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PRRINN-MNCH Midterm Review

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List of Acronyms

ANC	Ante natal care
BCC	Behaviour change communication
CE	Community engagement
CHEW	Community health extension worker
COMPASS	Community participation for action in the social sector
CS	Caesarean section
DFID	UK Department for International Development
DHIS	District health information system
DQA	Data quality assessment
DSS	Demographic surveillance system
DRF	Drug Revolving Fund
EC/EU	European Commission/Union
EDL	Essential Drug List
ENC	Essential newborn care
EOC	Emergency obstetric care
ETS	Emergency transport scheme (maternal emergencies)
FANC	Focussed Antenatal care
FMOH	Federal ministry of health
FP	Family Planning
GAVI	Global alliance for vaccines and immunization
GoN	Government of Nigeria
HERFON	Health reform foundation of Nigeria
HDSS	Health and Demographic Surveillance System
HMIS	Health management information system
HR	Human resources
IACC	Inter Agency Coordinating Committee
IMCI	Integrated management of childhood illnesses
IPDs	Immunisation plus days
ISS	Integrated supportive supervision
KM	Knowledge management
KMC	Kangaroo Mother Care
LATH	Liverpool Associates in Tropical Health
LEC	Local engagement consultant / officer
LGA	Local government authority / area
LLGA	Learning local government authority
LSS	Life saving skills
M&E	Monitoring and evaluation
MDG	Millennium development goals
MLG	Ministry of local government
MLGCA	Ministry of local government and chieftaincy affairs
MNCH	Maternal, newborn & child health
MoU	Memorandum of Understanding
MSP	Minimum Service Package
MSS	Midwife Service Scheme
NC	Newborn Care
NEEDS	National economic empowerment & development strategy
NEPAD	New partnership for Africa's development
NGOs	Non-governmental organisations
NICS	National immunisation coverage survey
NPHCDA	National primary health care development agency
OR	Operations research
OVIs	Objectively verifiable indicators

PAC	Post-abortion care
PATHS (2)	Partnership for Transforming Health Systems
PEI	Polio Eradication Initiative
PHC	Primary health care
PHCDA	Primary health care development agency
PHCDB	Primary health care development board
PHCUOR	Primary health care under one roof
PPRHAA	Participatory peer rapid health appraisal for action
PRRINN	Programme for reviving routine immunisation in Northern Nigeria
PS	Permanent Secretary
RI	Routine immunisation
SBA	Skilled birth attendant
SDSS	Sustainable Drug Supply System
SEEDS	State economic empowerment & development strategy
SIACC	State inter-agency coordinating committee
SMOH	State Ministry of Health
SPARC	State partnerships for accountability, responsiveness and capability
SPHCDA	State primary health care development agency
SPHCMB	State primary health care monitoring board
SRIP	Support to reforming institutions programme
SSMS	Sentinel site monitoring system
SuNMap	Support to the national malaria programme
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
V&A	Voice and Accountability
WHO	World Health Organisation

1 Executive Summary

PRRINN MNCH Programme Summary

PRRINN-MNCH is a six-year maternal, newborn and child health programme working across four states in Northern Nigeria. It is jointly funded by DFID and the Government of Norway. The programme began in 2006 as a DFID-funded health system project with a focus on routine immunization (£19m). In 2007, the Government of Norway provided an additional £24m to target maternal, neonatal, and child health (MNCH) components. This integrated programme works in a maternal health cluster approach as recommended by the World Health Organisation. In 2010, DFID provided a funding extension of £19m (until 2013) to expand the coverage and scale of MNCH interventions. Funding for PRRINN-MNCH now totals £61 million.

A multi-disciplinary evaluation team visited the four Northern Nigerian states where PRRINN-MNCH is operating; Jigawa, Katsina, Zamfara and Yobe. This report provides annual review findings (2010) as well as a midterm review component.

Routine immunization major success

PRRINN-MNCH has made very substantial progress in routine immunization. Immunisation coverage has increased in all states, with Jigawa showing the greatest increase in coverage of any state in Nigeria. The National Immunisation Coverage Survey (NICS) 2010 (see table below) shows important progress in fully immunised children in three out of four states. The PRRINN-MNCH programme states show Jigawa as a major success, Zamfara and Yobe improving well, and Katsina lagging behind. While progress has been most encouraging, it is important to realise that significant challenges remain in areas such as logistics and supplies.

Table 1: Children fully immunised in four states in Northern Nigeria, 2006-2010

Indicators	Jigawa		Katsina		Yobe		Zamfara	
	NICS 2006	NICS 2010	NICS 2006	NICS 2010	NICS 2006	NICS 2010	NICS 2006	NICS 2010
Fully immunized – any (by either history or card)	15.5	76.76	21.30	22.22	12.90	35.27	11.00	61.28

For Nigeria as a whole, the reasons for this improvement (based on the NICS survey which showed an increase in immunisation coverage across most states) include fewer mothers citing 'lack of information' as a major obstacle. Mothers are stating that their major motivation is 'to prevent sickness' or 'for protection' implying that their understanding of the benefits of RI is increasing. The increased role and engagement of NPHCDA through evidence-based policy responses is also likely to be a factor. The Review Team was unable to determine how much of this national improvement (if any) might be attributable to the project but welcomes these positive survey results as an indication of the Nigerian health system beginning to show signs of functional improvement.

Scaling up the cluster approach

The MNCH component of the programme commenced in 2008 and was designed on the basis of the comprehensive emergency obstetric care model[1]. The programme is now halfway through work on the first cluster in each state and the second cluster facilities have now been chosen. The programme plans to scale up coverage of two complete states with maternal health clusters by 2013 (Zamfara and Yobe) and to cover half of Katsina. Testing this approach in a low resource setting has enormous implications for work in other countries.

Table 2: Maternal Health cluster coverage of PRRINN-MNCH states to 2013

State	Population	Number of clusters (500,000 people) to cover whole state	Number of clusters planned by 2013	Percent of state coverage
Yobe	2.5 million	5	5	100%
Zamfara	3.5 million	7	7	100%
Katsina	6.5 million	13	6	50%

(Note: Jigawa's MNCH activities are covered by the DFID funded PATHS 2 programme.)

1.1 Key findings

The evaluation team conducted site visits to health facilities and medical stores and met with government officials, midwives, community health workers, primary beneficiaries and other stakeholders. They found many improvements since last year; for example, three states have improved their relationships and funding mechanisms with State government, State human resource strategies are in place and there was improved staffing and patient attendance at facilities. Operations research is moving apace and beginning to generate findings. The programme has also created a culture of performance management guided by high quality data. Community engagement is making excellent progress and the targeted policy work at federal level was also progressing well.

Several challenges were also noted. The need for specialist governance support in health service and planning was determined as PRRINN-MNCH was facing cross-government constraints outside of the health sector. Despite the midwifery service scheme investment which begins to fill gaps, a shortage of midwives persists. Defining minimum standards for service delivery and determining what makes a facility 'good enough' (see box) will be an important part of the programme's work for the next year as they move from the first CEOC cluster and begin to work on others. Finally, challenging the programme to use HMIS data as a quality improvement tool; and how to balance the trade offs between cost efficiency and generating increased demand and scale-up of service provision will continue for the rest of the programme.

1 This design uses one CEOC facility per 500,000 people. Underneath and referring to this CEOC facility are four Basic EOC facilities (each serving 100,000 people with the CEOC facility serving the other 100,000 people) and a number of 24/7 facilities providing maternal care. Together this is called a CEOC cluster.

The Review Team's biggest concern was whether MNCH service provision in the facilities in the first set of clusters in the three states had fully achieved the key milestones under output 3 (service delivery) to achieve 'good enough' status (see box below). The evaluation team discussed the difficulty of achieving a balance of minimum standards of basic care whilst striving for high quality services to continue to generate demand. In addition, supplies and equipment delivery delays slowed progress. PRRINN-MNCH staff reported chronic **delays from Crown Agents (the procurement agent) of up to 15 months**. An action plan is now required to prevent future supply delays from affecting service delivery.

Figure 1: Health Facilities: How good is good enough?

Health Facilities: How good is 'good enough'?
In a low resource setting, health facilities must be resourced to achieve maximum impact at the lowest cost. This implies careful decisions are being made to staff, train, refurbish, supply and equip a health facility. The PRRINN-MNCH programme must assist the Government of Nigeria to find the delicate balance in their health facilities where quality MNC health services can be delivered to save the most lives while excess resources are not being wasted on changes that won't make a big difference. Facilities do not need to be better than 'good enough' or resources will be too concentrated in a few facilities when the programme needs to be expanded. The Review Team found improvements in the health facilities[2] but deemed the first cluster not yet quite 'good enough' to completely meet all nine maternal health signal functions. Small and targeted adjustments in clinical standards and guidelines still need to be made to bring the facilities to be just 'good enough'—but no better.

1.2 Midterm Review

The midterm evaluation team concluded:

- The programme was making good progress towards achieving its programme objectives. The original programme milestones for the programme outputs are still considered reasonable and can be reached.

  It is too early to determine whether the programme can meet its ambitious targets of the new extended MNCH cluster scale up in Yobe and Zamfara and half of Katsina by 2013; Some concerns whether quality of work can be ensured while expanding the coverage considerably; The programme design was still deemed valid, but the team recognized that while maternal and neonatal needs were well addressed, the programme addressed relatively few inputs that would make a substantial contribution toward reducing child mortality—other than routine immunization.

- Some technical and resource constraints were noted—particularly in facility quality and the likelihood that the community engagement work was not going to be able to reach as many people as it might need to; Building service delivery from a low base as in Northern Nigeria will take a long time to do well; and there will continue to be enormous (and growing) numbers of people to both educate and cover with high quality health care. The MTR team recommends that donors take a long term perspective on health care

[2] 24 targeted EOC facilities are showing an increase in the number of signal functions provided (milestone 20) while 36 targeted PHC facilities providing MNCH services show an increase in the number of signal functions provided (milestone 32).

development in Northern Nigeria. Ending the programme in 2013 will entail great risks of setbacks of important achievements.

