Type of Review: Project Completion Review

Project Title: Partnership for Reviving Routine Immunisation in Northern Nigeria – Maternal Newborn and Child Health Initiative, PRRINN-MNCH

Date started: 27/10/2006 **Date review undertaken: 28 Oct. – 8 Nov. 2013**

Introduction and Context

What support did the UK provide?

The Partnership for Reviving Routine Immunisation in Northern Nigeria and Maternal Newborn and Child Health Initiative (PRRINN-MNCH), is a maternal, newborn and child health programme implemented in four States in Northern Nigeria (Jigawa, Yobe, Katsina and Zamfara). It is jointly funded by DFID and the Government of Norway, with UKAID as the coordinating development partner. The total funding for the programme for the period 2006-2013 is £65 million. Over this period the DFID contribution has been approximately £38 million and Norway has contributed approximately £27 million[1].

The programme is implemented by a consortium of providers led by Health Partners International (HPI) in partnership with Save the Children and GRID Consulting. The programme started in 2006 as PRRINN, a DFID-funded health systems project with a focus on State-wide routine immunisation activities in the four States (£19 million).

In September 2008, with an additional £27 million funding from Norway[1], the programme was extended to include maternal, newborn and child health and came to be implemented as a combined programme, PRRINN-MNCH. The same consortium with additional partners (Liverpool Associates in Tropical Health, Mailman School of Public Health – Columbia University and Ahmadu Bello University) was awarded the contract for the joint programme.

While the focus of the joint programme was on MNCH, there was a much broader mandate, including substantial emphasis on governance issues and the inter-linkages between these and systems issues at primary health care (PHC) level. A stronger focus on operational research (OR) was also included.

Applying a cluster approach concept (see outputs 2 and 3), the MNCH component fully covers Yobe and Zamfara States, while in Katsina the programme covers only half of the State. In Jigawa State, the programme covers only the operational research and health systems strengthening aspects of the MNCH component. The separate DFID funded programme Partnership for Transforming Health Systems (PATHS 2) leads on MNCH activities in Jigawa.

In October 2010, DFID approved contract extensions for both PRRINN and MNCH (£19 million) until December 2013 with revised key results that sought to double coverage of maternal and newborn care.

[1] The Norwegian contribution was in Kroner. Following conversion, and including interest accrued in the bank account where the money was deposited, the total sum equated to £26.97million

What were the expected results?

At **Goal/Impact** level the programme was expected to contribute to improved maternal and child health in northern Nigeria, and therefore contribute to the achievement of Nigeria's MDG 4 & 5 targets.

At **Purpose/Outcome** level the programme aimed to improve effective access to MNCH (including routine immunisation) services in four States. Impact and Outcome level indicators, baseline and targets are presented in Table 1.

Table 1 PRRINN-MNCH Impact and Outcome level indicators, baselines and targets

Indicator	Baseline	End of Project Target
Impact		
MDG4, Target 5. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	153[1]	138[2]
MDG5, Target 6. % of births attended by skilled birth attendant (SBA)	39%[3]	52%[4]
Outcome		
% of infants fully immunised by their first birthday	16%	32%
% of pregnant women with appropriate tetanus toxoid	15%	50%
% of women ages 15-49 with access to modern family planning services	n/a	4.18%
Caesarean section rates in targeted CEOC clusters	0.5%	1.25%
% of women receiving antenatal care	21%	50%
Measles incidence reduced by 80%	22,250 cases	1,112 cases
Polio incidence reduced to near zero	237 cases	0 cases

1: Extrapolated from Nigeria Demographic Health Survey 2008 U5 Mortality of 157
2: Target is based on national 2/3 reduction of 1990 U5 mortality rate
3: Nigerian Demographic and Health Survey, 2008
4: Target based on trends seen from 1990 to 2008 and projection of estimated impact of donor programmes.

What was the context in which UK support was provided?

Nigeria is the most populous country in Africa, with an estimated 170 million people. It has a quarter of the continent´s extreme poor. More than 100 million Nigerian live on less than £1 a day. Nigeria now has 10% of the world´s children out of school.

Northern Nigeria
The Northern States of Nigeria, are among the poorest in the country. They also have the

highest infant and child mortality rates, the highest fertility rate and the highest adolescent birth rate[2]. Northern Nigerians also experience lower life expectancy, and higher rates of vaccine preventable diseases such as polio, measles and meningitis.

Working in the north poses considerable challenges, both as a result of the State of the existing health systems as well as from the significant civil disturbances, particularly since 2010.

At the start of this programme the health facilities in the States were poorly staffed and equipped, they were lacking essential medicines and supplies and were poorly patronised by the population. Access to health facilities for the population is hampered not only by the lack of trust in the health system, but often health facilities are not accessible due to long distance or bad roads. Socio-cultural factors also prevent citizens from accessing health services; however, poverty is the greatest barrier that prevents access to health care for women and children.

Health Systems

The health system in Nigeria is very fragmented. At State level there are a number of institutions (Ministries, Departments, Agencies) dealing with health issues, including the delivery of primary health care services. There is little coordination or communication between these agencies. The health service is characterised by poor planning, budgeting, financing, financial controls and weak governance. Lack of adequate staff, lacking both in skills and in numbers, particularly in rural and remote areas, is an important constraint to the provision of health services.

Maternal health

Nigeria has the highest number of maternal and newborn deaths in all of sub-Saharan Africa. It is estimated that 33,000 women die every year in Nigeria from pregnancy complications. The maternal mortality rate in Nigeria is 545 per 100,000 live births[3]. This rate is higher than the sub-Saharan average and the 19th highest global rate. Over the past ten years maternal deaths have decreased by 24% and child deaths have dropped by 22%, but this is not enough to achieve Nigeria's Millennium Development Goals 4 and 5.

Newborn and child health

Nigeria's under-five mortality rate is 170 per 1,000 live births. With 946,000 children dying every year, Nigeria has the highest number of newborn and child deaths in sub-Saharan Africa. About six million babies are born in Nigeria every year; nearly one million of them will die before the age of five.

Nationally, 28% of all under-five deaths occur during the neonatal period. In many cases these are due to young, under-nourished mothers, giving birth to small babies without skilled attendance. Exclusive breastfeeding is not a common practice. Only about one in ten (13%) of infants below six months of age are exclusively breastfed.

Future DFID health programming in Northern Nigeria

At the time of conducting this review, DFID and HPI were negotiating an extension of PRRINN-MNCH to July 2014. DFID is also procuring, through competitive tender, a new health programme (MNCH2) with a similar focus on health system strengthening, RI and MNCH, that will be implemented across six States in Northern Nigeria (Jigawa, Katsina, Yobe, Zamfara, Kaduna and Kano). The anticipated start date for the MNCH2 programme is May 2014. This

[2] 2011 Multiple Indicator Cluster Survey
[3] 2008 Nigerian Demographic and Health Survey

project completion report is written cognizant of the proposed extension to PRRINN-MNCH and the new MNCH2 programme, and draws out lessons learned and issues to be considered during the transition between the two programmes.

Section A: Detailed Output Scoring

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

<u>Output 1 final score and performance description</u>: A - Output met expectation

<u>Progress against final results</u>

The PRRINN-MNCH programme took a health systems strengthening approach as the key approach to improving primary health care (PHC) delivery systems and subsequently the provision of MNCH/RI services. Under this output, PRRINN-MNCH supported the States to strengthen the health policy and strategy framework within which the health system functions. The programme built State capacity for formulation, monitoring and implementation of State health plans, and to improve public finance management, partner coordination, advocacy and institutional change.

A key institutional change fostered by the programme was implementation of the **Primary Health Care Under One Roof (PHCUOR) policy** which aims to integrate management of PHC at State level and to end fragmentation in the health sector. The programme supported the establishment of State Primary Health Care Boards/Gunduma Health Systems Boards (SPHCBs), the new authority responsible for all PHC services in the State. The creation of these Boards requires a redefinition of the roles and responsibilities of various government institutions working on health, among others the State Ministries of Health (SMOHs) and Local Government Authorities (LGAs).

The key elements of PHCUOR are:

- Integration of all PHC services under one authority with control over services and resources (human and financial)
- Principle of 'three ones' (one management body, one plan and one monitoring and evaluation system)
- Enabling legislative framework
- Decentralized authority, responsibility and accountability with appropriate span of control
- Integrated supportive supervisory system managed from a single source
- Effective referral system between/across the different levels of care.

The programme also provided technical support to the National Primary Heath Care Development Agency (NPHCDA), facilitating the exchange of information and evidence in relation to PHCUOR from State to Federal level and vice versa (see also Output 7 below).

Additionally, the programme supported the establishment of a **'basket fund' for RI and PHC** in Zamfara and Yobe States to address the challenges of poor disbursement and utilization of PHC funds and of poor coordination between the different funding sources. State and LGA contributions to PHC are pooled through the basket fund. Additionally, GAVI funds are also pooled through the basket fund in Zamfara State. The basket fund has increased transparency in the disbursement and utilization of funds for PHC**.** Activities supported through the basket fund include routine immunisation, supplemental immunisation, maternal health, supervision, routine data collection, community mobilisation and allowances for the midwives service

scheme.

Of the eight indicators for this output, six have been achieved and two have been partially achieved, Additionally, PRINN-MNCH supported the nation-wide roll-out of the PHCUOR policy which, although not measured by logframe targets, is a significant contribution to end fragmentation in the health sector. Therefore this output is scored as A, output met expectation.

Progress against logframe indicators

Indicator 1.1. State government staff led annual review and health planning process in all States.

Annual reviews and health planning processes have been carried out for the last three years in all States. These processes are fully led by government staff and with no support from the programme in Jigawa and Katsina. Limited support is provided to Yobe and Zamfara States. Reports from the health information systems on performance of key indicators are presented and discussed as part of these processes, facilitating the monitoring of plan implementation and providing evidence for decision making (see also Output 5 below).

Indicator 1.2 All States successfully access new federally managed health funds.

All States have accessed GAVI and MDG funds for 3 years. Some States have also accessed national health insurance scheme (NHIS) and Health Sector Development Plan (HSDP) funds. The programme has built capacity (through training and supervision) of government staff in financial management / accounting and in the establishment of transparent mechanism to manage these funds.

Indicator 1.3 Availability of PHC budget and expenditure reports for LGAs/Gundumas.

All States conducted budget performance /expenditure reviews in 2012. Furthermore, the approved budget reports for 2013 are available. The States are using data effectively to inform their budgets and plans. There is easier access to financial data for analysis and use at both LGA and State levels.

Budget allocations to the SMOH as percentage of total State budget have gradually increased in Yobe and Jigawa States. For example, the budget allocation to SMOH in Jigawa increased from 8.4% of the total State budget in 2008 to 16% in 2013. However, a barrier to ensuring effective implementation of health plans is the unpredictable disbursement of State funds to the SMOH, even if budget has been approved. For example in the period 2008-2013 Zamfara State only disbursed 45% of budgeted allocations to SMOH.

Indicator 1.4 Number of States with their State Health Plan incorporated into their State Development Plan.

All States have incorporated their State Health Plan into the State Development Plan and have adopted the national Strategic Health Development Planning M&E framework to track State health plan implementation. The State Health Plans are costed which facilitates both government and development partners to commit resources to planned and costed improvements within the health sector with an understanding of the full budgetary implications of doing this.

