indicator	Baseline (2007)	Milestone 1 (2009)	Milestone 2 (2010)	Target (2011)	Assumptions	
To improve delivery of routine immunisation for children and women of reproductive age via the primary health care system in 4 to 6 low-coverage states in northern Nigeria	% of infants fully immunised by first birthday	3%	20%	38%	60%	Maintenance of Federal allocations to State and LGA health budgets Continued political stability and absence of civil strife	
	Source NICS 2006, 2009, 2012, MNCH Household Surveys 09, 10, 12, Mini Household Survey 2011, HMIS/PMS <i>Baseline, milestones and target should be disaggregated by sex</i>						
	Indicator	Baseline	Milestone 1	Milestone 2	Target		
	% of women aged 15-49 have appropriate TT doses	15%	50%	60%	70%		
	Source NICS 2006, 2009, 2012; MNCH Household Surveys 09, 10, 12; Mini Household Survey 2011, HMIS/PMS						
	Indicator	Baseline	Milestone 1	Milestone 2	Target		
	Percentage of women receiving ANC	19%	25%	30%	38%		
	Source DHS 2008, MNCH Household Surveys, HMIS/PMS						
	Indicator	Baseline	Milestone 1	Milestone 2	Target		
	Measles incidence reduced by 80%	22,250	16,687	11,125	4,450		
	Source						

¹ Extrapolated from Demographic Health Survey (DHS) 2008 Under Five Mortality of 157

		Integrated Disease Surveillance and Response (IDSR) 2008, formerly DSN,			
	Indicator	Baseline	Milestone 1	Milestone 2	Target
	Polio incidence reduced to near zero	237	178	119	0
		Source			
		DSN 2008			
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)
	19,000,000				
INPUTS (HR)	DFID (FTEs)				

OUTPUT 1	Indicator	Baseline	Milestone 1	Milestone 2	Target	Assumption
Effective harmonization and alignment of all agencies' support for routine immunisation at State and LGA levels	Number of donor field missions and reviews done jointly	2	At least 2	At least 2	At least 2	All donors and partners provide common support and advocate for common strategy
		Source				
		Mission and review reports				
	Indicator	Baseline	Milestone 1	Milestone 2	Target	
	Number of donor PHC programmes reflected in State and LGA annual health plans	None	1 per state	2 per state	3 per state	
		Source				
		State and LGA health plans				
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target	
15	SIACCs support for RI through PHC system in all states	None	Little	Some	More	
		Source				RISK RATING
		Meeting records				Medium
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	1,900,000					
INPUTS (HR)	DFID (FTEs)					

OUTPUT 2	Indicator	Baseline	Milestone 1	Milestone 2	Target	Assumptions	
Improved capacity at State and LGA levels for strategic analysis, policy development, planning and budgeting of routine immunisation	State government staff lead annual review and health planning process in all states	No	Planning process facilitated and supported by the programme	Process 1 led by state teams with technical and financial support from the programme	Process led by state teams with limited support from the programme	Draft Health Bill enacted and effectively applied at Federal, State and LGA levels and NPHCDA funds distributed	
	Source		State health plans and budgets				
	Indicator	Baseline	Milestone 1	Milestone 2	Target	FGN and academic authorities approve curriculum for intensive, practical short course	
	State health plans reflect project data from 2010	None	Each state has 1-2 examples of evidence based planning	Each state plan has at least 3 examples of evidence based planning	Each state plan has at least 5 examples of evidence based planning		
	Source		State health plans				
	Indicator	Baseline	Milestone 1	Milestone 2	Target	Federal, State and LGAs willing open up planning, budgeting and financial records to public scrutiny (from MNCH)	
	All states successfully access new Federally managed health funds	None	One year in all states	Two years in all states	Three years in all states		
	Source		State financial statements or federal level statements (e.g. NPHCDA for GAVI and possibly the PHC fund)				
	Indicator	Baseline	Milestone 1	Milestone 2	Target	Federal funds are released to States for PHC services (from MNCH)	
	Availability of PHC budget and expenditure reports for LGAs /Gundumas	Minimal data available in 2 states	Limited data available in 3 states	Annual PHC budgets available for all targeted LGAs/ Gundumas	Annual expenditure reports available for all targeted LGAs/ Gundumas		
	Source		State and LGA financial statements				
	Indicator	Baseline	Milestone 1	Milestone 2	Target	Federally managed funds agree to allocate resources to PRRINN-MNCH states (from MNCH)	

	Demonstrated level of understanding in use of information by trained HMIS officers in each state	Little	Some	Basic	Moderate	
		Source				
		HMIS data and reports, HR performance indicators				
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target	
20%	% of LGAs with HMIS MNCH data collated at State level on a monthly basis	<5%	20%	40%	75%	
		Source				RISK RATING
		HMIS Reports, PMS				High
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	3,800,000					
INPUTS (HR)	DFID (FTEs)					