- Governance is major risk and increased government funding (commitment) is key to achieving the programme's goals and population based improvements in coverage of service delivery.

Midterm Review recommendations

- Intensify the focus on governance in collaboration with other DFID programmes;
- Further expand community based approaches. This may involve identifying additional funding opportunities to expand coverage
- Assess use of performance based measures to further increase government financing such as requiring matched government commitments as part of the expansion strategy or other performance based aid related requirements;
- Assess the full PRRINN-MNCH risks with a comprehensive modelling exercise of the scale up.

1.3 Scoring Assessment

PRRINN-MNCH is a combined programme. The original DFID PRRINN project has its own logframe that is still used to report to DFID separately. The PRRINN-MNCH has its own combined logframe and is the main logframe used by the programme. (See Annex X for full logframe.)

(ii) For the PRRINN-MNCH outputs, the scoring is as follows:

Table 3: PRRINN-MNCH Project scoring (by output)

PRRINN-MNCH Output	Annual Review Score[3]	2010 Score (previous year)
Output 1: Strengthened state and LGA governance	2	2
Output 2 – Improved human resource policies and practices for PHC	2	2
Output 3 – Improved delivery of MNCH services (including RI) via the PHC system	3	3

[3]

1. = Likely to be **completely** achieved. The outputs/ purpose are well on the away to completion (or completed).
2. = Likely to be **largely** achieved. There is good progress towards purpose completion and most outputs are likely to be achieved, particularly the most important ones.
3. = Likely to be **partly** achieved. Only partial achievement of the purpose is likely and/or achievement of some outputs.
4. = Only likely to be achieved to **a very limited extent**. Purpose unlikely to be achieved but a few outputs likely to be achieved.
5. = **Unlikely** to be achieved. No progress on outputs or purpose.

Output 4 – Operations research providing evidence for PHC stewardship, RI and MNCH policy and planning, service delivery, and effective demand creation	2	2
Output 5 – Improved information generation with knowledge being used in policy and practice	2	2
Output 6 – Increased demand for MNCH (including RI) services	2	2
Output 7 – Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities	1	2
PRRINN-MNCH OVERALL SCORE	2	2

PRRINN Output (DFID)	Annual Review Score	2010 Score (previous year)
Output 1 – Effective harmonisation and alignment of all agencies' support for routine immunisation at State and LGA levels	1	1
Output 2 – Improved capacity at State and LGA levels for strategic analysis, policy development, planning and budgeting of routine immunisation	2	2
Output 3 – Primary health care systems strengthened to support routine immunisation	2	2
Output 4 – Increased demand for routine immunisation	1	1
Output 5 – Improved capacity of Federal level to enable States' routine immunisation activities	2	2
PRRINN Overall Score	2	2

1.4 Risk Assessment

(i) The risks originally identified and discussed in the 2010 Annual Review for the PRRINN programme are still valid. The successful management of mitigation strategies is helping to reduce risks. See Annex 10 for an assessment of the PRRINN risks.

(ii) Overall rating of PRRINN remains: High Risk. The PRRINN programme is tipping toward 'Medium Risk' and the Review Team will need to revisit this next year.

(iii) DFID needs to consider the PRRINN-MNCH full programme risks and carry out an assessment of those risks. Currently, DFID only receives Aries reporting on PRRINN and the current risk assessment is only for PRRINN. (The two procurement contracts were issued separately.) Extending the PRRINN-MNCH programme would imply that the DFID reporting should be moved to full reporting on PRRINN-MNCH and that the risk assessment for the full programme be completely updated. The PRRINN-MNCH would be considered High Risk (based on the current revised logframe in Annex 14).

1.5 Summary of Recommendations

General

Recommendation: The extended PRRINN-MNCH programme requires a full risk assessment with a careful look at the demographics and the available funding for the revised programme. DFID should also consider whether an Aries report is required for PRRINN-MNCH for next year's review. The current PRRINN reporting and risk assessment does not cover all of DFID's funding commitments for the full programme.

Output 1: State Governance varies greatly by state. Upcoming elections may result in changes to the existing health structures and systems. On the positive side, Jigawa and Zamfara are looking extremely promising and Yobe has improved more than was thought possible. While the Review Team acknowledges considerable programme work in Katsina, its indicators remain poor. In summary, for this particular output, the programme has possibly done as much as a health programme can reasonably do and requires additional governance expertise and assistance from another source. The need for specialist governance support in health service and planning was noted as PRRINN-MNCH was facing cross-government constraints outside of the health sector. The Review Team suggests that DFID's governance programme (SPARC and SAVI) should play a significant role here. It is important that this programme can demonstrate increased Government ownership and commitment preferably in the form of increased Government financing flows to health at both federal and state level.

Recommendations for Output 1:

For the programme

- Continue good coordinated work at both state and federal level on PHCUOR.
- Keep the basket/pooled funds with a high level of accountability and continue to pursue the idea to pool some Free MNCH money in the same fund.
- Encourage further dialogue in Katsina, in consultation with DFID. There will be a need for more and different advocacy around high level political and budget-related issues. (At present, most advocacy stops at SPHCDA.) There is a SIACC about to be formed in Katsina; PRRINN-MNCH should assess the most useful forum for coordinating partners.

For DFID

- DFID should proceed with plans for additional intervention in the area of governance, building on the knowledge and experience that PRRINN-MNCH already has and the challenges identified.

For DFID (Katsina)

- Consider how to follow up the DFID presentation of the NICS data to the Governor in Katsina State and consider its options in high level advocacy.

- There needs to be more formal collaboration between DFID programmes in Katsina state.

Output 2: Human Resources. While the programme has made considerable progress in human resources policy, management, capacity building and training, it cannot provide suitable health personnel at short notice due to the shortage of female trained health-care providers in Northern Nigeria. Innovative approaches and working with the NPHCDA on the Midwife Service Scheme have begun to fill some gaps. Long-term solutions with midwifery schools will eventually ease the situation but the short-term gaps in human resources are probably this programme's biggest risk.

Recommendations for Output 2:

- Work with the soon-to-be designed DFID programme on building supply of female healthcare workers and share PRRINN-MNCH's experience.
- Continue advocacy for support of NPHCDA MSS to ensure that midwives receive their allowances and are well supported.
- Use the Katsina state employment embargo as an entry point for dialogue with government.
- Use mapping research as an advocacy tool to encourage states and LGAs to place more health staff in rural areas. Consider rural allowances, or other incentives, to keep them there.

Training

- The programme may need to increase technical supervision as clusters are consolidated. Post-training supervision will remain a challenge.
- Help ensure that HR committees are aware of the risk of newly qualified midwives being unsupported.
- The next step is to build staff personal knowledge and skills--ensuring that LGA and state providers can improve their own systems.

Output 3: Service Delivery. A skilled and sufficient workforce is required for the delivery of good quality services. Service delivery represents the culmination of all the programme has worked to achieve. There have been considerable improvements in this area having started from a very low base. It must be remembered that this programme is building something from very little as evidenced by services statistics in single digits (e.g. routine immunization rates in all states of well under 5% as recently as 2003). From this base, the programme is building the ability to deliver comprehensive emergency obstetric care. (Delivering emergency obstetric care 24/7 is to be compared with a functioning Accidents and Emergency Room available around the clock.) All this must be delivered to large populations in a low resource setting and this programme is attempting to see if this can be done at scale in 2 and1/2 states. The Review Team saw the need for considerable improvements still and did not deem the service delivery to be yet 'good enough' and has made suggestions for further improvements.

Recommendations for Output 3:

Routine immunization

- Consolidate RI progress and continue moving forward.
- The cold chain is not yet functioning as reliably as it should. Bring in high-level consultants for continued technical assistance.
- Waste disposal of injection equipment needs attention.
- Logistics and supply issues stem from deep-seated and persistent problems throughout the country and will require constant attention.
- Continue good work increasing leverage from states on routine immunization.

Facility quality
Facility quality needs to be no better than 'good enough' but facilities are not good enough yet.

- Define minimum clinical standards and draw up clear guidelines to ensure the delivery of high quality maternal health services.
- Use all lessons learned as programme moves to new clusters.
- Consider the impact of rapid scale up in next year's review.

Equipment shortages
Crown Agents continues to be a huge bottleneck: Explore alternatives.

Family planning

- There will be many opportunities to include family planning with both ANC and RI clinics.
- Continue to ensure that family planning is part of post-abortion care.
- Continue to work with partners to ensure that family planning supplies continue to be available.

Drug stock-outs remain a perennial problem and good efforts notwithstanding, more needs to be done. In addition, the team found some storage of drugs to be inconsistent (e.g. Oxytocin must be refrigerated). Continue good work on SDSS.

Reporting and recording

- Maternal death audits—Recording needs to be made more robust.
- Referral system—no feedback in some facilities (data needs to travel both up and down).

MSS

- Help ensure that HR committees are aware of the risk of newly qualified MSS being unsupported.

Tailor demand raising with current service delivery reality (balancing outputs 3 and 6—service delivery and demand generation).

Consider **missed opportunities and explore synergies**: Use the forthcoming nutrition programme to promote routine immunization and/or family planning.

For DFID

Crown Agents is impeding the programme in achieving its objectives. This arrangement needs careful scrutiny and perhaps a major change. [See page 22 for more detail.]

Output 4: Operations Research. The programme is using OR to test interventions within the northern Nigerian setting. The OR organizational platform is now operational and various studies are underway. The results of this research, over time, should allow the programme to find innovative ways to achieve the best results for the funds available.