Indicator 1.5 State health plans reflect project data from 2010.

All State health plans now reflect project data. Among others, all States have examples from operational research, integrated supported supervision, data quality audits and peer participatory rapid health appraisal.

Indicator 1.6 Number of donor PHC programmes reflected in State and LGA annual health plans.

Jigawa and Katsina States have at least 4 donor PHC programmes reflected in State and LGA annual health plans. Yobe and Zamfara have not reported yet on this indicator in 2013, but in 2012 they had 3 (Yobe) and 4 (Zamfara) donor PHC programmes reflected in their State annual health plans. Other donor programmes include UNICEF and WHO programmes and DFID funded programmes including, SunMaP (Support to the National Malaria Programme), PATHS2 (Partnership for Transforming Health Systems in Nigeria), and WINNN (Working to Improve Nutrition in Northern Nigeria).

Indicator 1.7 The State Interagency Coordinating Committee (SIACC or State equivalent) is providing significant support to RI through PHC systems in all States.

Through the SIACCs government and partners coordinate support to RI at State level. In 2013, SIACCs have played a key role in coordinating the release of funds for the purchase of emergency drugs to address this year´s measles outbreak and there is improved State governance and advocacy for RI.

Indicator 1.8 Number of donor field missions and reviews done jointly.

Under the programme period PRRINN-MNCH has participated in seven joint donor field missions or reviews, for example in 2013 the Programme participated in the review of the SunMap programme. This is slightly below target the target of 10 joint reviews.

Table 2: Summary of progress against Output 1 indicators

	Indicator	End of Programme targets	Achievement
1.1	State government staff led annual review and health planning process in all States	Process led by State teams – no support from programme	Fully achieved in Katsina and Jigawa. Partially achieved in Yobe and Zamfara.
1.2	All States successfully access new federally managed health funds	Federally managed funds accessed for 4 years in all States	Achieved
1.3	Availability of PHC budget and expenditure reports for LGAs/Gundumas.	Annual expenditure reports available for 90% of targeted LGAs/Gundumas	Achieved
1.4	Number of States with their State Health Plan incorporated into their State Development Plan	4 States	Achieved
1.5	State health plans reflect project data from 2010	Each State plan has at least 9 examples of evidence based planning	Achieved
1.6	Number of donor PHC programmes reflected in State and LGA annual health plans	4 or more	Achieved in Jigawa and Katsina. Yobe and Zamfara not

			yet reported.
1.7	SIACCs' support for RI through PHC system in all States	RI fully integrated	Achieved
1.8	Number of donor field missions and reviews done jointly	At least 2 per annum (10 in total)	7 – partially achieved

Lessons learned and recommendations for future DFID programming

a) PHCUOR

Substantial progress has been made on the establishment of SPHCBs and implementation of PHCUOR. However, there remains a need for further consolidation to ensure full institutionalisation of these processes in all programme States.

During the PRINN-MNCH extension period priority should be given to:

i) Strengthening of SPHCBs in Yobe, Zamfara and Katsina through training and technical assistance for integrated supportive supervision

ii) Technical support to the NPHCDA in relation roll out of the PHCUOR strategy

iii) Review and documentation of PHCUOR policies and processes at State and National level, to ensure that lessons learned to date are documented and inform future government policy

b) Health Financing

Ensuring adequate level of financing for health and addressing the financial barriers to access and utilisation of health services by the population is one of the main challenges that is still faced by the health system in Nigeria. Funding for health care remains fragmented with inefficiencies in the allocation and utilization of resources. Sources of government funding for health include non-ring fenced allocations to health through Federal, State and LGA budgets and special 'schemes' that carry a specific purpose such as allocations for 'free MNCH', SURE-P funding, funding for the Midwife Services Scheme, NHIS funding among others.

Despite the availability of funding from different sources, general government expenditure on health is low and a large proportion of the expenditure on health is born by the citizens. According to the WHO Global Health Data Repository, in 2011, the general government expenditure on health as a percentage of the total government expenditure was 7.51%, which is below the 15% suggested by the Abuja declaration. Private expenditure on health as a percentage of total expenditure of health is 63% (of which 95% is out-of-pocket expenditures). Additionally, at State level, budget allocations to health are not disbursed as planned, making budget planning efforts redundant and hindering health service provision.

PRRINN-MNCH attempted to improve efficiency in the allocation, and utilization, of funds at PHC level through the PHCUOR policy and establishment of the 'basket fund' in Yobe and Zamfara State. The programme also built State capacity for health service planning and financial management at State and LGA levels.

However, given that out-of-pocket expenditure on health remains high, there is a need to ensure adequate resources for health in the long-term and to further rationalize and streamline the various sources of health funding. Future DFID programming should give greater attention to these areas, building on the foundation laid by PRRINN-MNCH through the PHCUOR and

basket funding mechanisms.

During the PRINN-MNCH extension period priority should be given to:

i) Continuing technical support for State and LGA operational health planning and budgeting
ii) Advocacy and support for free MNCH care, including the allocation and release of sufficient funds
iii) Ensuring the availability of essential drugs within PHC facilities

Impact Weighting (%): 15%
Revised since last Annual Review? *N*

Risk: High
Revised since last Annual Review? *N*

Output 2: Improved human resource policies and practices for PHC

Output 2 final score and performance description: A - Output met expectation

Progress against final results

The availability of human resources in adequate quantities and with adequate skills is one of the major constraints to ensure quality and effective health service delivery. This is as much dependent on production factors, information systems, distribution, staff mix, recruitment and retention as it is on the political factors influencing human resources. Strengthening HR management has been a major thrust of the PRRINN-MNCH programme as this is one of the key bottlenecks to improving the PHC services in Northern Nigeria.

A particular success of the programme was the establishment of a Human Resource Information System (HRIS) in each State. The system is operational at State level in all 4 States and at LGA level in 74 LGAs. The HRIS has integrated a specific component to address the information needs of training institutions. Government staff have been trained on the management and operation of the system. The HRIS has proven to be a powerful tool to improve HR policies and plans. For example information provided by this system led Jigawa State to establish a School of Midwifery and the on-going recruitment exercise for skilled birth attendants (SBAs) and other health workers is guided by the information provided by the HRIS. In all States an HR coordinating committee meets quarterly to analyse the HR situation based on reports provided by the HRIS.

During the course of the programme, a specific need to increase the numbers and distribution of female health workers in northern Nigeria was identified. In response to evidence generated by PRRINN-MNCH, DFID has established a new 'Women for Health' (W4H) programme across five States in Northern Nigeria with a focus on supporting pre-service training and the deployment of women from rural communities. Initiated in 2012, W4H is implemented by the same consortium as PRINN-MNCH. Since inception the two programmes have collaborated well at State level with W4H taking a greater role to support training institutions and student recruitment and support, while PRINN-MNCH has maintained its focus on wider HR policy and planning.

Additionally, PRRINN-MNCH supported the Federal level to design a Midwifery Service

Scheme which has facilitated the posting of additional midwives in rural areas throughout the country.

Of the four indicators for this output, one (HR policy and plan implementation) was partially achieved and three were fully achieved. Additionally, PRINN-MNCH established and supported States to implement the HRIS which, although not measured by logframe targets, has made a significant contribution to improved HR policy and practices across the programme States. Therefore this output has been scored A, output met expectation.

Progress against logframe indicators:

Indicator 2.1 Percentage of targeted facilities with at least one health worker trained in Life Saving Skills (LSS)

For the provision of MNCH services, the programme focussed its activities on 6 clusters in each State (18 clusters in total). Each cluster has a catchment population of 500,000 and a network of health facilities comprised of one comprehensive emergency obstetric care centre, four basic emergency obstetric care centres, eight primary health care facilities and 50 communities in which community engagement activities were implemented. This corresponds to a total of 234 facilities across the 3 States. All facilities have at least one health worker trained in LSS. A challenge has been the retention of trained workers within target facilities, in part due to the government redeploying workers to other facilities. The programme has responded by increasing the planned amount of in-service training to ensure a steady supply of skilled health workers within the target facilities (see Indicator 2.4 below).

Indicator 2.2 Status of HR policies and plans developed, operationalised and implemented in each State.

All States have draft HR policies and plans, but these have not yet been formally approved, except in Jigawa. An issue identified during the project review is that many health workers do not secure employment after graduation and many leave to work in other States, despite there being a shortage of health workers to serve population needs in programme States. PRINN-MNCH has not adequately addressed these issues with States and hence although HR policies and plans have been developed, further work remains to rationalize HR strategies and implement State level HR policies and plans.

Indicator 2.3 Number of health professionals trained annually.

No target was defined for this indicator. PRINN-MNCH supported the accreditation of schools of nursing/midwifery and health technology, supported the institutions to revise/update training curricula and provided support and training to build the capacities of instructors/mentors. A total of 4,022 professionals were trained at training schools over the programme period (doctors, nurses, midwives and community health extension workers [CHEWs]). As indicated above, further support for training institutions is being provided through the W4H programme which was initiated in response to a need identified through PRINN-MNCH.

Indicator 2.4 Percentage of professional staff given in–service training in MNCH in targeted PHC facilities.

During the course of the programme, PRRINN-MNCH provided in service training to the equivalent of 95% of professional staff in the targeted PHC facilities. The training included primarily nurses, midwives and CHEWs. A training of trainers' methodology was used in order to leave behind the capacity to carry out training activities beyond the programme period as well as a means to reach the training targets. Among others, topics addressed in the training

included: lifesaving skills, focussed antenatal care, postnatal care, family planning, integrated management of childhood illness (IMCI), routine immunisation, kangaroo mother care and quality improvement methodology. The programme conducted post training follow up to assess the application of skills learned, staff satisfaction, retention and impact on health outcomes. This demonstrated improved health worker performance in the short term, although the quality and effectiveness of training in the long term was not systematically evaluated.

As indicated above, although a large number of health workers were trained, PRINN-MNCH was less successful in supporting States to rationalize the supply and distribution of health workers to ensure that those trained were deployed most effectively. None-the-less it is anticipated that through the W4H programme and the support provided to pre-service training institutions, a pipeline of skilled health workers will be created and the need for in-service training will decrease in the long term.

Table 3: Summary of progress against Output 2 indicators

	Indicator	**End of Programme target**	**Achievement**
2.1	% of targeted facilities with at least one health worker trained in LSS	100%	100%
2.2	Status of HR policies and plans developed, operationalised and implemented in each State	Implementation Sustained	Partially achieved
2.3	Number of health professionals trained annually	N/A (Baseline 904) no target defined	4,022 over programme period
2.4	% of professional staff given in–service training in MNCH in targeted PHC facilities	At least 85%	95%

Lessons learned and recommendations for future DFID programming

a) Human resource planning and distribution

Ensuring the availability and distribution of health care workers at the right numbers and in the right places remains a significant challenge. PRRINN-MNCH has done much to strengthen HR planning and management within programme States, but much work remains to be done.

Future DFID health programming should maintain a focus on HR for health, addressing issues such as the analysis of existing workforce productivity and distribution, elaboration of short and medium term strategies to fill human resources gaps, task shifting where appropriate (eg for CHEWS), and the implementation of policies to attract/retain staff to work in the Northern States and in rural areas.