OUTPUT 3	Indicator	Baseline	Milestone 1	Milestone 2	Target	Assumptions
Primary health care systems strengthened to support routine immunisation	% of health facilities providing RI experiencing vaccine stock-outs of TT	38%	34%	29%	19%	Global and national initiatives do not disrupt planning and implementation of PHC and RI at State and LGA levels States continues to provide drugs on a sustainable basis
		Source				
	Stock records or PPRHAA					
	% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%	7%	29%	40%	50%	
		Source				
	PPRHAA reports					
	Number of 1-year-old children immunised against measles	109,464	204,711	299,957	403,556	
		Source				
	NICS 2006; PRRINN Household Survey 2007, MNCH Household Survey 2009; DHS					
	Number of health professionals trained	904	Number	Number	Number	
		(M=552; F=352)				

	annually	Source				
		Survey of Health Training Institutions 2009, Annual Reports of Health Training Institutions. <i>Baseline, milestones and target should be disaggregated by sex</i>				
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target	
30%	Percentage of PHC facilities with tracer drugs available	41%	54%	58%	62%	
		Source				RISK RATING
		Stock records or PPRHAA				High
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	8,360,000					
INPUTS (HR)	DFID (FTEs)					

OUTPUT 4	Indicator	Baseline	Milestone 1	Milestone 2	Target	Assumptions
Increased demand for routine immunisation	Increased political support for RI evidenced by high level public events	None	1 at state level; 1 at LGA level	1 at state level; 2 at LGA level	1 at state level; 2 at LGA level	MNCH programme and other partners provide additional complementary support
		Source				
	Media reports; project reports					
	%of wards with a development committee and/or health partnership implementing a community action plan	None	7%	15%	30%	
		Source				
	Community monitoring process					
% of mothers of children <2 in targeted areas who know the childhood vaccination schedule	10%	25%	35%	50%		
	Source					
	PRRINN Household Survey 2007, MNCH Household Survey 2010; MNCH Rapid Household Survey 2011.					
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target	

25%	% of never immunised children <2 reduced in targeted areas	25%	20%	16%	13%	
Source						RISK RATING
NICS 2006, 2009; PRRINN Household Survey; <i>Baseline, milestones and target should be disaggregated by sex</i>						Medium
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	4,180,000					
INPUTS (HR)	DFID (FTEs)					

OUTPUT 5	Indicator	Baseline	Milestone 1	Milestone 2	Target	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	1 system designed	1 system implemented	2 systems implemented	All donors and partners provide common support and advocate for common strategy Sufficient funds allocated and released at Federal level for national immunisation supplies	
	Source						
	System reports						
	Indicator	Baseline	Milestone 1	Milestone 2	Target		
Federal level delivers X% vaccines and supplies to states on time	<80%	90%	100%	100%			
	Source						
	Stock records of zonal and state stores						
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target		
10%	Agreed strategies to improve efficiency of RI	None	Strategies developed	Strategies owned	Strategies implemented		
Source						RISK RATING	
Federal level reports						Medium	
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)		
	760,000						
INPUTS (HR)	DFID (FTEs)						

PRRINN-MNCH Combined Logframe 2009-2012

PROJECT NAME						
PRRINN-MNCH in Northern Nigeria, 2009-2012						
GOAL	Indicator	Baseline (2009)	Milestone 1 (2010)	Milestone 2 (2011)	Target (2012)	
To improve maternal, newborn and child health in Northern Nigeria	MDG4, Target 5 Reduce by two thirds, between 1990 and 2015, the under five mortality rate	153 ²	149	144	140	
		Source National Demographic Health Survey (DHS) 2008. ^{3 4}				
	MDG5, Target 6 % of births attended by a skilled birth attendant (SBA) in targeted CEOC clusters	38.9%			50% ⁵	
		Source NDHS 2008				

PURPOSE	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Assumptions
To improve effective access to MNCH (including RI) services in four states	% of infants fully immunised by first birthday	16%	38%	60% (PRRINN Target)	65%	Maintenance of Federal allocations to State and LGA health budgets Continued political stability and absence of civil strife
		Source NICS 2006, 2009, 2012, MNCH Household Surveys 09, 10, 12, Mini Household Survey 2011, HMIS/PMS <i>Baseline, milestones and target should be disaggregated by sex</i>				
	% of women aged 15-49 have appropriate TT doses	15% 2006	60%	70%	75%	
		Source				

² Extrapolated from Demographic Health Survey (DHS) 2008 Under Five Mortality of 157

³ Target is based on 2 thirds reduction of 1990 U5MR

⁴ MNCH Household Survey 2009 established <5 mortality in MNCH States (Yobe, Zamfara and Katsina) as 246.