Recommendations for Output 4:

- Promising plans—more understanding of OR plans among all staff would be ideal; the team looks forward to documentation of the Tick study and the results-based financing, in particular. Next year, the evaluation team would ask for increased clarity about state OR plans in the review.
- State ownership and understanding of the operations research agenda should remain a priority although international recognition also is a plus.
- While process is important and necessary, do not over emphasise it as it is only a means to the end which is useful OR on which to base a stronger programme.
- Be sure to build capacity of government staff at HDSS as they will be taking over at programme's end.

Output 5: Information and Knowledge. Again from a low base, the HMIS is functioning and data outputs have improved; particularly in data completion and quality. The system is working and is exceeding expectations (especially in Zamfara).

Recommendations for Output 5:

- Continue to use data to plan and improve coverage and budgeting.
- Maternal death audits are key to improvement so ensure that they are done properly.
- Ensure all pre-printed patient-held health records are available in the facilities.
- Use programme evidence as advocacy to hold politicians accountable, see next.

Output 6: Demand Creation. The Review Team saw excellent work in community engagement on the part of the programme. But the second highest risk to the programme may be found here. Questions remain on whether current resources are adequate to allow full-state scale up. Assessing this risk requires research beyond the scope of this review.

Recommendations for Output 6:

Community engagement

- Emphasize importance of delivery with an SBA as much as danger signs in community engagement.

- Interactions, particularly with the media, focus on knowledge transfer and not on achieving negotiated behaviour change when both will be required;
- Ensure Community Engagement is sufficient to ensure facility births/SBA and consider whether community engagement sustainable. DFID and the programme need to look seriously at the risks and options around these questions.

Voice and Accountability

- More interchange and sharing between the Facility Committees from various communities to expand 'voice' and begin to target the local government on health issues.
- The programme should begin to build on its engagement with SAVI. In Jigawa, PRRINN-MNCH can link with PATHS 2.
- Further work with SAVI to strengthen stakeholder engagement including training in advocacy and policy. Work with SAVI to link with improved services and consider these links: Facility/Community to LGA and then LGA to State. Consider the use of budget monitoring.
- Political engagement needs more careful consideration: Who are the influencers (both at state and LGA level)? Clearer understanding of the role of HERFON is required.
- The programme needs to reach out to the LGA chairmen and other LGA officials as nobody is engaging with them at present.
- Link with improved services—use HMIS data here.

Output 7: Federal Governance - The programme's investment at the federal level is relatively small although it has been prioritized well. While not implying that the NPHCDA is perfect, it is currently functioning more efficiently than some other federal agencies. PRRINN-MNCH's partnership way of working with the NPHCDA is paying dividends.

Recommendations for Output 7:

- Continue the excellent relationship with NPHCDA. Work with them to ensure systems for regular supervision for MSS midwives and CHEWS; and support to NPHCDA to improve recording and reporting at facility level.
- SAVI might assist in advocacy work with PRRINN-MNCH at the federal level, e.g. to work with the MDG Office Conditional Grants scheme at LGA or Governors Forum.

Midterm Review recommendations:

- Intensify the focus on governance in collaboration with other DFID programmes;
- Further expand community based approaches. This may involve identifying additional funding opportunities to expand coverage;

- Assess use of performance based measures to further increase government financing such as requiring matched government commitments as part of the expansion strategy or other performance based aid related requirements;
- Assess the full PRRINN-MNCH risks with a comprehensive modelling exercise of the scale up.

2 Main Report

2.1 Background

This programme incorporates two projects from two funding sources which have been merged into one programme. The 'Programme to Revitalise Routine Immunisation in Northern Nigeria' (PRRINN) project was a DFID-funded programme begun in 2006, as a health system strengthening programme, particularly focused on routine immunisation. In September 2008, the contract to implement the Maternal, Newborn and Child Health (MNCH) programme (funded by the Government of Norway) was awarded to the same consortia managing the PRRINN programme and the two programmes are now fully merged administratively and programmatically. (The one exception to this is that the PRRINN project must still report to DFID using its original five outputs in order to account separately for the DFID funding.) The logframes for both projects (PRRINN and PRRINN-MNCH) can be found in Annex 11.

2.2 Methodology

A multidisciplinary team spent two weeks in total in Northern Nigeria. Some members of the evaluation team have a long history with the programme while other members were new to the programme. This combination is important to be able to both understand progress and see the situation objectively. The review team met with programme staff in Kano before going out to the states and also had access to key documents and reports. In the states, the team met with government staff, other partners, toured health facilities and participated in community engagement work. Each team spent some hours with each PRRINN-MNCH state team at the beginning and end of their visit. Service delivery is the special emphasis of this review and the full terms of reference for the review can be found in Annex 6.

The review team was made up of 21 participants (see table) although all participants did not participate in both weeks of the review. Four team members participated in the full review and provided continuity. Team members were given responsibility to cover one or two project outputs as they went out to the states. Full names and titles of team members can be found in Annex 7 and the full itinerary for the review can be found in Annex 8. Annex 9 includes a list of the persons with whom the team met.

Table 4: Review Teams

Zamfara	Katsina
Carol Bradford, consultant & Team Leader Sarah Dobson, MNCH consultant Lene Lothe, NORAD Edward Idenu, DFID Abubakar Kende, ST Leader Jigawa, Paths2 Violaine Mitchell, Routine Immunization, Gates Bulama Umar Suleiman, SMOH, Yobe	Jane Miller, DFID, State lead Sarah Dobson, MNCH consultant Solvi Taraldsen, OB/GYN, Norway consultant Mick McGill, DFID Jummai Alhamdu, SAVI Steve Fraser, SAVI Daniel Carter, DFID Pharm. Usman Tahir SMOH, Jigawa

Jigawa	Yobe
Carol Bradford, consultant & Team Leader Susan Elden, DFID Abubakar Kende, STL Jigawa, Paths2 Kulchumi Hammanyero, Social Dev, DFID Violaine Mitchell, Routine Immunization, Gates Dr Lawal Aliyu Rabe, SPHCDA, Katsina	Susan Elden, DFID, State lead Dan Kress, Gates Foundation Solvi Taraldsen, OB/GYN, Norway consultant Samuel Usman, Paths2 Saul Morris, Gates Foundation Joe Abah, SPARC

(In addition, Kevin Gager and Adam Suleiman (SAVI) joined the review for key meetings.)

This multi-disciplinary team approach has become a PRRINN-MNCH Annual Review tradition and continues to be effective. Particularly helpful this year was the involvement of two members from PATHS 2, representatives from the DFID programmes SPARC and SAVI, and participants from the Bill and Melinda Gates Foundation. Finally, the state representatives once again participated in reviews of other states than their own. This approach offers opportunities for learning as well as encouraging a healthy rivalry between states. Advance planning by PRRINN-MNCH was good and the team enjoyed efficient and interesting itineraries in each state. Finally, appreciation is due to the PRRINN-MNCH team for providing reports well in advance and for providing an efficient list of documents as well as the documents on CD for each team member.

This report is both a DFID Annual Review and a Midterm Review. The team took a day to meet in Kano and take a 'big picture' look at the programme. Was the programme where it ought to be at the halfway point? Were adjustments needed? Was the programme going to be able to meet its goals by the programme's end? Will the programme be sustainable? The midterm review meeting is written up in section 4 of this report. Annex 12 contains the agenda for that meeting.

3 Assessment against Logframe Outputs

3.1 General Progress

The Review Team was impressed with the progress that the PRRINN-MNCH team had made toward achieving its objectives. However, the review team identified some significant gaps that the programme needs to focus on.

Biggest successes

- Primary Healthcare under one Roof (PHCUOR)—establishment of SPHCDB in Yobe and Zamfara;
- NICS results show clear routine immunization progress;
- Community response beyond programme's expectations; and
- Cluster approach helping to rationalize facilities—also working in phases supports need for sufficient equipment and supplies to perform task.

Biggest problems

- Facility upgrades are not quite 'good enough' yet equipment remains a major issue.
- Programme is coming up against cross-government governance restraints and requires specialist governance support.
- Demand creation activities of the programme may not be sufficient for requirement.

Programme extension: Looking ahead

In last year's Annual Review, the recommendation was made to extend the PRRINN project so that it ended in 2013 and coincided with the end of the MNCH funding provided by the government of Norway. DFID made the decision to lengthen the project for an extra year and increase its original funding by 46 per cent. The original PRRINN project was £19 million to which the Government of Norway added a further £24 million. The new DFID extension adds an additional £19. This brings the funding for the whole programme for six years to £61 million in total.

This means that both the DFID-funded PRRINN programme and the Norway-funded MNCH programme (run as a single programme in a single logframe) will end in 2013. This is good news for the programme as the jointly-funded programmes share most staff. New logframes were developed and ambitious plans to expand the maternal health clusters made. The revised logframes with new milestones can be found in Annex 14.

The programme extension has proportionately less money for the governance component which was reduced by 5 per cent. The Review team is aware that difficult decisions were made by the programme but would like to register some concern at this reduction in a key output.

The first cluster in each state was begun in 2010. In 2011, clusters II and III will begin in each state. In 2012, two additional clusters will be added. Finally, in 2013, one or two more clusters will be completed in each state. This means that Yobe and Zamfara states will be covered completely with clusters and half of Katsina's

population will be covered. (Jigawa's MNCH work was left to the PATHS 2 programme.)

Table 5: Maternal Health cluster coverage of PRRINN-MNCH states to 2013

State	Population	Number of clusters (500,000 people) to cover whole state	Number of clusters planned by 2013	Percent of state coverage
Yobe	2.5 million	5	5	100%
Zamfara	3.5 million	7	7	100%
Katsina	6.5 million	13	6	50%

Recommendations from 2010 report (for 2009)

Overall, the majority of recommendations were accepted and dealt with by the programme. Of particular note:

Commendable:

DFID

- DFID extended the programme as recommended to 2013;
- DFID's use of MOUs to ensure state government understanding and cooperation is giving excellent support to the programme;
- DFID's new programme to address the shortage of female health staff recognises that this is beyond the control of the current programme.