The project review team observed that there was some overlap in the remit of W4H and PRRINN-MNCH in relation to HR for health. This is not unexpected given that W4H is a relatively new programme that arose in response to a need identified by PRRINN-MNCH, and both programmes appear to be working well together with minimal duplication in effort. However, going forward, DFID should ensure that the mandate of W4H and the new MNCH2 programmes are clearly established to avoid duplication of effort, and should ensure the close collaboration between the two programmes continues.

During the PRINN-MNCH extension period activities under this work-stream should be scaled back and any interventions co-ordinated with the W4H project. The focus of activities should be to support the implementation of HR policies and plans at State and LGA levels to strengthen capacity for integrated supportive supervision, and to support roll out of the Human

Resources Information System (HRIS) with continuing transition to government during the extension period.

Impact Weighting (%): 15%
Revised since last Annual Review? No

Risk: *High*
Revised since last Annual Review? *No*

Output 3: Improved delivery for routine immunisation and maternal, neonatal and child health services via the primary health care system

Output 3 final score and performance description: B – output moderately did not meet expectation

Progress made against final results

Output 3 has fostered the provision of quality and effective MNCH and RI services and strengthening the systems supporting service delivery (availability of drugs, transport, supervision, infrastructure and equipment). Furthermore, the programme provided in-service training of staff on the delivery of key MNCH/RI services and advocated for posting of additional female staff (particularly midwives) to rural areas.

For the provision of MNCH services the programme focussed its activities on 18 clusters, as described under Output 2 above. The rehabilitation and the provision of equipment to the targeted health facilities contributed to improved conditions for quality services. Drugs are now available through the sustainable drug supply system (SDSS) which provided seed money (provided in drugs) to establish a revolving fund for drugs for the health facilities and for making good quality drugs accessible and affordable for the population. Furthermore the programme implemented measures to ensure quality of services by, among others, introducing standards and guidelines, quality improvement teams and regular supervision (both technical and managerial).

The programme also supported the three States to develop a Minimum Service Package (MSS) that sets out the minimum services to be provided within each State for the various levels of health facility. This process was undertaken to match the cost of the State MSP with the likely availability of funds. In addition, as more funds become available, the model allows for expanding the range of services included within the MSP.

However, although significant improvements have been made, the programme has not achieved consistency in high quality service provision across all facilities. Out of seven indicators for this output three were achieved, and an additional two (number of PHC facilities providing basic emergency obstetric care and family planning) were achieved numerically, but with some concern about the quality of the service underpinning the target. Two indicators were not achieved, specifically stock out of tetanus toxoid (TT) and facility performance assessment scores. Although the programme has made solid progress, it has not fully met expectations with regards to the quality of EmONC, FP and RI service provision hence this output has been scored B, output moderately did not meet expectation.

Progress against logframe indicators

Indicator 3.1 Percentage of LGAs reaching performance ranking tool (PPRHAA) scores over 75%.

The Peer and Participatory Rapid Health Appraisal for Action (PPRHAA) is a simple and rapid tool to generate a participatory and local assessment of facility performance. The tool assesses 6 thematic areas namely: Health Service Delivery, Leadership and Governance, Health Financing, Equipment and Infrastructure, Human Resources for Health, Clients and Community Accountability and Health Management Information System. PPRHAA involves the managers and staff of the LGAs and health facilities and communities. The programme target was that 70% of LGAs would reach PPRHAA scores above 75%. PPRHAA exercises are carried out once a year, usually in the last quarter of the year. The reports for the year 2013 are not yet available. However in the period 2009-2012 the percentage of facilities reporting scores over 75% was persistently less than 30%. Hence this target has not been achieved.

Indicator 3.2 Number of PHC facilities providing Basic Emergency Obstetric Care (BEmOC).

The number of facilities classified by PRINN-MNCH as BEmOC facilities at the time of the project completion review was 78, substantially greater than the programme target. However, the review team observed that some facilities were not, at the time of the review team visit, able to provide all BEmoC signal functions (for example assisted vaginal delivery, removal of retained products).

Indicator 3.3 Number of PHC facilities providing Family Planning (FP) Services.

The number of primary health care facilities providing FP services by the end of the project period was 265, substantially above the programme target. This was because non-cluster health facilities, receiving family planning commodities from Federal Ministry of Health, were included in the training of service providers. The programme approach to increase access to family planning services included: securing availability of staff at health facilities with adequate skills to provide family planning services; ensuring availability of family planning commodities at the health facilities; and raising awareness among women through the community engagement activities. However the choice of contraceptive methods provided is limited. No PHCs visited by the review team were able to provide IUDs or contraceptive implants for example. Although the utilisation of FP services is increasing gradually, coverage is still low (see Section 1.4 Outcomes, below).

Indicator 3.4 Systems for effective supervision in each State.

Systems for effective supervision have been established in all States. Health facility Integrated Supportive Supervision (ISS), which primarily addresses managerial issues, is now carried out by State and LGA level teams. The States and LGAs have allocated funds to carry out ISS. Additionally, technical supervision teams are also visiting the health facilities looking at technical aspects of service delivery. There is increased awareness among the stakeholders on the need for supervision and a better understanding of its contribution to ensuring quality in service provision. Although a solid foundation has been laid, the supervision system must take into account the need for more visits to a larger number of primary health care facilities than in the current clusters, so although effective supervision has been established, it is not yet operational on a scale sufficient to reach ***all*** facilities in each State.

Indicator 3.5 Number of 1-year-old children immunised against measles.

More than 2.5 million one-year-old children have been immunised against measles over the programme period, exceeding the programme target. Measles immunisation coverage increased from 20% to 40% but still remains too low to prevent outbreaks (see Section 1.4 Outcomes, below).

Indicator 3.6 Percentage of health facilities providing RI experiencing vaccine stock-outs of TT.

The percentage of health facilities experiencing stock out of tetanus toxoid remained higher than target in all programme States, in large part due to stock out of vaccines at national and State level. The programme has supported the States to establish control mechanisms that allow the identification of stock-outs of vaccines and related supplies and has built capacity for minor maintenance and repair of cold chain equipment. The programme has also engaged at Federal level to improve the availability of vaccines (see Section 3.1 below). However despite these efforts stock outs persist at an unacceptably high level.

Indicator 3.7 Percentage of PHC facilities with tracer drugs available.

An SDSS was established in the programme States through the capitalization of a central medical store and establishment of a revolving drug fund in PHC facilities within each cluster. As a result PHC facilities have a reliable drug supply and 74% reported no stock outs of tracer drugs in the last reporting period, an achievement above the programme target.

Table 4: Progress against Output 3 indicators

	Indicator	End of Programme Target	Achievement (% of target)
3.1	% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%	70%	Progress reported 2009-2012: 21%, 29%, 28%, 8%. Target not achieved
3.2	Number of PHC facilities providing Basic Emergency Obstetric Care	58	78 (135%)
3.3	Number of PHC facilities providing Family Planning Services	72	265[1] (368%)
3.4	Systems for effective supervision in each State	Visits planned, financed and implemented by the States	Achieved
3.5	Number of 1-year-old children immunised against measles per year	1,927,067 (cumulative target)	2,561,308 (133%)
3.6	% of health facilities providing RI experiencing vaccine stock-outs of TT	10%	30%
3.7	% of PHC facilities with tracer drugs available	70%	75%

[1] Non-cluster health facilities, receiving family planning commodities from Federal Ministry of Health, were also included in the training of service providers

Lessons learned and recommendations for future DFID programming

a) Ensuring quality provision of BEmOC services

As described above, the review team observed that some facilities classified by the programme as BEmOC facilities were not providing all BEmOC signal functions. The provision of BEmOC services might be the hardest level to maintain within the cluster system, and ensuring the sustainable functioning of these facilities as BEmOC centres in the long term should be a focus of future programming.

b) The cluster model

The cluster approach is a valuable model for the development and organisation of emergency obstetric care in an environment with limited resources. However, programme targets in relation to routine immunization were not achieved (see also Section 1.4 Outcomes, below) indicating that the cluster model might not be suitable for comprehensive primary health care service provision, including the provision of RI services, and may need to be further adapted to the particular circumstances in each State, taking into consideration, among others, issues related to population density, geographic access and the vulnerability of communities. Future programme design should review the cluster approach concept.

c) Paradigm shift and rationalisation of facility numbers and distribution

In Northern Nigeria people have the expectation that politicians will build health facilities in almost every community. Responding to this demand is a quick win for politicians since erecting a building is relatively easy. However the more challenging issue of ensuring adequate staffing, equipment and supplies is less commonly considered. As a result many facilities end up functioning poorly or non-functional due to lack of staff, equipment and drugs. Communities generally lay the blame for non-functioning facilities upon health workers, believing that health professionals are unwilling to work at the facility, rather than appreciating that there are wider system issues that limit the number and availability of health workers, as well as issues related to drug procurement and supply chain management at higher levels. More work needs to be done to change this paradigm, both in the population as well as among politicians. Future programming should introduce a stronger rights based approach as part of the work with policy makers/opinion makers as well as in the work with communities. Community empowerment should ensure that communities demand their right to a *functioning health system* with an understanding that this may *not* require a facility within every community. Instead, community expectation and demand should be for an appropriate number and mix of facilities that are accessible, affordable and provide a quality service to meet community healthcare needs. At the same time future programming should support States to rationalize the number, type and distribution of facilities across each State, building upon the work laid by PRRINN-MNCH through the MSP.

During the PRRINN-MNCH extension period emphasis should be given to improving the quality and efficiency of MNCH and RI service delivery, and deepening the reach of services to increase coverage within cluster communities (see also Output 6, below). Particular focus should be given to increase facility deliveries and family planning uptake, where attainment of targets has been particularly challenging. Innovative approaches to vaccine service provision such as outreach, service integration and increasing results in secondary care facilities to minimize 'missed opportunities', should be employed.

PRRINN-MNCH should support each State to rationalize the number, type and distribution of health facilities across each State. This work should build upon lessons learned from the

cluster approach, the minimum service package and forecasts of the availability of health workers of all cadres.

Technical support should continue to be provided at facility, State and national levels to institutionalise quality improvement activities including perinatal audit and maternal death reviews, with continuing transition to government during the extension period.

The programme should continue to support implementation of the National Routine Immunisation Strategic Plan (NRISP) and Accountability Framework at State level and at national level the project should continue to provide technical assistance for national rollout of the Plan and Framework (see also Output 7 below).

Impact Weighting (%): 25%
Revised since last Annual Review? *No*

Risk: *High*
Revised since last Annual Review? *No*

Output 4: Operational research providing evidence for primary health care stewardship, routine immunisation and MNCH policy, planning, service delivery, and effective demand creation

Output 4 final score and performance description: A+ Output moderately exceeded expectation

Progress made against final results

This Output cuts across all others. The programme has concentrated on strengthening State operational research (OR) capacity and in the use and dissemination of the research results. Learning Local Government Areas (LLGA) and Operational Research Advisory Committees (ORACs) were established in each State. The members of the ORACs were trained in research, data management, reporting, and publishing. Among others, the ORACs have participated in the identification of research questions to be the subject of OR as well as in the design and conduct of OR activities supported by PRRINN-MNCH. Their respective Ethics Committees are now screening health research protocols. The stakeholders consulted confirmed that there is now a growing understanding of the importance and usefulness of research in their respective States. Provisions have been made to secure the continued operation of the ORACs after the finalisation of the programme.