⁵ Target based on trends seen from 1990 to 2008 and projection of estimated impact of donor programmes

		NICS 2006, 2009, 2012, MNCH Household Surveys 09, 10, 12, Mini Household Survey 2011.			
	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)
	Caesarean section rates (in targeted CEOC clusters)	0.5%	>0.5%	1%	>1%
		Source			
		MNCH Services Survey 2009, PMS, MNCH Household Survey			
	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)
	Percentage of women receiving ANC	21%	30%	38%	45%
		Source			
		MNCH Household Surveys, HMIS/PMS			
	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)
	Measles incidence reduced by 80%	22,250	11,125	4,450	2,225
		Source			
		Integrated Disease Surveillance and Response (IDSR) previously DSN.			
	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)
	Polio incidence reduced to near zero	237	119	0	0
		Source			
		IDSR; WHO monitoring system			
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)
	22,700,000				
INPUTS (HR)	DFID (FTEs)				

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	Planning process facilitated and supported by the programme	Process led by state teams with technical and financial support from the programme	Process led by state teams with limited support from the programme	Process led by state teams with no support from the programme	Federal, State and LGAs willing open up planning, budgeting and financial records to public scrutiny

	Source				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 Federally managed funds agree to allocate resources to PRRINN-MNCH states
	State health plans and budgets				
Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
All states successfully access new Federally managed health funds	One year in all states	Two years in all states	Three years in all states	Four years in all states	
	Source				
	State financial statements or federal level statements (e.g. NPHCDA for GAVI and possibly the PHC fund)				
Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
Availability of PHC budget and expenditure reports for LGAs /Gundumas.	Limited data available in 3 states	Annual PHC budgets available for all targeted LGAs/ Gundumas	Annual expenditure reports available for all targeted LGAs/ Gundumas	Annual PHC budget and expenditure reports available for 80% of all LGAs/Gundumas	
	Source				
	State and LGA financial statements				
Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
Number of states with their State Health Plan incorporated into their State Development Plan	Some linkage to SEEDs in 2 states	2 States	3 States	4 States	
	Source				
	State development plan document				
Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
State health plans reflect project data from 2010	Few examples of evidence based planning	Each state plan has at least 3 examples of evidence based planning	Each state plan has at least 5 examples of evidence based planning	Each state plan has at least 7 examples of evidence based planning	
	Source				
	State health plans				
Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
Number of donor PHC	1 per state	2 per state	3 per state	3 or more per	

	programmes reflected in State and LGA annual health plans				state	
		Source				
		State and LGA health plans				
	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
	SIACCs support for RI through PHC system in all states	Little	Some	More	RI fully integrated	
		Source				
		Meeting records				
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
15	Number of donor field missions and reviews done jointly	2	At least 2	At least 2	At least 2 (8 in total)	
		Source				RISK RATING
		Mission and review reports				High
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	2,514,000					
INPUTS (HR)	DFID (FTEs)					

OUTPUT 2	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Assumptions
Improved human resource policies and practices for PHC	% of targeted facilities with at least one health worker trained in LSS	5%	40%	70%	100%	Increased commitment to PHC at State and LGA level
		Source				
		Facility and staff monitoring reports, PMS, HRIS linked to DHIS				
	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 annually	904 (M=552; F=352)	Number	Number	Number	
		Source				
		Survey of Health Training Institutions 2009, Annual Reports of Health Training Institutions. <i>Baseline, milestones and target should be disaggregated by sex</i>				
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
15	% of professional staff given in-service training in MNCH in targeted PHC facilities	0%	33%	66%	100%	
		Source				RISK RATING
		MNCH services survey, In service training schedules, PMS, HRIS				High
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	2,794,000					
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	% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%	18%	40%	50%	60%	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)	
	Number of PHC facilities providing basic emergency obstetric care	1	12 BEOCs	24 BEOCs	36 BEOCs	
		Source				
		MNCH services survey, PMS				
	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
	Systems for effective supervision in each State	Designed	Teams visiting with technical and financial support from the programme	Visits planned and implemented with limited technical and financial support from the	Visits planned, financed and implemented by each state	

				programme			
		Source					
		Facility and staff monitoring reports, PMS					
	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)		
	Number of 1-year-old children immunised against measles	126,439	299,957	403,556	485,624		
		Source					
		MNCH Household Survey; NICS, PMS <i>Baseline, milestones and target should be disaggregated by sex</i>					
	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)		
	% of health facilities providing RI experiencing vaccine stock-outs of TT	38%	29%	19%	15%		
		Source					
		Stock records or PPRHAA, PMS					
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)		
25	% of PHC facilities with tracer drugs available	50%	58%	62%	66%		
		Source					RISK RATING
		Stock records or PPRHAA, PMS					High
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)		
	9,169,000						
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	Number of pieces of OR into supply & demand aspects of MNCH feed into programme	None	2	2	2 (6 in total)	Results of operational research acceptable to government RISK RATING	
		Source					
		Project reports					

IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Low
10	State plans reflect OR results	None	1 example per state	1 example per state	1 example per state (12 in total)	
Source State plans						
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	2,960,000					
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	Demonstrated level of understanding in use of information by trained HMIS officers in each state	Some	Basic	Moderate	Substantial understanding		
	Source						
	HMIS data and reports, HR performance indicators						
	State plans increasingly built on evidence from HMIS	None	Some	Moderate	Substantial		
Source							
State plans, Evidence based planning guidelines							
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)		
10	% of LGAs with HMIS MNCH data collated at State level on a monthly basis	<10%	40%	75%	85%		
Source						RISK RATING	
HMIS Reports, PMS						Medium	
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)		
	1,404,000						
INPUTS (HR)	DFID (FTEs)						

OUTPUT 6	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Assumptions
Increased demand for MNCH (including RI) services	Increased political support for MNCH (including RI) evidenced by high level public events	1 at state level; 1 at LGA level	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)	
	%of wards with a development committee and/or health partnership implementing a community action plan	4%	15%	30%	40%	
	Source					
	Community monitoring process					
	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
	% of women in targeted areas who have standing permission to take their child to a health facility	55%	65%	74%	83%	
	Source					
MNCH Household Survey					RISK RATING	
					Medium	
Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)		
% of women who know at least four of the maternal danger signs in targeted areas	1.4%	15%	30%	40%		
Source						
MNCH Household Survey;						
Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)		
% of facility health committees for intervention facilities in targeted areas actively monitoring drugs	0%	25%	50%	75%		
Source						
Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)		
% of mothers of children	10%	35%	50%	60%		

	<2 in targeted areas who know the childhood vaccination schedule	Source				
		Household survey 2007, MNCH Household Survey 2010, 2012; MNCH Rapid Household Survey 2011.				
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
20	% of never immunised children <2 reduced in targeted areas	25%	16%	13%	11%	
		Source				
		NICS 2006, 2009, 2012; MNCH Rapid Household Survey 2011. <i>Baseline, milestones and target should be disaggregated by sex</i>				
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	3,366,000					
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 systems for leveraging, accessing and utilising additional PHC funding	None	1 System implemented	2 Systems implemented	Systems functioning	All donors and partners provide common support and advocate for common strategy
		Source				
		System reports				
	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	TBD	90%	100%	100%	
		Source				
		Stock records of zonal and state stores				
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Federal government willing and have capacity to do
5	Agreed strategies to improve efficiency of RI	Some strategies developed	Strategies owned	Strategies implemented	Strategies implemented	
		Source				RISK RATING
		Federal level reports				Medium
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	

	493,000				
INPUTS (HR)	DFID (FTEs)				

Annex 12: Letter of appreciation from Zamfara SMOH

Annex 12

ZAMFARA STATE OF NIGERIA
MINISTRY OF HEALTH

OFFICE:
J. B. Yakubu Secretariat,
Gusau, Zamfara State
☎: 063-203772, 200906, 200896

Our Ref: _____
Your Ref: _____ Date: _____

15th February 2010

The Head, DFID
Northern Nigeria
Kano

Letter of Appreciation

On behalf of His Excellency, Alhaji Mahmud Aliyu Shinkafi, (Dallatun Zamfara) the Executive Governor of Zamfara State, Ministry of Health and the entire people of Zamfara State, we wish to express our profound gratitude to the United Kingdom Department for International Development and the Government of Norway for their support to the State, especially the health sector through the PRRINN-MNCH programme.

The presence of this project has not only partnered with the State to revive routine immunization and of recent MNCH services; it has also been a very positive catalyst for some needed transformations in the health sector. The State is particularly appreciative of the series of efforts aimed at building local capacity within the State to enhance sustainability of interventions being implemented.

We will like to assure you of our willingness to continue to partner with your organization, honour our commitments and provide the necessary conducive atmosphere and cooperation to ensure the success of this partnership.

Going by the visible progress recorded so far, the State is very confident that the coming years shall witness an accelerated rise in coverage of the immunization and MNCH services in the State.

Kindly accept the assurance of our highest regards

Thank you.


Alhaji Halilu Aliyu Anka
Permanent Secretary
For Honourable Commissioner

CC
Health adviser, DFID, Kano
NPM, PRRINN-MNCH
STM, PRRINN-MNCH Zamfara Office

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