Government of Nigeria

- GON is continuing their momentum on simplifying the health system architecture.
- CHEWS added to MSS.

Remains an issue:

- Crown Agents was highlighted as a bottleneck in last year's report and remains one;
- State government budget and planning is not yet transparent;
- Programme plans to publish HR data and advocacy report in 2011 to facilitate awareness of HR shortages.

Assessment by output

The PRRINN-MNCH programme has seven outputs and the report will present feedback by output.

General

Recommendation: The revised PRRINN-MNCH logframe requires a full risk assessment. DFID should also consider whether an ARIES report should be considered for PRRINN-MNCH for next year's review. Current PRRINN reporting does not cover all of DFID's funding commitments for the full programme.

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

Primary Healthcare Under One Roof (PHCUOR) approach continues to look extremely promising by pulling together a fragmented primary healthcare system into a single decentralised authority with responsibility and accountability and one management plan and M&E system. In both Yobe and Zamfara, the PHCUOR bills were passed and signed into law, committing states to specified spending on PHC as a proportion of state funds. In Yobe, the state appointed a Board Chairman and members of the State Primary Health Care Board. At Federal level, policy documents and implementation guidelines were endorsed by the NPHCDA Board who will now take them to the next National Council of Health for ratification. In Jigawa, the Gunduma Board applies many of the PHCUOR principles. The process in Katsina is currently stalled.

Table 6: Primary Healthcare Under One Roof (PHCUOR)

What does Primary Healthcare Under One Roof actually mean?
• One single management body • Enabling legislation and regulations • Decentralised authority, responsibility and accountability • One management, one plan, and one M&E system • Integrated supportive supervisory system • Integration of all PHC services under one authority

Source: Workshop on 'Bringing PHC under one roof' (2010).

MSP and Free MNCH. There is continued good coordinated work at both state and federal level. For example, the costing of the minimum service package (MSP) is completed in Yobe, Zamfara and Katsina and the costing of free MNCH is completed in Yobe and Katsina. In Zamfara, the costing of free MNCH is ongoing. The final report on costed, free MNCH was shared with other DFID programmes working in the health sector.

Pooled funds. Each state has its own model and mechanism for transparent pooling of resources (e.g. the Primary Health Care Fund (known as the "basket fund" in Zamfara). Each demonstrates promise as an LGA sharing formula as well as an opportunity to pool some Free MNCH funds alongside those for Routine Immunisation. State models are in early stages and their long term sustainability remains uncertain in the current political climate. Eventually, the aim is to no longer require a transparent pool fund as the government funds will be flowing smoothly. Meanwhile, keep these funds with a high level of accountability (but see next).

State and LGA contributions are not always disbursed and Government officials are reluctant to release financial information to outsiders. State governments are not always making their own contribution to the funds nor releasing money to the LGAs (so that they can contribute). Changing the budget structure and process may be beyond the scope of the programme's mandate.

Budget tracking, flows and releases remain a big problem at both the state and LGA level. Expertise from the outside is needed to conduct Public Expenditure Tracking Surveys. The states are poor at making meaningful budgets in the first instance and then poor at estimating and tracking their actual revenue. Unsurprisingly, fiscal projections are often politically driven rather than based on real needs. Fiscal discipline is lacking as well as the enforcement of proper policy and procedures. The programme made the most progress in Zamfara where some tracking of budget flows was possible this year. The problems there are a mixture of a lack of political will and, in some cases, capacity. Further pushing on the part of the PRRINN-MNCH staff risks straining the relationship between the programme and the Government. This is where SPARC and SAVI could possibly work with PRRINN-MNCH to make further progress (e.g. use of media and State Houses of Assembly in oversight and budget formulation, and in identifying viable civil society groups from the community to state and federal level for advocacy work)

Working with governance and voice and accountability programmes: In trying to deliver its outputs, PRRINN-MNCH has encountered some of the wider governance challenges that stand in the way of positive changes in the Nigerian state and local government. These difficulties have been especially marked in the areas of Public Financial Management (particularly around the non-release of allocated funds) and in Public Service Management (especially around the failure to post suitable staff to rural locations). PRRINN-MNCH is not currently resourced to engage with state governments at the Central Ministry or Executive levels to address these wider issues. It is within this context that DFID perceived the need for additional intervention in the area of governance from specialist governance programmes. The general objective of planned engagement in these states is to improve governance across the board. However, it would be sensible to start by building on the knowledge, experience, intelligence and data that PRRINN-MNCH already has, and the challenges that have already identified.

MOUs signed with DFID. MOUs were signed with DFID in Yobe and Zamfara and M&E frameworks are being discussed.

Katsina has not made substantial progress on routine immunisation. This is a key indicator of a poorly functioning health system. The state must look inward at the real problems (e.g. PHCs owned by local government). The poor progress in Katsina is believed to be partly due to lack of clear state level planning and budgeting but also the absence of a forum to bring the SPHCDA and LGA's together. While PRRINN-MNCH has a good relationship with key stakeholders, there was a real lack

of urgency by state government in prioritizing PHC which is being demonstrated by the poor statistics. Weak budget allocation and non-strategic financial allocation reflects a lack of political will. There will be a need for more and different advocacy around high level political and budget-related issues. (At present, most advocacy stops at SPHCDA.) There is a SIACC about to be formed in Katsina; PRRINN-MNCH should assess the most useful forum for coordinating partners. Proceed carefully in Katsina, in consultation with DFID.

Recommendations for Output 1:

For the programme

- Continue good coordinated work at both state and federal level on PHCUOR.
- Keep the basket/pooled funds with a high level of accountability and continue to pursue the idea to pool some Free MNCH in the same fund.
- Encourage further dialogue in Katsina, in consultation with DFID. There will be a need for more and different advocacy around high level political and budget-related issues. (At present, most advocacy stops at SPHCDA.) There is a SIACC about to be formed in Katsina; PRRINN-MNCH should assess the most useful forum for coordinating partners.

For DFID

- DFID should proceed with plans for additional intervention in the area of governance, building on the knowledge and experience PRRINN-MNCH already has and the challenges identified.

For DFID (Katsina)

- Consider how to follow up the DFID presentation of the NICS data to the Governor in Katsina State and consider its options in high level advocacy.
- There needs to be more formal collaboration between DFID programmes in Katsina state.

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

Human Resources Information System. Excellent progress with the HRIS; the team saw evidence of government buy-in for this resource. HR Admin software has been installed and training on its use has been conducted in all states. State level senior health officials in both Jigawa and Zamfara told the team how useful it has proved. In Yobe, the number of non-productive staff (ghost-workers) on the payroll came to light through the process of human resource mapping. The critical issue will be for the state to gain good control over staffing and financing in order to achieve health impact. The review team saw good pro-active work embedding human resources into state plans and policy and addressing gender issues; and also good reactive work by introducing person to post matching and exposing ghost workers.

Rural staff shortages. The overall shortages of staff in rural areas remain a challenge. (This shortage is well documented in the MNCH baseline survey.) The refusal of posting to rural areas continues to be an issue that PRRINN-MNCH is tackling. Ultimately, this will depend on Government commitment to be willing to

offer incentives to staff to be posted to rural areas. (This is a strategy that has been adopted in Yobe.)

Shortage of female health workers. The programme has been exploring models for deploying and supporting female CHEWS to work at community level. In Jigawa, these CHEWS required a refresher course to increase their practical skills to enable them to be an effective link between the community and the facilities in handling referrals and feedback. The shifting of CHEWS to community outreach is largely dependent on ensuring adequate staffing at facility level. This can only be achieved over a longer period of time as interventions are put in place to help girls in Northern States qualify for entry to courses for the health professions. (DFID are currently considering new interventions to increase female workers in a new programme they are developing.)

Meanwhile, the Nursing-Midwifery council have not accepted that a new cadre of staff should be trained above the level of a CHEW and below that of a midwife to perform as a skilled birth attendant. PRRINN-MNCH is maintaining a dialogue as to the acceptance of a possible bridging course of 18 months (as opposed to 3 years for basic midwifery training) which would allow CHEWS to achieve a midwifery qualification. This remains at a formative stage but is clearly worth pursuing.

Midwife Service Scheme (MSS). The scheme, run by NPHCDA, is working relatively well in addressing the shortage of midwives in northern rural areas and despite some persistent problems, should be considered a success. MSS midwives were found at the PHC facilities visited, to be well engaged with their work and well received by the communities. In addition to midwives, female CHEWS have been deployed to rural areas under this scheme. Shortages, however, remain an issue and the programme has seen both drop outs as well as fluctuating attendance with some returning home for periods of time. Among the MSS midwives asked, their greatest concern was the failure of the State and LGAs to pay their allowances which act as an additional work incentive on top of their salary (provided through the NPHCDA). Accommodation was also sometimes an issue. Their value to the community is evident as the latter have provided accommodation where this has been lacking from the LGA.

Although the NPHCDA clearly stated that new graduates were not to be posted alone without initial support from an experienced midwife, it was observed by the review team that this is in fact happening and given acute staff shortages, there is risk it will continue. These new graduates would not have the experience to proficiently manage obstetric emergencies alone prior to referral or to proficiently mentor CHEWS until they have gained experience. This is more likely to result in poor retention of these midwives and, if unable to handle an emergency, it may lead to loss of their credibility with the community.