More than 14 OR studies have been conducted over the programme period, including among others, studies on emergency transport system, performance based financing /conditional cash transfer, and community based service delivery. Studies have been disseminated locally to inform health sector policy and planning within the programme States, and have been disseminated nationally. For example PRRINN-MNCH completed pre-post intervention studies to test Performance Based Financing/Conditional Cash Transfer (PBF/CCT) approaches in each State which provided important insights into determinants of success with respect to mechanisms and systems requirements for PBF. The FMOH in collaboration with PRRINN-MNCH, National Planning Commission and the Nigerian Academy of Science convened a policy round table around PBF/CCT through which participants agreed that PBF could be an appropriate means to increase access and utilisation of health services. As a result of the round-table a Nigerian Community of Practice on PBF is being established that will link-up with the pan-African Community of Practice.

Additionally, OR arising from the programme has been disseminated internationally. The

programme's Knowledge Management Strategy included publication of results in peer reviewed journals (over 14 publications to date) and presentation of research results and programme achievements nationally and internationally. The programme´s web site http://www.prrinn-mnch.org/ represents a one-stop place to access, amongst others, annual reports, implementation tools, technical briefs, summaries of the research carried out and links to peer reviewed articles.

A strength of the research programme is that it has been responsive to ideas generated by programme staff and ORACs, and used to test innovative approaches to service delivery which then informed programme design (see description of indicators 4.1 and 4.2 below for examples of how research results have been integrated into programme activities). However, the research agenda could have benefitted from a greater strategic overview to ensure a managed and cumulative programme of research that maximized learning from the programme.

A further success of the programme is the establishment of the Nahuche Health and Demographic Surveillance System (HDSS) site/centre that meets international data quality standards. The establishment of HDSS has been a collaborative effort between PRRINN-MNCH, the Zamfara State Ministry of Health and Usman Dan Fodiyo University, Sokoto. The centre was established to carry out longitudinal studies to monitor health and demographic events and populations at risk over time. The centre is now a member of the INDEPTH Network and has established relations with similar centres in the region. Provisions are being made by the Zamfara State Ministry of Health and Usman Dan Fodiyo University Sokoto to secure the operation of the centre after PRRINN-MNCH comes to an end.

There were two indicators for this output both of which were achieved. Additionally, the programme demonstrated significant accomplishments, beyond the programme targets, such as the establishment of HDSS and the establishment and strengthening of ORACs in each State. For these reasons, this output has been scored A+, output moderately exceeded expectations.

Progress against logframe indicators

Indicator 4.1 Number of OR outputs into supply & demand aspects of MNCH feed into programme.

Throughout the programme, OR outputs have informed programme design across all States. For example a study undertaken in 2009-10 found a clustering of child deaths among a small proportion of households where women and children had the least social support. In response to the study, the programme trained community health volunteers to actively identify women with low social support and to target them for participation in programme activities such as the community education/discussion groups and the **Young Women's Support Groups** (see Output 6 below). A second example is the establishment of the **emergency transport scheme** whereby passenger transport vehicles, driven by professional drivers who are all members of the National Union of Road Transport Workers (NURTWs) provide transport for pregnant women to reach BEmOC and CEmOC facilities. The driver receives payment for fuel costs only, sometimes reimbursed from emergency maternal health care savings schemes that have been established in some communities. In return, there is an agreement with the NURTWs that the emergency transport workers can join the front of the queue of drivers waiting for work in NURTW authorized motor parks. The success of this approach to reduce delays in accessing emergency obstetric care was demonstrated through a pilot study, and the approach was then rolled out across all States. Another example is **community based service delivery** whereby community health extension workers travel to remote areas to provide basic promotive and curative health interventions at community level. The success of

this approach was demonstrated by OR within one cluster and subsequently scaled up.

Indicator 4.2 State plans reflect OR results

All State plans reflect OR results. Example include:

- In Jigawa, Community Based Service Delivery is included in the State plans and has expanded, motor cycles were procured by the State for CHEWS
- In Katsina, a review of mobile PHC services led to better procurement plans and biannual monitoring and supervision of ambulance schemes.
- In Yobe, outreach services were adopted as a State strategy to extend services to underserved rural communities in response to research arising from the programme.
- In Zamfara PRRINN-MNCH has promoted Women Investing and Saving for Health groups as a community support system to increase MNCH service utilisation and this has been incorporated into the State plan.

Table 5: Progress against Output 4 indicators

	Indicator	End of Programme Targets	Achievement
4.1	Number of OR outputs into supply & demand aspects of MNCH feed into programme	8	Achieved
4.2	State plans reflect OR results	1 example per State per year (16 in total)	Achieved

Lessons learned and recommendations for future DFID programming

PRRINN-MNCH demonstrated that an active programme of operational research can generate context specific evidence to inform implementation and policy making. A particular strength of the programme was its responsiveness to locally identified research needs. However, while maintaining a responsive approach to OR, future programming should ensure a stronger strategic overview of the research agenda, to establish a managed and cumulative programme of research, particularly in areas where the programme provides a unique opportunity to contribute to the global evidence base (for example issues related to human resources or health financing).

During the extension period, PRRINN-MNCH should focus OR on improved understanding of demand side interventions, particularly to improve understanding of the impact and reach of community based interventions (see Output 6, below). All ongoing studies should be completed during the extension period.

Impact Weighting (%): *10%*
Revised since last Annual Review? *No*

Risk: *Low*
Revised since last Annual Review? *No*

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

<u>Output 5 final score and performance description:</u> A+ Output moderately exceeded expectation

<u>Progress made against final results</u>

This output focussed on the establishment and implementation of a Health Management Information System (HMIS) at State level. At the start of the programme health information was not routinely collected and analysed to inform policy and planning within the health sector in the programme States. PRINN-MNCH has significantly improved health information systems and embedded this within the health sector. A web based district health information system known as DHIS2 has been adopted as the platform for the health information system. The programme has trained HMIS officers at all levels (facility, LGA and State) to use DHIS2 and a system for data quality assurance has been established, led by the States. The majority of facilities report HMIS data which is collated at LGA level and then passed onto the State. Each

State produces quarterly health reports and conducts quarterly performance review meetings that are informed by HMIS data.

The programme has piloted innovative approaches to collect HMIS data, including the use of mobile phone technology for data transmission. Additionally, following the successful implementation of HMIS within the programme States, the NPHCDA has adopted DHIS2 as the national health information system and is currently rolling out DHIS2 nationwide.

None-the-less, although the programme has demonstrated success in the establishment of HMIS and its use at State level, the analysis and use of information at LGA and facility level, and feedback from the State to LGA and facility levels is relatively weak.

All three indicators for this output were achieved. Additionally, the use of innovation to achieve results and the adoption of the system at national level are significant achievements of the programme. For these reasons this output has been scored A+, output moderately exceeded expectation.

Progress against logframe indicators

Indicator 5.1 Demonstrated level of understanding in use of information by trained HMIS officers in each State.

HMIS Officers in all the programme States and the LGAs are proficient in the use DHIS2. At State level, the HMIS officers are able to analyse data, and use it for feedback, advocacy, and dissemination to inform policy makers.

Indicator 5.2 State plans increasingly built on evidence from HMIS.

All State plans are built on evidence from HMIS. The quarterly performance reviews and annual health planning processes are informed by HMIS data.

Indicator 5.3 Percentage of LGAs with HMIS MNCH data collated at State level on a monthly basis.

In the last reporting period 95% of LGAs /Gundumas reported HMIS data to the State, an achievement greater than the project target of 85%.

Table 8 Progress against Output 5 indicators

	Indicator	End of Programme Targets	Achievement
5.1	Demonstrated level of understanding in use of information by trained HMIS officers in each State	Proficient	Achieved
5.2	State plans increasingly built on evidence from HMIS	Substantial	Achieved
5.3	% of LGAs with HMIS MNCH data collated at State level on a monthly basis	85%	95%

Lessons learned and recommendations for future DFID programming

PRRINN-MNCH has demonstrated that a functioning HMIS system can be established, even

in the context of a fragmented health system. Indeed the establishment of a functioning HMIS was one of the strategies employed by the programme to address the challenges of poor governance and coordination in the health sector. While a solid foundation has been laid, future programming should ensure that data flows down the system as well as up, and should empower lower levels to analyse and act on their own data.

In addition more data should be presented in decision rationalizing ways, for example using maps to show facilities and catchment areas, staffing patterns etc.

During the extension period, PRRINN-MNCH should continue to provide technical assistance at facility, LGA, State and national levels to support the roll out of the national HMIS system. Emphasis should be given to building capacity at State and national levels to ensure sustainability.

Impact Weighting (%): *10%*
Revised since last Annual Review? *No*

Risk: *Medium*
Revised since last Annual Review? *No*

Output 6: Increased demand for routine immunisation and maternal, neonatal and child health services

<u>Output 6 final score and performance description:</u> B - Output moderately did not meet expectation

<u>Progress made against final results</u>

PRRINN-MNCH adopted a comprehensive community engagement (CE) approach to increase demand for RI and MNCH services. Over 3,000 communities within the clusters were directly supported by the programme. The CE activities had a diffusion effect in neighbouring communities ('CE light' communities) that were not directly supported by the programme, but where members of the community none-the-less had some exposure to CE discussions and other programme interventions. The communities where CE activities took place are rural, remote communities, with low levels of education and in which women are very much confined at home and have little autonomy. The levels of knowledge and understanding on RMNCH issues were very low at the beginning of the programme, as shown by the baseline Knowledge, Attitudes and Perceptions (KAP) survey.

The CE approach included:

1) Facilitated **community discussions** to increase knowledge on RMNCH issues, to discuss the social factors that result in poor health outcomes and to identify barriers to access to care. **Community volunteers**, mentored, monitored and supervised by **local engagement consultants** (LECs) facilitated the community discussions. The discussions included men and community leaders.
2) Through the community discussions demand side barriers to care, such as lack of transport, fees for treatment and perceptions of poor quality care at the facilities including lack of blood transfusion services, were identified. The programme initiated a package of **interventions to address demand side barriers** including:

a. Emergency transport systems (see Indicator 4.1 above). Over 21,000 women have been transported through the emergency transport system to date
b. Community emergency savings funds
c. Networks of community blood donors
d. A system of mother's helpers

3) Strengthened community engagement with and 'ownership' of local health services through **Health Facility Committees (HFC)**. HFCs have been established by the programme for every facility in each cluster. The HFCs provide a link between facilities and the communities served. Most HFCs have actively monitored the functioning of the facilities' drug supply systems, ensuring the proper use of funds for drugs procurement as well as the availability of quality drugs at affordable prices. Although almost all committees have lobbied for improvements in the quality of services provided at the facility, the potential wider role of the HFC to provide oversight for all aspects of facility performance (and not just drug supply) has not been fully developed.
4) Since 2012, **Young Women Support Groups** (YWSGs) have been established, aiming to reach the most vulnerable and socially isolated women to enable them to take better care of their own and their children's health
5) **Door stop health services** to address inequity in access to MNCH services
6) **Inclusion of MNCH topics into Islamiya schools**
7) **Radio messaging:** PRRINN-MNCH in partnership with State governments and radio stations, has promoted airing of health promotion jingles, songs and spots over the radio.
8) PRRINN- MNCH has **mobilised high-level support** (from policy makers, opinion leaders, religious and traditional leaders) for MNCH and RI activities both as a means to raise awareness on these issues and as a mechanism to generate financial commitment to support the provision of MNCH services and community level activities as well as to ensure sustainability of programme interventions.

In addition, the programme sought to **build sustainability** for CE by advocating to LGAs and States for the approach and by training LGA/Gunduma staff as LECs. All State ministries of health/SPHBs have assigned a budget for CE activities and partially led CE activities. A small number of LGAs have also allocated budget for CE activities.

Although the CE approach has improved women´s knowledge and understanding of issues related to their health (when pregnant) and the health of their children, programme targets for this output were not wholly achieved indicating that knowledge and understanding does not always produce behavioural changes. Additionally, CE work is labour intensive and requires a continuous presence in the community. The programme has only been able to reach a small proportion of communities in each State and although government capacity has been built to sustain and extend the approach, consideration needs to be given to whether this is the most cost-effective approach to increase demand and/or which elements of the comprehensive CE approach are the most effective.

There were 7 indicators for this output. Three indicators were achieved while three were not achieved. The results for one indicator are not yet available. The indicators not achieved all relate to acquiring new knowledge on MNCH issues or behavioural changes, which can be an indication of the need to intensify these efforts and/or to re-assess the approaches/strategies employed to address behavioural change, communication and health education activities. For this reason the output has been scored B, output moderately did not meet expectation.

<u>Progress against logframe indicators</u>

Indicator 6.1 Increased political support for MNCH (including RI) evidenced by high level public events.

Throughout the lifetime of the programme increased political support for MNCH (including RI) was evidenced in all States. Examples of high-level public events at State and LGA levels in 2013 include:

- In Yobe, H.E The Governor of Yobe State reconstituted the Free MNCH Committee and increased funding to free MNCH by 150%; 5 Emirs continued to support PHC/RI.
- In Jigawa, Minister of health and Deputy Governor initiated the re vaccination exercise at Dutse. All LGA Chairmen made commitment to Polio Eradication Initiative / RI.
- In Katsina, there was National level participation (NPHCDA) and the participation of the wife of the deputy governor, speaker of the House of Assembly and others in the Anguwar Agage celebration of 2 years without a maternal death. A directive from the wife of the governor was given to all LGAs to roll out community engagement activities / Young Women Support Groups in their respective LGAs. Faskari, Danja and Musawa have started rolling out CE in their LGAs.

Indicator 6.2 Percentage of wards with a development committee and/or health partnership implementing a community action plan

802 out of 976 wards (82%) in the project area, have established a development committee and implemented a community action plan. A typical development committee is composed of stakeholders representing community leaders, religious leaders, community organisations, community volunteers, and community members. The FHC and the Community Volunteers groups (with whom PRRINN-MNCH has worked directly) could be described as the health subcommittee of the ward development committee. Each FHC/community volunteer group plans mobilisation activities (teaching danger signs and vaccination hands for example) to be carried out, identifies the number of households they wish to reach with these interventions, maps the number of pregnant women in the locality, etc. The FHC/community volunteer groups then report on these activities to the ward development committee at the end of each month in line with the data elements of the community monitoring system. The FHC mobilise resources, organise community dialogues to address issues such as low facility utilisation, service satisfaction etc. In terms of resource mobilisation, for example, the FHCs in Gegeta (Kaura Namoda LGA) and Sadawa (Bukkuyum LGA), both in Zamfara State, built a 2-bedroom flat for Community Based Service Delivery CHEWs posted to the communities. There are also examples of FHCs taking health workers to court over the misuse of drugs funds, and of lobbying LGAs to ensure that staff are posted to their communities.

Indicator 6.3 Percentage of women in targeted areas who have standing permission to take their child to a health facility.

Baseline and end of programme surveys showed an increase from 40 to 79% in the percentage of women who have standing permission to take their child to a health facility. However the programme target of 90% was not achieved.

Indicator 6.4 Percentage of women who know at least four of the maternal danger signs in targeted areas.

Baseline and end of programme surveys showed an increase from 10 to 21%. However the final result remains significantly below the programme target of 55%.

Indicator 6.5 Percentage of facility health committees for intervention facilities in targeted areas actively monitoring drugs.

209/234 facilities (85%) have a FHC that actively monitors drug stock, purchasing and control

within the health facility**,** exceeding the programme target of 66%

Indicator 6.6 Percentage of mothers of children <2 in targeted areas who know the childhood vaccination schedule.

Baseline and end of programme surveys showed an increase from 8 to 44%. However the final result remains significantly below the programme target of 65%.

Indicator 6.7 Percentage of never immunised children <2 in targeted areas.

The project baseline survey found that 25% of children <2 in the project area had never been immunised. End-line survey results were not yet available at the time of this project review.

Table 7 Progress against Output 6 indicators

	Indicator	End of Programme Targets	Achievement
6.1	Increased political support for MNCH (including RI) evidenced by high level public events	2013: 1 at State level 3 at LGA level	2013 achievement 4 at State level 6 at LGA level
6.2	% of wards with a development committee and/or health partnership implementing a community action plan	50%	82%
6.3	% of women in targeted areas who have standing permission to take their child to a health facility	90%	79%
6.4	% of women who know at least four of the maternal danger signs in targeted areas	55%	21%
6.5	% of facility health committees for intervention facilities in targeted areas actively monitoring drugs	66%	85%
6.6	% of mothers of children <2 in targeted areas who know the childhood vaccination schedule	65%	44%
6.7	% of never immunised children <2 in targeted areas	<10%	*Results awaited*

Lessons learned and recommendations for future DFID programming

The CE approach employed by PRRINN-MNCH to increase demand for MNCH and RI services was wide reaching and comprehensive in scope. However the approach was resource intense, and while PRRINN-MNCH has demonstrated that much can be achieved (at low cost) through community volunteers, a significant degree of oversight is necessary to

sustain this approach. It is uncertain if States and LGAs will be able to maintain capacity to oversee these activities, across the whole State and without partner support, in the long term.

Future DFID programming should continue the CE approach but should, as a matter of priority, work with government, communities, partners and DFID to establish a long term strategy for community level activities. The strategy should be informed by the evidence base of what works internationally, as well as lesson learning from the approach taken by PRRINN-MNCH to date. The strategy should set out which elements of the CE work should be scaled up, and by whom, and should identify which elements should be dropped or adapted. As described under Output 3 above, the community engagement should introduce a a stronger rights based approach to ensure that communities demand their *right to health* in its broadest sense, and do not demand for nor accept the provision of non-functioning facilities.

During the extension period, PRRINN-MNCH should 'dig deep' within cluster communities to increase demand for MNCH services (particularly facility deliveries and family planning) and RI. Approaches taken to date, such as women's support groups and community education ('CE complete' and 'CE light') should be critically examined to determine which elements are the most successful, and to understand who is reached by these services and most importantly who is *not*. Particular attention should be given to identify and reach women who do not yet participate in community based interventions. The number of women's support groups and community education activities should be increased to reach a wider population and innovative approaches to increase facility deliveries, family planning uptake and immunisation uptake among unimmunized children should be tested.

Impact Weighting (%): *20%*
Revised since last Annual Review? *No*

Risk: *High*
Changed to high following recommendation of last annual review

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

Output 7 Final score and performance description: A output met expectation

Progress made against final results

PRRINN-MNCH´s federal-level office in Abuja has established strong relations with Government Ministries, Departments and Agencies (i.e. FMOH, NPHCDA, MDG, NHIS, MSS), as well as with other development partners and programmes. Senior programme technical staff have participated in a number of national technical & policy advisory groups and committees. The programme has facilitated linkages between States, LGAs and Federal agencies, ensuring that successful interventions and strategies implemented by PRRINN-MNCH at State level inform decision making, policy and planning at Federal level.

A significant number of the initiatives implemented by PRINN-MNCH at State level have been adopted for national roll-out, illustrative of the key role that the programme has played to strengthen MNCH (including RI) activities nationwide.

For example,

- The PHCUOR concept has been adopted for nationwide rollout and the NPHCDA (with support from PRRINN-MNCH) has supported the establishment of State Primary Health Care Boards in 27 States to date. The establishment of these Boards is also contemplated in the Health Bill which is pending final approval.
- The 56th National Health Council gave a clear directive to adopt DHIS2 as the national reporting system for health facilities. Nationwide 30 – 60% of government´s health facilities are now reporting to the national HMIS.
- The maternal death and perinatal death reviews instruments developed by PRINN-MNCH have been adopted for national roll-out
- The HRIS system implemented in the four States is now being used by the FMOH to build a national platform for information on human resources.
- PRINN-MNCH has been a constant advocate for routine immunisation in the country and contributed significantly to the development of the RI Strategic Plan 2013 – 2015 and the RI accountability framework
- PRINN-MNCH provided key technical assistance in the design of the Midwifery Service Scheme through which midwives are contracted and posted, primarily to rural areas.

There were three specific indicators for this output. It should be recognized that achievement of these indicators are not solely dependent on the inputs provided by PRRINN-MNCH but instead require the combined effort of all stakeholders and partners working in the health sector at Federal level. Two indicators for this output were achieved, while the third (100% delivery of vaccines from Federal level to States) was not achieved. Although all three indicators were not achieved, the programme has clearly played a catalytic role to strengthen PHC policy and strategy at national level, and hence this output is scored A, output met expectation.

Progress against logframe indicators

Indicator 7.1 Formal systems for leveraging, accessing and utilising additional PHC funding.

This indicator refers to the establishment and sustainability of funding mechanisms available to the States to support primary health care activities. A number of such funds are available, including GAVI, MSS, Community Based Health Insurance, SURE-P, CCT and MDG funds. All States have successfully accessed and used some, although not necessarily all, of these funds.

Indicator 7.2 Federal level delivers 100% vaccines and supplies to States on time

This target has proven particularly challenging to attain. Recognizing these challenges, PRRINN-MNCH adapted during the project period to provide greater technical support to RI at Federal level, including membership of the RI Logistics Working Group and RI donor partners group. However, although vaccine stocks and delivery systems have improved throughout the programme period, stock outs are still reported for selected antigens at State level (for example Zamfara State reported a stock out of tetanus toxoid in Sept 2013). Hence this indicator has not been achieved.

Indicator 7.3 Agreed strategies to improve efficiency of RI

At the Federal level, PRRINN-MNCH has contributed to the development and implementation of a number of strategies to improve the efficiency of RI, including the RI Strategic Plan 2013 – 2015 and RI Accountability Framework, and the Strategic plan for GAVI HSS 2014 – 2018.

While it is too early to determine the impact of the RI Strategic Plan and Framework, the identification of roles and responsibilities at all levels of the health system as set out in the Strategic Plan, supported by performance indicators and mechanisms to hold all parties to account provides an unprecedented platform for future improvements in the national RI system, including the regular provision of vaccines and supplies to States.