Training. The amount of training conducted over the past year is impressive with good coverage of health staff in facilities visited. (54 % of professional staff had been given in-service training in MNCH in targeted PHC facilities by the end of 2010 (milestone 25%) and 62% of targeted facilities had at least one health worker trained in LSS (MS 40%). In all facilities visited it was clear that training coverage was high and included IMCI, KMC, ENC, LSS EOC and NC and FANC. Staff also confirmed that they had received one follow-up visit by trainers (LATH) and ongoing supervision through integrated supportive supervision. In addition, approximately 40% of health workers trained were outside of the project clusters. PRRINN-MNCH must be congratulated on this coverage. However it is imperative that they support the state in ensuring that supervision is delivered by adequate numbers of staff with strong

technical capacity and is rigorous in looking at clinical competence i.e. knowledge transferred to practice. The programme may need to increase technical supervision as clusters are consolidated; post-training supervision will remain a challenge. Supervisory teams would benefit from having representatives from state level and occasionally federal level institutions (clinical tutors and obstetricians). PRRINN-MNCH benefit hugely from having clinical staff on their teams and are therefore in a strong position to work with states and LGAs to strengthen this area.

The current **Katsina employment embargo** does reduce inappropriate staffing (filling posts with staff without the right qualifications), its intended purpose. It does not ensure that needed employment gaps will be properly filled, however, and should not last too long. This issue would make a good entry point for dialogue with government. When there is funding for new posts, it should be used as an advocacy opportunity, with both PRRINN-MNCH and government recognising that the issue of ghost workers is a problem.

Recommendations for Output 2:

- Work with the soon-to-be designed DFID programme on building supply of female healthcare workers and share PRRINN-MNCH's experience.
- Continue advocacy for support of NPHCDA MSS to see that midwives receive their allowances and are well supported.
- Use Katsina employment embargo as an entry point for dialogue with government.
- Use mapping research as an advocacy tool to encourage states and LGAs to place more health staff in rural areas. Consider rural allowances, or other incentives, to keep them there.

Training

- The programme may need to increase technical supervision as clusters are consolidated. Post-training supervision will remain a challenge.
- Help ensure that HR committees are aware of the risk of newly qualified midwives being unsupported.
- The next step is to build staff personal knowledge and skills-- ensuring that LGA and state providers can improve their own systems.

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

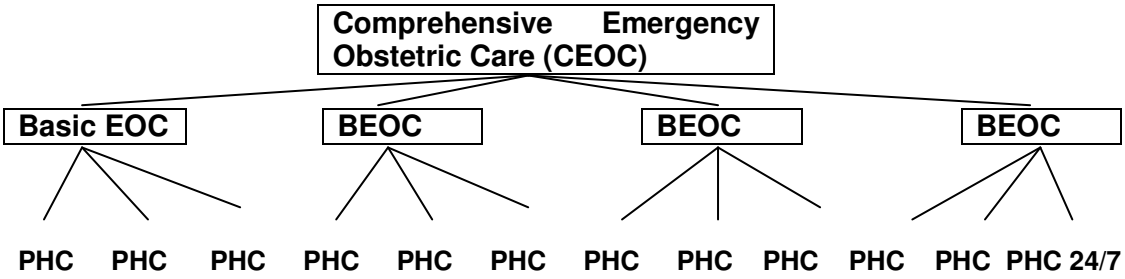
[NOTE: Service delivery is priority for this year's review.]

General service delivery. It is clear that good progress has been made on service delivery over the last year and the review team do not underestimate the efforts achieved and substantial progress made. Service delivery is one of the more complex and multidimensional areas of the programme and PRRINN-MNCH staff have demonstrated a clear recognition of the challenges and initiated steps toward addressing these. The recommendations made here serve to reinforce the steps necessary to tackle these mutually identified issues.

The Cluster approach used to deliver services in this programme is radical for Nigeria. And it solves two problems at once: rationalization and adequacy for task. A huge health system problem has been too many poorly placed and under-

resourced facilities in the country. Nobody could identify which facility to close down and supplies were spread thinly or not present at all. The maternal cluster system provides the rationale for one CEOC able to perform all nine signal functions, four BEOC able to perform seven of the signal functions, and eight Primary Care Facilities where staff are trained to identify maternal cases that require referral. Each facility must have all it needs to perform the requisite signal functions. PRRINN-MNCH will only proceed in this cluster approach, demonstrating in the process a functioning three-tiered health system.

Figure 2: An illustration of a CEOC Cluster



(Actual: 8 PHCs per BEOC)

Equipment shortages continue to dog the programme and Crown Agents continues to be a huge bottleneck. In fact, the greatest set back to the delivery of services is the significant delay by the supplier 'Crown Agents' on the delivery of essential equipment for facilities (now 15 months behind schedule). This has had numerous repercussions for the programme including: inability of trained health staff to put knowledge into practice following the huge gains made in training over the last year; inability for EOC facilities to fully meet the signal functions at any level; and pressure on the poorest to pay for drugs and supplies from the private market.

Specifically, the issues include agreement of compliant standards for suppliers, the high cost of items on the lists, and measures for reducing lead times for delivery of procured items. In addition, Crown Agents were unable to provided information on freight charges on equipment. In sum, the procedures of Crown Agents remain exceedingly complex. (see page 10)

Routine Immunisation. PRRINN-MNCH appears to have made very substantial progress in routine immunization. Immunisation coverage has increased in all states, with Jigawa showing the greatest increase in coverage of any state in Nigeria; yet there is still limited progress in Katsina. Immunisation services are now offered weekly at most health facilities and Jigawa is moving towards daily services in more populated settings. The programme should consolidate its achievements and ensure further progress as coverage needs to be increased to ensure herd immunity and to protect against outbreaks due to state to state variations.

While Routine Immunization has shown major progress, it is still an unfinished agenda:

- The cold chain is not yet functioning as reliably as it should.
- Waste disposal of injection equipment needs attention as only one facility the team inspected was making use of their properly constructed incinerators.
- Logistics and supply issues stem from deep-seated and persistent problems throughout the country (documented in the SDSS survey) and the programme is addressing them. Still, that there has been so much good progress shows that there is hope for more.

- The evaluation team lauds the programme for continued excellent relationships with WHO on improving the dialogue and integration of routine immunisation and polio. Both at national and state level, the PHCDA, WHO and UNICEF have acknowledged the outstanding efforts made by PRRINN-MNCH in this area.

Most maternal health milestones exceeded. This last year has seen a significant and encouraging rise in the number of ANC visits in facilities. In 2010, 39,272 mothers attended the ante-natal care first visit (milestone 19,365) and 22,170 deliveries were attended by SBA (milestone 10,886) in targeted clusters. (These milestones may have been underestimated and are adjusted in the revised PRRINN-MNCH logframe.) This is likely to be associated with the presence of MSS midwives and female CHEWS deployed under the MSS scheme but also to strong community engagement by PRRINN-MNCH. While women mainly continue to stay in the community for delivery, this is slowly changing. At one BEOC facility in Yobe a considerable change had been noticed from 2009 when there was only male staff present, no deliveries and no FP services. By 2010 there were female staff in place 24/7 (2 MSS midwives and 2 MSS CHEWS) resulting in 142 deliveries. The number of maternal complications transferred to health facilities via the emergency transport scheme was 1, 115 (milestone 150)—a six fold increase. Caesarean section cases were reported at 0.5% (milestone 0.5%). On the other hand, only 12% of births were attended by SBA in targeted clusters—far below the milestone of 21%, see next.

Table 7: Maternal Health Signal Functions

Used to identify basic and comprehensive emergency care services

Basic Services	Comprehensive Services
1) Administer parenteral antibiotics	*Perform signal functions 1-7 PLUS:*
2) Administer uterotonic drugs (e.g. parenteral oxytocin)	8) Perform surgery (e.g. caesarean section)
3) Administer anticonvulsants for pre-eclampsia and eclampsia (e.g. magnesium sulphate)	9) Perform blood transfusion
4) Manually remove the placenta	
5) Remove retained products (e.g. manual vacuum aspiration)	
6) Perform assisted vaginal delivery (e.g. vacuum extraction)	
7) Perform basic neonatal resuscitation (e.g. with bag and mask)	
A BEOC facility can perform functions 1-7.	**A CEOC facility can perform functions 1-9.**

Balancing the supply and demand of facility-based deliveries.
Rates of home-based delivery have not substantially decreased, particularly in rural areas. As facilities in targeted clusters begin to function properly (with female SBA and adequate medical equipment and supplies) and community engagement activities alert communities to these changes and educate them about the advantages of facility-based deliveries, facility-based delivery should increase. In cluster I, the review team was not able to yet see all these supply-side improvements yet in place.

Quality of refurbishment of facilities in state clusters shows major improvement but are still not quite 'good enough' (see box in Executive Summary). Issues remain to be addressed in the first cluster. It is acknowledged that addressing the quality maternal health services is extremely complicated and that the staff are making major progress in increased antenatal visits (milestones exceeded) and skilled birth attendance. Issues remain to be addressed in cluster I and renovation needs to be given very careful attention to ensure that it is able to support delivery of a good standard of care. For example, in Yobe a bore hole was not connected at one facility and there were no curtains provided for privacy in the delivery room. At a CEOC in Zamfara there was no acceptable provision of an area in or around the operating theatre for staff to prepare, including changing and hand washing. Whilst the team acknowledges that it is the state that leads the activity, the programme staff have themselves acknowledged the need to be vigilant in monitoring activity at this early stage to ensure the minimum standard is sufficient and to check that refurbishment has been carried out as planned prior to the scale up of the programme. The programme needs to:

- Define minimum clinical standards and draw up clear guidelines.
- Use all lessons learned as programme moves to new clusters to ensure the delivery of quality maternal health services.
- The review team did not know of the planned rapid scale up was possible by 2013. The programme should proceed with finalising cluster I and begin on subsequent clusters and next year's review team should consider the pace of the rapid scale up again. This reconsideration would be based on progress in clusters I and II and improvements in clinical standards (as above) and the arrival of key equipment, see next.