Table 8: Progress against Output 7 indicators

	Indicator	End of Programme Target	Achievement
7.1	Formal systems for leveraging, accessing and utilising additional PHC funding	System Sustained	Achieved
7.2	Federal level delivers 100 % vaccines and supplies to States on time	100%	Not achieved
7.3	Agreed strategies to improve efficiency of RI	Strategies Sustained	Achieved

Lessons learned and recommendations for future programming

The focus of PRRINN-MNCH was at the State level with a relative minor investment on activities at Federal level. The experience showed that important gains can be made by working with the Federal level. The Federal level is the key space to promote/advocate for federal policies that can then be taken on by the States. This is also a space to foster partner coordination, harmonisation and alignment. PRRINN-MNCH selected key areas of work at Federal level, all of them related to the programme's activities at State level. The feedback from the field to the policy level was effectively used for learning and sharing, policy advocacy and influencing policy making and decision taking. However, the programme was less successful at ensuring a sustainable supply of vaccines from Federal to State and finally to facility level, and did not achieve programme RI results as intended.

Future programming should take a similar approach to linking State and Federal level activities but should also give priority to working with partners to advocate/support government to address the bottlenecks that impede progress towards high RI coverage.

At Federal level PRRINN-MNCH primarily engaged with the NPHCDA while DFID's PATHS2 programme has engaged primarily with the FMOH. Both programmes have participated in technical advisory and working groups at Federal level. As PRRINN-MNCH and PATHS2 draw to a close, DFID should consult with programmes, partners and government to determine the most appropriate levels of engagement for DFID staff and programmes to ensure the most rational and effective approach going forward, particularly engagement around RI. This should always be kept under review with adaptation as necessary in response to the changing policy landscape.

As described under Output 3, **during the extension period** PRRINN-MNCH should continue to provide technical assistance for rollout of the National RI Strategic Plan and Framework while supporting its implementation within programme States.

Impact Weighting (%): *5%*
Revised since last Annual Review? *No*

Risk: *High*
Revised since last Annual Review? *No*

Section B: Results and Value for Money.

1. Achievement and Results

1.1 Has the logframe been changed since the last review? No

1.2 Final Output score and description: A Outputs met expectation

1.3 Direct feedback from beneficiaries

The review team collected feedback from beneficiaries by visiting two communities in Katsina State where the team met with women's group members and male community members and leaders.

Feedback from beneficiaries demonstrated a high level of support for the programme. Community members attributed improved maternal and child health outcomes to the programme and women reported a small increase in financial resources resulting from income generating activities established by the project.

None-the-less, community members recognized that not all women living in the community participated in the women's groups and those who did not participate were, for example, less likely to attend facilities for delivery and to have lower levels of knowledge about the dangers signs of pregnancy or childhood illness.

These findings concur with the results described under output 6 above, which showed improved health knowledge among communities when compared to baseline, but that knowledge levels remained below programme targets.

The women's groups included young (teenage) women and older women. They indicated that through the women's groups and community education activities they now know how to take better care of themselves and their children and are more likely to deliver their babies in a health facility, they have obtained standing permission from their husbands to take their children to the health facilities, and through the income generating activities they now have some cash within their control that was not previously available to them. The women reported that they are now are more likely to deliver in a health facility. Among the reasons given they mentioned that they know it is good for them, they can now find transport if needed (through the emergency transport system), they can have the blood donors with them to give blood if necessary and could get some cash from the groups´ savings. Nevertheless, a small number reported that they delivered their last baby at home and when asked why they explained that at the time they had inadequate knowledge about the benefits of delivering at the health facility, there was no transport available or it was at night and too late to go to the health facility. Most women were aware of family planning, but few were making use of family planning methods.

When asked about their experiences from the services received at health facilities the women reported that they had been treated well, with no harassment, had received adequate information from the health workers, that drugs were generally available and sometimes although not always, these drugs were free.

The team also met with male community members. Most of them were involved as community volunteers, blood donors or members of the health facility committee. They also indicated that now they know that it is important for women and children to go to health facilities and that it is good for women to deliver at health facilities.

The government stakeholders met by the review team universally expressed their satisfaction

with working with PRRINN-MNCH and the progress made in improving the primary health care system in their States, the progress made in immunisation services and in getting women to deliver their children at health facilities. They very much appreciated the efforts made towards the establishment of the various processes and systems introduced by PRRINN-MNCH as a routine practice within the respective institution and expressed their own commitment to support the continued strengthening of PHC services in the States.

1.3 **Overall Outcome score and description: B Outcome moderately did not meet expectation**

Table 9 Progress against Outcome level indicators

Indicator	**Target**	**Achievement[1]**
% of infants fully immunised by their first birthday	32%	19%
% of pregnant women with appropriate tetanus toxoid	50%	86%
% of women ages 15-49 with access to modern family planning services	4.18%	5.2%
Caesarean section rates in targeted CEOC clusters	1.25%	1.5%
% of women receiving antenatal care	50%	49%
Measles incidence reduced by 80%	1,112 cases	Increase in cases
Polio incidence reduced to near zero	0 cases	7 cases (all in Yobe)

[1]Source PRINN-MNCH endline survey

All four outcome level targets relating to reproductive and maternal health care were achieved (or almost fully achieved). However, the level of ambition in these targets was relatively low. For example, the WHO estimates that a population level Caesarean section rate of 5% is the minimum level to ensure safe maternal health care. The programme demonstrated a three-fold increase in Caesarean section rates from 0.5% to 1.5% but this remains significantly below the WHO standard.

In contrast to the maternal health indicators, none of the targets for RI were achieved. Less than one fifth of children are fully immunized by their first birthday. Polio cases have declined, but do still occur. A nationwide measles outbreak in early 2013 resulted in an increase in the number of measles cases, not a decrease. It should be recognized that factors contributing to some of these result did not lie under the direct control of the programme. For example a national stock out of measles vaccine resulted in low population immunisation coverage which allowed an outbreak to occur, while insecurity and inadequately conducted polio eradication efforts (such as poorly planned and managed campaigns) have contributed to the continuing transmission of polio. None-the-less, given the intense effort expended by the programme to build capacity for service delivery and to increase demand for MNCH and RI services, the outcome results achieved are less than expected. Hence the outcome has been scored B – outcome moderately did not meet expectation.

Lessons learned and recommendations for future DFID programming

The reasons for the lower than expected outcome level results can be deduced from the output level scores described in Section A above. Of the seven outputs, five met or exceeded expectation while two did not meet expectation. Critically, the two that did not meet expectation ('Improved delivery for RI and MNCH services via the primary health care system' and 'Increased demand for RI and MNCH services') are the two outputs that are most strongly associated with the desired outcome, as reflected in the impact weightings for those outputs (25% and 20% respectively). It is possible that the effort given to wider system strengthening resulted in insufficient attention being given to service delivery and to address demand side barriers. On the other hand, it could be argued that *without* the system strengthening efforts outcome level results would have been even lower. Similarly, it could be argued that the system strengthening efforts have set the foundation for an accelerated increase in service uptake that would have been seen if the project had continued for a longer period, i.e. the programme gains will be realized beyond the end of the programme period. It has not been possible, in a limited review of this nature, to fully understand the above factors. However, future DFID health system/RMNCH programming in Northern Nigeria should be cognizant of these issues and outcome level results should be closely monitored from the outset with course corrections made if outputs do not translate into expected results at an early stage.

Additionally, the programme was not able to ensure the adequate provision of vaccines from Federal to State level (see Indicator 7.2 above) and at the end of the project period the national RI system remains fragmented with poor ownership and accountability at all levels, although a foundation for improvement has been set through the National RI Strategic Plan and Accountability Framework. DFID and future DFID programming should maintain momentum and pressure on government and to ensure that the Plan and Framework are fully implemented.

1.4 **Impact and Sustainability**

At impact level, the programme was intended to contribute to a nationwide reduction of under-five mortality from 153 to 138 per 1000 live births and to increase the nationwide percentage of births attended by skilled birth attendants from 39% to 52%. Baselines were determined from the 2008 Nigerian Demographic and Health Survey (DHS). A DHS survey was conducted in 2013; however results will not be available until early 2014. Hence it is not yet possible to assess whether impact level indicators have been achieved.

Although impact at national level cannot yet be assessed, changes in impact indicators within project areas indicate that the project has contributed to a reduction in under-5 mortality and increased skilled birth attendance, as shown in Table 10 below.

Table 10: Progress against impact goals within MNCH project States

Indicator	Baseline (project States)[1]	End of Programme achievement (project States)[2]	Comment
MDG4, Target 5. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	Under 5 mortality rate = 160 Infant mortality rate = 90	Under 5 mortality rate = 91 Infant mortality rate = 55	The under-5 mortality rate decreased by 43%, and infant mortality by 39% in project areas during the project period

	MDG5, Target 6. % of births attended by skilled birth attendant (SBA)	11%	25%	Skilled birth attendance rates more than doubled in the project areas during the project period.

[1]**2009:PRRINN-MNCH Baseline survey**

[2]**2013: PRRINN-MNCH Endline survey**

The approach taken by PRINN MNCH was to build capacity of government health systems and hence ensure sustainability beyond the immediate lifetime of the project. To the extent possible the programme has been successful. However, it must be recognized that health systems in the programme States are not yet fully functional and further external support is needed to build on the foundation laid by PRINN-MNCH.

At all stages of the programme, interventions were designed in consultation with government and systems supported by the programme were embedded into the corresponding institutional set-up that is /should be responsible for the continued implementation of these systems. The political will to maintain the gains and continue further implementation seems to be in place.

Capacity of government was strengthened at all levels, for example HMIS officers were trained at facilities, LGAs and State agencies, a sustainable drug supply system was established at facility and State levels, government health workers were trained to provide essential maternal and child health care and State and LGA staff were trained and then supported to undertake integrated supportive supervision. Communities have been empowered with increased knowledge and understanding on health issues pertaining to women and children and with the creation of community systems to address barriers (transport, financial, access to blood donors) to access maternal and child services. These gains are likely to be sustained in the long term.

A particular success of the programme is the influence it has exerted at national level, where the programme can be seen to 'punch above its weight'. For example the HMIS system developed by PRRINN-MNCH has been adapted as the national model, and the programme has contributed to national RI strategies and plans.

Lessons learned and recommendations for future DFID programming

The major threats to sustainability, that should be addressed through future programming include:

<u>The capacity of the systems established to survive changes in the political landscape</u>. In Nigeria (as in many other countries), the introduction of health systems changes and their continuity depends largely on the political will to adopt, sustain and invest in those systems. Presently, in the programme supported States, this will seems to be in place. However sustained advocacy will be necessary until the systems have been fully institutionalised.

<u>Ensuring full institutionalisation of the systems and processes supported</u>. The processes and systems introduced have not yet been operating long enough for full institutionalisation. A solid foundation has been laid and there are staff able and capable to keep the systems running. However, additional years are needed to fully embed these systems as the 'norm' and to ensure they are resilient to changes in political will and the withdrawal of external support.

<u>Ensure adequate level of financing for health / address financial barriers</u> to access and utilisation of health services. Government expenditure on health is low, at 7.5% of total government expenditure in 2011. Private expenditure on health as a percentage of total expenditure of health is 63% (of this 95% is out-of-pocket expenditures). At State level, budget

allocations to health are not disbursed as planned, making it impossible to ensure service provision and making efforts in planning and budgeting redundant. Further advocacy is needed to ensure adequate financing for health and to ensure that financial barriers do not limit access to health care.

Ensure adequate human resources in skills and numbers. There is a pressing need to fill the gap in human resources for the provision of health services in general, but in particular to fill this gap in rural and remote areas. For the purpose of MNCH services it is vital to scale-up efforts to fill the gap for skilled birth attendants (midwives or similar cadres) as well as the general availability of health staff. This is an area that needs to be addressed in a comprehensive and strategic way (i.e. formal training outputs, recruitment of new staff, rational distribution of staff, mechanisms to retain staff at their posts particularly in rural areas). Clear strategies and goals for the short and medium term need to be determined and additional resources will need to be mobilised. Task shifting options might be necessary.

Future DFID health programming in Northern Nigeria should continue to address the above challenges to ensure the sustainability of a functioning health system, without external support, in the long term.

2. Costs and timescale

2.1 Was the project completed within budget / expected costs: Yes

The total programme budget, including DFID and NORAD funding was £65.3m. As shown in Table 11 below, total expenditure to October 2013 was £61.9m. The project is on track to complete all planned activities within the total budget envelope by the end of the project period.

Table 11: PRRINN-MNCH – budget and expenditure, 2006 – October 2013

Year	Budget	Actual
2006/2007	1,030,391	1,030,391
2007/2008	3,328,276	3,328,276
2008/2009	5,194,495	5,194,495
2009/2010	9,012,975	9,012,975
2010/2011	10,984,748	10,984,748
2011/2012	10,635,843	10,632,917
2012/2013	12,012,270	12,012,270
2013/2014	13,094,360	9,695,408
Grand Total	65,293,362	61,891,484

2.2 Key cost drivers

The cost drivers identified when the programme was approved and used to monitor budget performance throughout the lifetime of the project are presented in Table 12 below. The main cost drivers were the costs of long term staff and activity costs (work carried out at State level plus rehabilitation of health facilities), each one representing 28% of total budget. Actual expenditure within each category closely approximated the planned budget.

Table 12 Cost drivers

Cost drivers	% budget	% actual spend
Long term staff	29%	28%
Reimbursables (activity costs and rehabilitation)	27%	28%
Short term technical assistance	16%	15%
Procurement (drugs, medical equipment, office equipment, vehicles)	14%	14%
Office running costs	6%	7%
Senior technical staff	5%	5%
Operational research short term technical assistance	2%	2%
Security	1%	1%

2.3 Was the project completed within the expected timescale: Yes

The programme ends in December 2013 and activities have been planned with a clear exit strategy. A seven-month extension period from Jan- Jul 2013 has been approved to ensure smooth transition towards a new MNCH 2 programme that will be implemented in six States in Northern Nigeria.

3. Evidence and Evaluation

3.1 Assess any changes in evidence and what this meant for the project.

The project memorandum did not describe a theory of change to underpin programme design. However critical assumptions were described and associated risks identified. Throughout the project period, when assumptions were not met, or where risks emerged, the programme responded to mitigate these as far as possible, as shown in Table 13 below.

Table 13 Programme design assumptions and response during implementation

Assumption	What happened	Programme response
National level provision of required vaccines, syringes and safety boxes to the States	Stock outs of antigens and commodities continued at national level, although improvements were seen during the programme period	PRINN-MNCH contributed to the development of a national RI strategic plan and accountability framework, and is a valued member of national level committees and working groups aiming to improve vaccine supply and delivery, including the Routine Immunisation Logistics Working Group
Maintenance of Federal allocations to State and LGA health budgets	Federal allocations to State and LGA budgets were maintained throughout the project period	n/a
Continued political stability and absence of civil strife	Political instability and civil strife have escalated in Northern Nigeria in recent years. This led to a number of challenges to the programme including	Throughout the lifetime of the project PRINN-MNCH has endeavoured to recruit and deploy local staff to work in project

	restrictions on the movement of international consultants to programme areas which prevented their involvement in key reviews and other activities where an external, strategic view would have been beneficial. In 2011 PRRINN-MNCH had to move its staff from Kano to Abuja and reduce the number international staff. Security concerns were particularly acute in Yobe State where planned activities such a training could not always be conducted.	areas, thus giving a lower profile to the programme and lessening the chance that the programme will be the direct target of any insurgency. The project has focused on building government capacity and strengthening existing health systems rather than initiating stand-alone interventions, again ensuring a lower profile to the project. Trainings were conducted out of State for Yobe and additional security measures were put in place to protect programme staff
Draft Health Bill enacted and effectively applied at Federal, State and LGA levels	Bill not yet approved	PRINN-MNCH has contributed to the content of the draft Health Bill and continues to advocate at Federal level for its enactment
Global and national initiatives do not disrupt planning and implementation of PHC and RI at State and LGA levels	With the exception of single antigen campaigns, global and national initiatives have facilitated PHC and RI planning and implementation at State and LGA levels	n/a
Single antigen campaigns do not detract from the continuing work of PHC and RI	Frequent polio campaigns have negatively affected PHC service delivery and RI by taking health workers from facilities and consuming significant time and attention of facility, LGA and State staff.	PRINN-MNCH has advocated strongly to government and partners for less frequent and better quality polio campaigns. Specific information provided by PRINN-MNCH, demonstrating the negative impact of polio campaigns was provided to DFID and enabled DFID to have a stronger voice to lobby partners and government for improvements in the polio campaign. The most recent Polio Emergency Response Committee, held in Nov 2013, acknowledge the negative impact of the campaign schedule for the first time and made recommendations to address this

3.2 Set out what plans are in place for an evaluation.

There are no plans for an evaluation of this programme.

4. Risk

4.1 Risk Rating (overall project risk): High

Did the Risk Rating change over the life of the project? No

4.2 Risk funds not used for purposes intended

Independent financial audits of the programme were conducted in 2010 and 2012 and a further audit was on-going at the time of this project completion review. The 2010 audit made

recommendations on procedural issues which were addressed by PRRINN-MNCH. Particularly the 2010 audit review recommended the setting up of an internal audit unit for the programme and the engagement of Compliance Officer. The coming of the compliance officer strengthened scrutiny and helped uncover fraudulent practices in one of the PRINN-MNCH State Offices in 2012. The programme took swift action to address the irregularities and took appropriate action against errant staff members. Additional measures put in place by the programme included the roll out of a tailored anti-corruption policy and procedures, refresher training for State Team Leaders on financial management responsibilities, controls and compliance, and a review of the existing financial systems and their implementation. The financial transgressions were reported promptly to DFID and the consortium took responsibility to bear the cost of the non-recoverable losses without loss to DFID or the programme**.** The 2012 audit raised no concerns.

The programme also implemented measures to involve communities in the overview and scrutiny of programme activities and systems established by the programme. For example a specific activity of the programme was the establishment of revolving drug funds within programme supported facilities. The programme trained and supervised facility staff on the management of a revolving drug fund and provided commodities to capitalize the drug store. To provide further reassurance that drugs were used as intended and that funds were not misappropriated, the project established a Facility Health Committees with a specific remit to oversee the revolving drug fund (see Output 6 above). Thereis no evidence to suggest that programme funds have been used for other than the intended purposes.

4.3 Climate and Environment Impact

The MNCH Programme Memorandum suggested that the programme would have a number of positive environmental impacts, including:

- improvements in environmental health
- improved sanitation through health education
- better health care waste management
- better drug management to reduce wastage
- support to health planning at LGA level would provide scope to introduce environmental impact methodologies

During the visit to health facilities the team was able to verify that there is better drug management at health facility level. Safe disposal containers for sharps were available and in use at the health facilities visited.

Environmental health and community sanitation were not monitored and so it is not possible to assess any possible project impact on these.

5. Value for Money

5.1 Performance on VfM measures

Specific value for money measures were not described in the original project memorandum, and although the project mid-term review and annual reviews considered the value for money offered by the project, no explicit indicators to track value for money on a systematic basis were recommended.

None-the-less, PRINN-MNCH endeavoured to achieve value for money and the programme routinely gathered information to demonstrate improved economy, efficiency and effectiveness

and reported on VfM to DFID on a regular basis. In addition to VfM gains of benefit to the programme itself and to DFID as a funder, the programme also led to efficiency savings for State government in a number of areas. Selected examples are presented below.

Economy (cost control, buying quality inputs at right price)

- The use of international staff decreased from 55% (2008) to 20% (2011)
- Average per diem rate decreased by 24%
- 20% reduction in travel costs
- Use of health worker training institutions and Federal Medical Centres as venues for health workers training instead of hiring private meeting rooms
- The training programmes developed by PRRINN-MNCH are significantly cheaper and have greater emphasis on skill transfer than FMOH designed programmes and are therefore more highly rated by participants of both. For example, the PRRINN-MNCH´s training cost per participant for IMCI case management step-down training is £414, which is 60% of the cost per participant of the FMOH Model (£721).

Efficiency (maximising outputs from inputs)

- The programme drew on an extensive network of community volunteers who were trained by PRRINN-MNCH to raise awareness of MNCH issues and mobilise communities to organise themselves to enable pregnant women to access medical services. This included transport organised and funded by communities (delivered by trained emergency transport drives), identification of blood donors and mentoring of women groups (see Section A, Output 5 above)
- Awareness raising among 42 Islamic scholars resulted in reaching 1600 people with health messages on routine immunisation (RI) and MNCH at no extra cost
- Baseline quantification of micronutrients such as zinc and folic acid in the program States revealed excessive stock that was redistributed to facilities, resulting in an estimated N17million procurement saving to State goverments
- In Zamfara, the use of mobile phone for monthly health management information system (HMIS) reporting is estimated to cost about 2 Naira per facility as compared to paper based reporting which costs more than 200 Naira for transportation, an estimated saving of N50,000 per year
- Leveraging stakeholders and partner contributions to MNCH:
    - State partners contributed 58% of the total costs of establishing learning LGAs;
    - Gradual increases in State allocation to health activities. For example, the budget allocation to SMOH in Jigawa has increased from 8.4% of the total State budget in 2008 to 16% in 2013;
    - A rapid survey of stakeholder and partner contributions to PRRINN-MNCH activities, undertaken by the programme in February 2011, reported that stakeholder / partner contributions amounted to 29% and 44 % of total programme contributions in 2009 and 2010 respectively;

Effectiveness (achieving greatest outcomes)

As outlined in Section 1.4 above, the project did not achieve all outcome level targets. None-the-less, the programme made substantial progress towards establishing sustainable and better quality health systems in each State and it is likely that the impact of these efforts will be realized beyond the end of the immediate programme period, thus representing value for money.

Equity and Inclusion

The programme sought to reach underserved populations, with a specific focus on young and marginalized women and their children. Over 2000 community groups with safe spaces for

girls were established. However it was not possible to disaggregate outcome and impact level indicators for socio-economic status or other variables.

5.2 Commercial Improvement and Value for Money

DFID ensured that value for money was attained throughout the lifetime of the project by putting in place measures to maximize results while at the same time minimizing project costs. Firstly, the implementing consortium for the PRRINN project was selected through competitive tender. and the contract awarded to HPI included a break-clause to allow the termination of contract if performance was unsatisfactory. It was not necessary to apply this clause.