Family Planning. The evaluation team noted considerable progress on family planning in one year. It is very encouraging to see increases in commodity availability and family planning provision. Nearly all of the facilities visited had FP commodities in stock. The CEOC visited in Katsina was fully supplied with virtually a full range of methods available. The register at CEOC level showed up to 14 women being supplied with family planning per day. At the same facility, all nurses in the female ward had been trained to perform manual vacuum aspiration (MVA) and the equipment looked good. According to the MVA register, all patients were offered family planning which is best practice. It was also apparent through talking to women both in facilities and to community volunteers that they were aware of the benefits of child spacing (mainly to recover the women's strength/health prior to the next pregnancy) and that there was substantial demand from women. It should be noted, however, that women were very unwilling to discuss family planning openly as it was seen as a private and personal choice. In addition, the programme should be commended for its work with traditional and religious leaders who have been supportive of family planning. (State level forecasts of the unmet need for contraceptives are beyond the scope of this review.)

Drug stock-outs and storage remain a perennial problem and good efforts notwithstanding, more needs to be done. In addition, the team found some storage of drugs to be inconsistent (e.g. Oxytocin must be refrigerated). There were serious drug stock outs of Government supplies (free MNCH drugs) in most facilities visited and in two CEOCs, this included Magnesium Sulphate. Pharmacists informed us that resupply arrived twice a year and was often incomplete. SDSS drugs have arrived recently in some facilities but attention should also be given to cold storage of items when required. A limited supply of emergency obstetric drugs should be readily accessible to maternity departments and not locked in pharmacies (observed in some CEOCs).

Integrated Service Supervision Training. While it is acknowledged that health providers cannot become proficient in newly taught skills if the drugs and equipment to perform them are absent for a considerable period of time, it is important that supervision thoroughly supports staff in clinical practice. It should ensure that practitioners are referring to and using case management protocols, where they are unsure of procedure. This was not always apparent on the review (on observation of clinical care). This is likely to prove one of the major challenges to PRRINN-MNCH staff, particularly as they scale up the programme. And the next step is to build staff personal knowledge and skills--how can they improve their own systems (e.g. addressing drop-outs)?

Newborn Care. Unfortunately there was not sufficient time to assess newborn care in any detail. However, staff had been trained in Kangaroo Mother Care (KMC) and Newborn Care and Life-saving skills. Equipment for newborn resuscitation was not yet available. What was apparent is that early and exclusive breastfeeding is being promoted and women are receptive and practising this.

Reporting and recording is improving and the programme should be commended for this. However, maternal death audits needed improvement. In 2010, the programme has conducted training in maternal and perinatal death audits and supported the establishment of Quality Improvement Committees in BEOC and CEOC facilities within the target clusters. Clinical audits should be a key tool in improving case management; however their effectiveness depends on the quality of information recorded. At CEOC level in Katsina, the review team tried to track data from delivery registers at the maternity unit and registers kept in hospital's register unit down to actual caesarean section (CS) cases and maternal deaths. In general, clinical data is not available after patients have left the hospital and referrals cannot be traced. Some but very few data are transferred from the delivery register to note books in the register unit, like CS performed, child born alive, and mother dead, but nothing regarding indications and treatment. This means that clinical events like CS and perinatal deaths cannot be reconstructed and makes it very difficult to review and improve practices based on cases treated and results. The audit reports we saw were well structured and filled in carefully, including recommendations for improvements. (This data should then be used for advocacy work—either to highlight the problem or illustrate improvements.)

Referral. It was noted that feedback forms on referrals are not being returned to the referring facility. This is apparently partly because women are leaving the facilities prior to formal discharge.

Missed opportunities. Use events like nutrition distribution to promote routine immunization and/or family planning. It was noted by the review team in Katsina that there was a very large response to the Nutrition outreach day (UNICEF and SCF) at BEOC level. This was seen as a good opportunity for integrating other activities such

as promotion of family planning and health education. It also provides an opportunity for immunisation, including Tetanus Toxoid for women of reproductive age.

Recommendations for Output 3:

Routine immunization

- Consolidate RI progress and continue moving forward.
- The cold chain is not yet functioning as reliably as it should. Bring in high-level consultants for continued technical assistance.
- Waste disposal of injection equipment needs attention.
- Logistics and supply issues stem from deep-seated and persistent problems throughout the country and will require constant attention.
- Continue good work increasing leverage from states on routine immunization.

Facility quality

Facility quality needs to be no better than 'good enough' but we are not there yet.

- Define minimum clinical standards and draw up clear guidelines to ensure the delivery of high quality maternal health services.
- Use all lessons learned as programme moves to new clusters.
- Consider the impact of rapid scale up in next year's review.

Equipment shortages

Crown Agents continues to be a huge bottleneck: what are the alternatives?

Family planning

- There will be many opportunities to include family planning with both ANC and RI clinics.
- Continue to ensure that family planning is part of post-abortion care.
- Continue to work with partners to ensure that family planning supplies continue to be available.

Drug stock-outs remain a perennial problem and good efforts notwithstanding, more needs to be done. In addition, the team found some storage of drugs to be inconsistent (e.g. Oxytocin must be refrigerated). Continue good work on SDSS.

Reporting and recording

- Maternal death audits—recording needs to be made more robust.
- Referral system—no feedback in some facilities (data needs to travel both up and down).

MSS

- Help ensure that HR committees are aware of the risk of newly qualified MSS being unsupported.

Tailor demand raising with current service delivery reality (balancing outputs 3 and 6).

Consider **missed opportunities and explore synergies**: Use the forthcoming nutrition programme to promote routine immunization and/or family planning.

For DFID

Crown Agents is impeding the programme in achieving its objectives. This arrangement needs careful scrutiny and perhaps a major change.

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

The Review Team could see much evidence of progress in operations research since last year. Progress included:

- Establishment of OR governance structure and capacity for research in all states
- Operational Research Advisory Committees are now functional in each state. There are also sub-committees for technical, ethics, and advocacy issues. State Ethics Review Committees were trained by the West African Bioethics Committee.
- All states have established baselines and have begun implementation on their OR studies (see table below).
- Five pieces of OR into supply and demand aspects of MNCH have fed into the programme including rapid demand-side assessment of barriers to MNCH services forming the basis of the design of demand side approach in all states.
- Also, findings of the study on the clustering of child mortality have led to plans to train CHEWs operating in communities to recognise high risk families.

Table 8: State Operations Research Implementation

State Operations Research implementation	
Jigawa	Community-based service delivery scheme
Katsina	Mobile ambulance services (MAS) Health facility performance-based financing (Gift bags for giving births in facilities, being considered)
Yobe	Outreach MNCH services Demand-side PBF
Zamfara	Using Women's groups to increase MNCH service uptake: Women Investing Savings for Health (WISH) groups TICK study: system of tallying immunizations
Other Studies	Child mortality clustering study Demographic surveillance

The team saw excellent progress on the **Health and Demographic Surveillance Facility** (HDSS) in one year and the full baseline census competed of the Nahuche Keku district (102,000 population). The Facility is now fully staffed and equipped and it will be important to build capacity of government staff as they will be taking over at programme's end.

Recommendations for Output 4:

- Promising plans—more understanding of OR plans among all staff would be ideal; the team looks forward to documentation of the Tick study and the results-based financing, in particular. Next year, the evaluation team would ask for increased clarity about state OR plans in the review.
- State ownership and understanding should remain a priority although international recognition also a plus.
- While process is important and necessary, do not over emphasise it as it is only a means to the end which is interesting and useful research on which to base a stronger programme.
- Be sure to build capacity of government staff at HDSS as they will be taking over at programme's end.

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

Health Management Information Systems (HMIS). The Review Team saw continued improvement in the use of information for the management of the health system. Those who had been on several reviews were very impressed with the progress made in building a 'data culture' when just a few years ago it had seemed somewhat improbable. Particularly in Zamfara, the facility submission rate is very high and the systems and procedures for an integrated system have been established with great success. The state HMIS databank for Zamfara in the MOH HQs is now used as the main data source for partners (when it used to be that the partners were the only ones with the data).

The next step is to continue working on analysis and use of the data for problem solving and improving MNCH coverage across all four states. The review team next

year should see evidence of HMIS and clinic staff understanding how data can be used to improve services.

Tracking maternal deaths is always difficult but the team were concerned that many maternal deaths could be being missed. Some but very few data are transferred from the delivery register to note books in the register unit (E.g. CS performed, child born alive, mother dead) but nothing regarding indications and treatment. This means that clinical events like CS and perinatal deaths cannot be reconstructed and makes it very difficult to review and improve practices based on cases treated and results.

- Maternal death audits—what is recorded? Make it more robust.
- Referral system—no feedback in some facilities (data needs to travel both up to the state level to be centrally recorded as well as back down to the facilities so facility staff understands what happened to the women they referred).

Patient-held health records provide important information regarding the care needs of Northern Nigerian women and they, in turn, seem very well able to save and guard their own records. And yet:

- ANC cards were not always available in facilities (e.g.Katsina didn't have any pre-printed patient held records and women-held records were school exercise books in which notes were disordered and difficult to follow).
- Availability of immunization cards was inconsistent across the facilities.

Use **programme evidence as advocacy** to hold politicians accountable, see next.

Knowledge Management. PRRINN-MNCH has begun to have a more public face. The programme has developed a brochure and a website this year—both of high quality. The programme has also submitted some articles for publication. One article in Open Demography appeared while the team was in Nigeria: 'Northern Nigeria Maternal, Newborn and Child Health Programme: Selected Analyses from Population-Based Baseline Survey'. The article provides good baseline data and outlines the difficult conditions in while the programme is working. More publications like this as the programme proceeds will bring it to moderate international attention. In addition, the programme can use this data for evidence-based advocacy—to make the problems real to politicians.