In 2008, recognizing the success of PRRINN, the government of Norway provided an additional £27m to expand the programme to include MNCH and to include a greater health system strengthening component. This joint funding enabled HPI to build on the foundation laid in the initial years of the project, and to implement PRRINN-MNCH as a single programme, thereby attaining efficiencies and achieving greater impact than would have been possible if the two funding streams had been run as two separate programmes.

In Sept 2011 DFID negotiated contract extensions with HPI for both the PRRINN and MNCH components, to Dec 2013. These extensions afforded a two-fold increase in outputs for only a 50% rise in costs. Whilst negotiating this extension, the service providers met DFID's requests to scale down the company's fees and overhead charges considerably to meet the new demands of the Operational Plan.

The PRRINN-MNCH programme itself also employed effective commercial practices to ensure value for money. For example independent consultants contracted by the programme were selected through competitive tender and the Project Management Board ensured that the end products were satisfactory to requirements before consultants were paid.

HPI used Crown Agents to secure procurement of goods from overseas. Crown Agents enjoy a Core Country Agreement with DFID based on their professional skill, market knowledge and buying power to achieve best prices. Additionally, PRRINN-MNCH invited Crown Agents to provide training to support the programme's procurement plans, including quantifying requirements. An independent financial audit of the programme, carried out in 2012, indicated that procurement plans, costs and billing, were in accordance with international accounting standards and in accordance with the contract agreement.

5.3 Role of project partners

The three key implementing partners are Health Partners International (HPI), GRID Consulting and Save the Children UK. Crown Agents undertook the procurement of equipment and drugs.

HPI (UK-based) is the lead partner providing overall coordination, oversight, strategic planning and international expertise. GRID Consulting, (Nigeria-based) provided financial expertise to the project and financial training for project staff. Save the Children UK provided inputs on new born health. The combination of expertise and experience provide by the consortium and their knowledge of Nigeria provided an adequate combination that fitted well to the needs and demands required for implementation of the wide spectrum of interventions supported by PRRINN-MNCH.

The Consortium recruited a strong team of predominantly national staff to deliver the

programme. Senior programme staff brought an in-depth understanding of the Nigerian context and extensive experience of working in Northern Nigeria. This facilitated communication and coordination with stakeholders, and enabled the programme to establish strong and trustful relationships with government partners. Programme staff were adaptive to changing circumstances and demand, and proactively identified opportunities for engagement, for example through participation in various national technical advisory and working groups and by providing technical input for the development of national policies, plans and guidelines such as PHCUOR and HMIS.

Feedback provided to the review team from federal and state ministries and parastatals, indicated a high regard for project staff and a strong appreciation of the technical expertise they brought.

PRRINN-MNCH was implemented in a decentralised way, by a team based in each State working in close coordination with stakeholders. The State teams had a technical role and acted as facilitators of processes and systems which catalysed change. This approach gave enough space for adaptation of the strategies to the particularities of each State, the introduction of strategies, systems and processes when the conditions were ready and allowed the project to respond to specific demands from stakeholders. It also contributed to greater stakeholder´s ownership of the systems and processes established.

Recommendations for future DFID programming

In order to sustain momentum and maintain the collaborative relationship developed with government partners, the new MNCH2 programme should prioritize the recruitment of senior programme staff who are familiar with the Nigerian context and should give priority to establishing relationships with government counterparts at Federal and State level.

As discussed under Output 7 above, DFID should work with partners and programmes to rationalize the approach to Federal level engagement, and the new MNCH2 programme should have flexibility to respond to changing needs, in consultation with DFID.

Future DFID programming should maintain the decentralized approach, ensuring sufficient expertise and capacity at State level to tailor the programme for each State and to consolidate lessons from State level to inform national level activities.

5.4 Did the project represent Value for Money : Yes

The programme has substantially improved the performance of the health system in programme States, and has contributed to increased MNCH service utilization and to reduced maternal and child mortality, thereby representing value for money for DFID's investment. Greater VfM could have been attained if RI targets had been met, but none-the-less the programme has laid a solid foundation for future RMNCH programming and health system strengthening efforts in Northern Nigeria.

6. Conditionality

6.1 Update on specific conditions

Not applicable

7. Conclusions

PRRINN-MNCH has made a significant contribution to improved maternal and child health in Northern Nigeria and has contributed to building stronger health systems and capacity in the four programme States.

The programme adopted a comprehensive health systems approach for strengthening primary health care, given the State of health systems in Northern Nigeria at the beginning of the programme. This approach allowed structural issues that were important bottlenecks for the functioning of the health system (i.e. the fragmentation of health services) to be addressed, as well as developing key systems and processes essential to a well-functioning health system (i.e. health information systems, drug supply, rehabilitation of infrastructure, human resources).

Despite these achievements, not all programme targets at outcome level were attained and there is still a large gap to enable adequate coverage for key maternal and child health interventions in the programme States. Less than 20% of children in project areas are fully immunized by their first birthday and vaccine stock outs persist at national, state and facility level. Half of pregnant women do not currently receive ANC, seven out of ten pregnant women are still delivering at home, and access to emergency obstetric care, as reflected by the Caesarean section rates, is very low. Access to family planning is also very low, inadequate to impact significantly on maternal mortality rates.

These indicate the need to scale-up efforts towards MNCH and a need to go deeper and broader to reach a larger population and achieve higher coverage of MNCH services to further impact maternal and child morbidity and mortality. The appropriate balance needs to be struck between federal level engagement and broader health system strengthening work, and activities to improve service delivery and increase demand for MNCH and RI services. The new MNCH2 programme should be designed cognizant of these issues.

PRRINN-MNCH should work closely with MNCH2 during the transition period to ensure a firm understanding of how PRRINN-MNCH has been working within each State and nationally, and and an understanding of how the successes of the programme can be continued.

8. Review Process

The review team included:

Ruth Lawson	DFID senior health adviser for Northern Nigeria	Full time
Austen Davis	Norad senior health adviser	Participated in the second week of the review
Siaka Alhassan	DFID State Representative	Participated in the visit to Katsina State
Marta Medina	Team leader, Independent Consultant	Full time

The review was based on the review of documentation provided by DFID and PRRINN-MNCH (see Annex 1, below), and interviews and consultations with key informants during a visit to Nigeria between 28 October and 8 November 2013. Key informants included PRINN-MNCH management and State teams, national level representatives from the Federal Ministry of Health, National Primary Health Care Agency, UNICEF, PATHS 2, HERFON and MSS and State level representatives from the State Ministries of Health, the Ministries of Local Government, the State Primary Health Care Boards/ Gunduma Health Boards and members of the Operational Research Advisory Committees. The team made a three-day visit to Katsina which included meetings with key stakeholders and development partners, and visits to the State HMIS databank and the School of Nursing Katsina. Furthermore, the team visited several health facilities including two CEOCs: General Hospital Daura and General Hospital Funtua and one BEOC, Zango Comprehensive Health Centre. The team also visited two communities, Zango and Unguwar Agage Community where discussions were held with women's groups and with male community members.

On November 8, 2013, the team debriefed to PRRINN-MNCH partners and DFID-Nigeria and received feedback on preliminary findings of the review

The Project Completion Report was drafted by Marta Medina and circulated to the other team members for feedback and comments which were then incorporated. The final version of the report was completed by DFID.

Annex 1 Documents available to the review team

1. Project Memorandum Nigeria, Reviving Routine Immunisation in Northern Nigeria, December 2005
2. Project Memorandum Nigeria, Northern States, Maternal, Newborn and Child Health Programme, April 2008
3. PRRINN-MNCH combined logframe
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5. Bradford, Carol., Dobson Sarah, PRRINN-MNCH Midterm Review, DFID human development resource centre, 4 May 2011
6. Duby, Fiona, PRRINN-MNCH, Annual Review 2011, Narrative Report (Final), DFID human development resource centre, August 2012
7. Duby, Fiona, PRRINN-MNCH, Annual Review 2011, DFID Report, DFID human development resource centre, August 2012
8. PRRINN-MNCH Progress Report, June 2013

9. PRRINN-MNCH Appendices to June 2013 Progress Report: National Report, Jigawa State Report, Katsina State Report, Yobe State Report, Zamfara State Report, M&E Report
10. PRRINN-MNCH 2013 Final Report
11. PRRINN-MNCH Progress against logframe and primary M&E indicators 2009-2013 (September 2013)
12. Mecaskey, W. Jeffrey, Documentation of effectiveness & Value for Money approaches of PRRINN-MNCH, PRRINN-MNCH, October 2013
13. PRRINN-MNCH, Cost-Effectiveness of Health System Strengthening and Value for Money, 19 November 2013 revision (Annex to Draft Value For Money Report, summary note developed for the PCR)
14. Weatherhead, Michael, Anifalaje Adebusoye, Treen Jenna, Supporting Programme SROI Analysis, PRRINN-MNCH, January 2013
15. Shutt, Catty, Value for Money-Qualitative Analysis, PRRINN.MNCH, May 2012
16. PRRINN-MNCH Value for Money Report, February 2011
17. Klouda, T Anthony, Implementation of Endline Knowledge, Attitude and Practice Survey in PRRINN- MNCH States, July 2013
18. Mecaskey, W. Jeffrey, Cross States Synopsys on results based financing initiatives including cash transfers on the PRRINN-MNCH Project and a Round table in Nigeria, PRRINN-MNCH, June-October 2013
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20. Developing a State Minimum Service Package: Vol 1 Introduction and Process; Vol 2: Using the HR Planning Tool, Vol 3 Using the MSP Planning Tools, PRRINN-MNCH, July 2013
21. How to conduct an Annual Peer and Participatory Rapid Health Appraisal for Action, for Primary Health Care Facilities, Impact Manual, PRRINN_MNCH
22. Saving Newborn Lives in Nigeria, Newborn Health in the context of the Integrated Maternal, Newborn and Child Health Strategy, Revised 2nd edition, 2011, Ministry of Health Federal Republic of Nigeria.
23. Nigeria Demographic and Health Survey 2008, National Population Commission (NPC) [Nigeria] and ICF Macro. 2009.
24. Nigeria Demographic and Health Survey 2003. National Population Commission (NPC) [Nigeria] and ORC Macro. 2004 Calverton, Maryland
25. Nigeria Multiple Indicator Cluster Survey 2007 Final Report, National Bureau of Statistics (NBS) 2007, Abuja, Nigeria
26. Nigeria Multiple Indicator Cluster Survey 2011, 07 Final Report, National Bureau of Statistics (NBS), UNICEF, UNFPA, April 2013, Abuja, Nigeria
27. Technical Technical/policy briefs on various interventions or studies carried out by the project were made available to the team, among others:
    - Technical Brief - Emergency Transport System
    - Technical Brief – Bringing PHC under one roof (PHCUOR): an overview of progress with special focus on Jigawa
    - Technical Brief – Increasing Skilled Birth Attendance in Nigeria: National Primary Health Care Development Agency – Midwives Service Scheeme and PRRINN-MNCH collaboration, an Updtate, October 2013
    - Maternal Death Reviews
    - Pentavalent vaccine introduction in Jigawa – lessons learned
    - Implementation of Sustainable Drug Management System
    - PRRINN-MNCH Community Engagement Approach: Replication Costs