Recommendations for Output 5:

- Continue to use data to plan and improve coverage and budgeting.
- Maternal death audits are key to improvement so ensure they are done properly.
- Ensure all pre-printed patient-held health records are available in the facilities.
- Use programme evidence as advocacy to hold politicians accountable.

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

The Review Team saw a tremendous amount of work by a very small Output 6 team. There has been considerable innovation and learning from what works.
For example:

- Community mobilization efforts have identified volunteers and blood donors;
- Emergency transport schemes are functioning in many communities;
- Community members are well aware of when immunisations are offered and when their children should be brought for their vaccines;
- Emergency maternal care savings are set up in many communities;
- Committees are monitoring drug availability; and
- Many health jingles have been aired.

The Emergency Transport Scheme (ETS) system appears to be known in rural areas in all states, pulling in a variety of stakeholders. In Yobe the team heard about a case of a woman with post partum haemorrhage identified by community volunteer who called for ETS – resulting in successful rapid transport and a life saved.
Unfortunately, many of the problems under this output relate to how much there is to do and how little money and staff there is to do it with. This output is under-resourced.

Community engagement. The team saw excellent progress on the complicated and delicate process of community engagement. There has been considerable innovation and learning from what works. However, there was considerable worry in the team about whether Community Engagement component is sufficient to the need. In Yobe, Zamfara and Katsina, targeted MNCH community engagement activities are aimed at approximately 1% of the population (or less). Such activities, however successful, are unlikely to alter population-based health indicators. The question becomes: Is Community Engagement sufficient for the need? Is there sufficient emphasis on negotiated behaviour change beyond knowledge transfer? The team felt this output was under-resourced (at 19% of 2010 funding). (See Midterm Review section for further discussion.) In undertaking the PRRINN-MNCH risk assessment, these questions deserve special attention. If the CE component is found to be insufficient to spur the use of the improved health facilities, ways to increase CE funding for more activities will have to be explored.

The next question is will this amount of community engagement mean sufficient facility-based births with a skilled birth attendant? How to address the 'stay at home' syndrome which has been encouraged both by the culture and by the polio eradication approach will continue to be a challenge for the programme. The biggest challenge will be working out how the community engagement activities can be spread to surround each new cluster. PRRINN-MNCH community engagement should focus as much on the importance of delivery with SBA as on the danger signs. In one community visited the men were clearly under the impression that women only need transfer once there is a sign of a complication arising. It is important that Community engagement also raises awareness of the high risks of complication occurring in the early postpartum.

Voice and Accountability. PRRINN-MNCH is creating the pre-condition for voice and accountability whereby communities are able to hold their service providers accountable—but not as yet, the authorities (SPARC and SAVI's role). The programme should be getting facility data out to health facility committees. The Health Facility Committees then need to work together to push the LGAs to do more. This stronger relationship could translate into deeper commitment for the Chairman of the LGA on issues relating to health. In addition, there needs to be more interchange and sharing between the Facility Committees from various communities to expand the voice.

Monitoring local government spending would be within PRRINN-MNCH's remit. HERFON should also be working with the programme to play a major role. The programme should continue its engagement with SAVI and, in Jigawa, PRRINN-MNCH can link with PATHS2. (It should be noted, however, that SAVI's current mandate is not to reach down to LGA level.) Further work with SAVI to strengthen stakeholder engagement including training in advocacy and policy at State Level (including SHoA) would strengthen the programme's work. SAVI is well versed in how to link with improved services and working out who are the influencers. This assistance can take place at state level already. Improvements in voice and accountability at local government level will have a far reaching effect and should be prioritised.

Recommendations for Output 6:
Community engagement

- Emphasize importance of delivery with an SBA as much as danger signs in community engagement.
- Interactions, particularly media, focus on knowledge transfer and not negotiated behaviour change when both will be required;
- Ensure Community Engagement is sufficient to ensure facility births/SBA and consider whether community engagement sustainable. DFID and the programme need to look seriously at the risks and options around these questions.

Voice and Accountability

- More interchange and sharing between the Facility Committees from various communities to expand the 'voice' and begin to target the local government on health issues.
- The programme should begin and build its engagement with SAVI. In Jigawa, PRRINN-MNCH can link with PATHS2.
- Further work with SAVI to strengthen stakeholder engagement including training in advocacy and policy. Work with SAVI to link with improved services and consider these links: Facility/Community to LGA and then LGA to State: Consider the use of budget monitoring.
- The programme needs to reach out to the LGA chairmen and other LGA officials as nobody is engaging with them at present.
- Political engagement needs more careful consideration: Who are the influencers (both at state and LGA level)? Clearer understanding of the role of HERFON is required.
- Link with improved services—use HMIS data here.

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

PRRINN-MNCH is clearly a respected player in RI and increasingly MNCH at the federal level judging from its participation in key meetings and the interviews with federal staff. This is even with a small staff presence in Abuja.

A subset of the evaluation team met with **NPHCDA** (Dr Pate and all his senior staff). Dr Pate mentioned that he planned for PHCUOR to be his 'legacy'. In addition, the team discussed with NPCHDA senior staff:

- The importance of ensuring systems for regular supervision for MSS midwives and CHEWS;
- Support to NPHCDA to improve recording and reporting at facility level.

FMOH—Perhaps after the election, more areas of promising work will open up here.

Recommendations for Output 7:

- Continue excellent relationship with NPHCDA. Work with them to ensure systems for regular supervision for MSS midwives and CHEWS; and support to NPHCDA to improve recording and reporting at facility level.
- SAVI might assist in advocacy work with PRRINN-MNCH at the federal level, e.g. to work with the MDG Office Conditional Grants scheme at LGA or Governors Forum.

4 Midterm Review: PRRINN-MNCH

4.1 Midterm Review Discussion

The Evaluation team spent one day in Kano to discuss the programme's progress from a "big picture" perspective. The agenda for this meeting (with the discussion questions) can be found in Annex 12.

Looking back:

The team concluded that the programme was making good progress towards its objectives and was where it ought to be halfway through the programme (based on milestone achievement as well as state visits and interviews with key informants). The programme has met or exceeded all of its milestones at purpose level except the proportion of births delivered by skilled birth attendants and had achieved the majority of it milestones at output level.

How good was the programme design? The group discussed whether there were any aspect of the programme design that could have been omitted. The group considered the importance of the Operations Research component and decided that the learning from the programme was part of its success. After some debate, the governance component was deemed by most of the group as an essential part of the program design, but agreed that there were limits to how much a health programme should push the very challenging governance issues. Too much pressure from within the programme could be counterproductive and damage the ability to progress on important health service delivery issues. The group then debated if there could have been others who could have reliably carried out the infrastructure rehabilitation. While there were many good suggestions, it was concluded that using anybody else would have severely slowed the programme's progress. In the end, the group concluded that the programme had been well designed and that there was little change they would make to the current programme design (except suggesting that it might benefit from more resources).

What interventions are missed? The group agreed that while maternal and neonatal needs were well addressed, the programme addressed relatively few inputs that would make a substantial contribution toward reducing child mortality—other than routine immunization.

Looking forward:

PRRINN. The programme began in 2007 as a routine immunization programme and it is looking very likely that the original PRRINN logframe indicators will be met or exceeded.

PRRINN-MNCH. The addition of maternal, neonatal, and child health inputs made the programme much more complicated as delivering quality MNCH services (even within a comprehensive maternal care cluster) is exceedingly difficult to do. Without the ground-breaking work of the original PRRINN health system strengthening-RI project, it might have been very difficult. PRRINN-MNCH is currently working on its first CEOC cluster and the Review Team has deemed the work to be very good but not quite yet 'good enough' and maintains that there are some significant gaps that the programme will need to address.

The Revised and extended PRRINN-MNCH. This current programme design builds on the previous but includes an ambitious scale-up of maternal health clusters. It is the aim is to develop a functioning health system that is staffed, trained and equipped in a rational and comprehensive way to save (in the most cost-effective way possible) the most maternal and child lives. The scale up will cover 100% of Zamfara and Yobe and 50% of Katsina. The MTR team questioned whether this was possibleand resources would be adequate.

The risks for this achievement need a careful examination and a mitigation strategy need to be completed. This exercise might go a long way to answering these questions.

Will the programme purpose and goal be achieved in 5/6 years?

This programme is likely to meet its realistic logframe milestones because they have been carefully set as ambitious but not impossible. The sad reality is that the baseline indicators are so low in these four states (e.g. contraceptive prevalence rates of less than 2% (national CPR=15%) or caesarean rates of less than .5% (WHO recommends minimum rate of 10%) that progress is made from a very low base. Proving that a health system can function in Northern Nigeria and make slow and steady improvement in a difficult setting will be an important programme outcome. Showing that it can be done with the Government (instead of next to the Government) is something very difficult indeed. The Review Team toured an MSF maternity hospital in Jigawa and it was delivering much-needed services very well indeed. However, it did not represent reality in Northern Nigeria and reality is what is required to make a population-based difference.

Here is a brief consideration of each output and its likely outcome:

Output 1: State Governance varies greatly by state. Upcoming elections may result in changes to the existing health structures and systems. On the positive side, Jigawa and Zamfara are looking extremely promising and Yobe has improved more than thought possible. While the Review Team acknowledges considerable programme work in Katsina, its indicators remain poor. In summary, the programme has possibly done as much as a health programme can reasonably do and requires additional governance expertise and assistance from another source. The need for specialist governance support in health service and planning was noted as PRRINN-MNCH was facing cross-government constraints outside of the health sector. It is important that this programme can demonstrate increased Government ownership and commitment preferably in the form of increased Government financing flows to health at both federal and state level.

Output 2: Human Resources. While the programme has made considerable progress in human resources policy, management, capacity building and training, it cannot conjure up suitable health personnel where it is needed when there is a shortage of female trained health-care providers in Northern Nigeria. Using innovation and working with the NPHCDA on the Midwife Service Scheme, gaps are being filled. Long-term solutions with midwifery schools will eventually ease the situation but the short-term gaps in human resources are probably this programme's biggest risk.

Output 3: Service Delivery. A skilled and sufficient workforce is required for the delivery of good quality services. Service delivery is the culmination of all the programme has worked to achieve and there is no question that there have been

considerable improvements here - but from such a low base. It must be remembered that this programme is building something from very little as evidenced by services statistics in single digits (e.g. routine immunization rates in all states of well under 5% as recently as 2003). From this, the programme is building the ability to deliver comprehensive emergency obstetric care. (Delivering emergency obstetric care 24/7 is to be compared with a functioning Accidents and Emergency Room available around the clock.) All this must be delivered to large populations in a low resource setting. This programme is attempting to see if this can be done at scale in 2 and1/2 states. The Review Team saw the need for considerable improvements still and did not deem the service delivery to be yet 'good enough' (see box) and made suggestions for further improvements.

Output 4: Operations Research. The programme is using OR to test interventions within the Northern Nigerian setting. The OR organizational platform is now operational and various studies are underway. The results of this research, over time, should allow the programme to find innovative ways to achieve the best results for the funds available.

Output 5: Information and Knowledge. Again from a low base, the HMIS is functioning and data outputs have improved; particularly in data completion and quality. The system is working and is exceeding expectations (especially in Zamfara).

Output 6: Demand Creation. The Review Team saw excellent work in community engagement on the part of the programme. But the second highest risk to the programme may be found here. Questions remain on whether current resources are adequate to allow full-state scale up. Assessing this risk requires research beyond the scope of this review. The Review Team also saw missed opportunities in holding the Government accountable at all levels. Again, work here with other DFID governance programmes will help.

Output 7: Federal Governance. The programme's investment at the federal level is relatively small although they have prioritized well. While not implying that the NPHCDA is perfect, it is currently functioning more efficiently than some other federal agencies. PRRINN-MNCH's partnership way of working with the NPHCDA is paying dividends.

Figure 3: Health Facilities: How good is good enough?

Health Facilities: How good is 'good enough'?

In a low resource setting, health facilities must be resourced to achieve maximum impact at the lowest cost. This implies careful decisions are being made to staff, train, refurbish and equip a health facility. The PRRINN-MNCH programme must assist the Government of Nigeria to find the delicate balance in their health facilities where quality MNC health services can be delivered to save the most lives while excess resources are not being wasted on changes that won't make a big difference. Facilities do not need to be better than 'good enough' or resources will be too concentrated in a few facilities when the programme needs to be expanded. The Review Team found improvements in the health facilities[4] but deemed the first cluster not yet quite 'good enough' to completely meet all nine maternal health signal functions. Small and targeted adjustments in clinical standards and guidelines still need to be made to bring the facilities to be just 'good enough'—but no better.

[4] 24 targeted EOC facilities are showing an increase in the number of signal functions provided (milestone 20) while 36 targeted PHC facilities providing MNCH services show an increase in the number of signal functions provided (milestone 32).

4.2 The theory of change and sustainability

Establishing a functional government led health system that deliver quality MNCH services in an equitable manner at full scale, requires more than the programme itself can deliver within its timeframe. It requires that government itself continuously upholds RI and MNCH as a political and funding priority and that there is a substantial increased resource allocation by government. In this regard, there was some discussions regarding the theory of change that would underpin the expansion strategy (where the programme goes quickly to full scale).

Some team members suggested that the programme should further explore its catalytic opportunities and link the programme expansion to certain performance, governance, policy, and fund allocation criteria. It was suggested that such performance-based funding strategies could be considered as tools to further increase political and financial commitments by government. Increased government commitment is also essential to programme sustainability.

Team members, however, also emphasized the opportunity to significantly and rapidly go to scale with the programme, and the potential to contribute to reduce maternal and child health mortality.

Lessons Learned:

What has been learned from way the programme was set up?

- **Comprehensive approach.** Nigeria has a fragmented health services so many vertical programmes and disparate donor approaches only compound the problems. The comprehensive approach taken by PRRINN-MNCH means that a multi-dimensional and wide range of supply and demand issues can be addressed.
- **Coordinated NGO Consortium**. The PRRINN-MNCH programme has a team of NGOs working together in a central and coordinated fashion. The management approach (with the three main NGOs represented on a Programme Management Board) means that resources and management are shared in a manner that reduces the politics that sometimes plagues consortia. It also means that all the organizations contributing to the programme move forward in a coordinated manner.
- **Provision of TA and Capacity Building**. The Review Team could see the appreciation that the state governments and health providers have for the supportive work of PRRINN-MNCH. The programme has managed to support without patronizing. The approach seems to be around the concept of a common problem that needs teamwork.
- **Governance and Ownership**. In meetings with State Government in every state but Katsina, the people the team met were assured that PRRINN-MNCH had made their jobs easier and more productive. It is clear that this work is Nigerian and not seen as donor driven (even when the states were signing MOUs with DFID).
- **Decentralised, state-run approach**. What works in Zamfara is not necessarily the case in Yobe. And even if the same things work, the states

needed to work this out for themselves. The power resides with the State Team Leaders and this shows.

- **Maternal Health Cluster Approach**. This approach is a relatively recent innovation in the world of maternal health but there is now consensus that emergency obstetric care availability (along with skilled birth attendance and family planning) is the only way to reduce maternal mortality. Testing this approach in a low resource setting has enormous implications for work in other countries.
- **Learning LGAs**. Each state has what is called a 'learning LGA'. It is here that operations research can be most easily tested and lessons learned. (This is taken from the Ghana Navrongo model.) It is too soon to see the fruits of this approach for this programme.

Value for Money. Value for money is a multidimensional construct—especially when the project's activities create capacities; models are developed and proven; and government commitment and financing is realised. This catalyzes a benefits stream much larger than that produced simply in the project area. Of most importance in this programme is the need for the project to attain a high degree of impact, something that can only be achieved if the project is successful at going to scale and sustained by the Government. Measuring this commitment and seeing it sustained will require some time passing as well as careful analysis.

Post programme sustainability:

How long will the process PRRINN-MNCH has started take? Most of the group ended up agreeing that the programme might finish its work of a fully-embedded well-run health system in about 20 years. Nobody thought that this could be effectively achieved in much less although many agreed that future follow-on projects might have different inputs once the clusters were up and running. (Improvements in MNCH and RI should be seen sooner though.) A long term approach and commitment is needed.

Enormous risks remain

- Governance is major risk and increased government funding (commitment) is key;
- Human resources for health remain a constraint;
- Building service delivery from a low base will take a long time to do well; and
- There will continue to be enormous (and growing) numbers of people to both educate and cover with high quality health care.

Midterm Review recommendations

Both the UK and the Government of Norway are committed to a strong results orientation for the programme. Here are the recommendations from the midterm review:

- Intensify the focus on governance in collaboration with other DFID programmes;

- Further expand community based approaches. This may involve identifying additional funding opportunities to expand coverage;
- Assess use of performance based measures to further increase government financing such as requiring matched government commitments as part of the expansion strategy or other performance based aid related requirements;
- Assess the full PRRINN-MNCH risks with a comprehensive modelling exercise of the scale up.

5 Amendments to the logframe

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

Note that the expanded programme to 2013 has a new logframe with new milestones which is included in Annex 14. Future work with SPARC and SAVI may need to be reflected in the PRRINN-MNCH logframe so this may mean further changes.

6 Risk Assessment

(i) The risks originally identified and discussed in the 2010 Annual Review are still valid. The successful management of mitigation strategies is helping to reduce risks. See Annex 10 for an assessment of the risks.

(ii) Overall rating of PRRINN remains: High Risk., although improvements have reduced this risk. The Review Team will need to revisit this next year.

(iii) DFID needs to consider the implications the full PRRINN-MNCH programme extension. The programme risk assessment will need major attention. Currently, DFID only receives an ARIES report on PRRINN and the current risk assessment is only for PRRINN. (The two procurement contracts were issued separately.) Extending the PRRINN-MNCH programme would imply that the DFID reporting should be expanded to include PRRINN-MNCH and that the risk assessment for the full programme be completely updated. The PRRINN-MNCH would be considered High Risk (based on the current revised logframe in Annex 12).

7 Project Management

7.1 Management

The Review Team found that management structures within PRRINN-MNCH as well as DFID management of the programme remained sound and have no major issues to report. The administrative and financial relationships between the Kano central office and the state team offices seemed to be functioning well. The team heard that the Yobe office had experienced some delays in fund transfers.

The Review Team acknowledged the high quality of the State Team Leaders. Without exception, the programme has managed to keep excellent leaders at the state level and this is surely part of the key to the programme's success.
Finally, the PRRINN-MNCH is to be commended for running such a complicated review.

7.2 Reporting to DFID

PRRINN-MNCH provides quarterly reports to DFID with the December report encapsulating the activities of the previous year. These documents report progress against logframe outputs and are well presented and clear. The Annual Progress Report uses a layered approach whereby the Executive Summary gives high level detail, the body of the report the next layer, and the real detail is put in Annexes. DFID staff have reported that the programme produces timely and high quality reports.

7.3 Financial Reporting and Budget Performance

Financial reports to DFID in Abuja demonstrate good financial management procedures. The programme is able to present expenditure by output and by state without difficulty. A full routine external audit of the programme took place in March 2010. The recommendations covered procedural issues which were addressed by the PRRINN/MNCH team.

7.4 Communications

The programme's continued low key profile within Nigeria using its own logo should be encouraged. Nigerian Government ownership of this programme will continue to remain important.

7.5 Procurement

The length of time for the procurement process with Crown Agents was already an issue in last year's Review. This is an issue that DFID must take extremely seriously as bottlenecks such as these sorely challenge a programme;s ability to deliver services in a timely manner. Community expectations are raised and their local

facilities do not have the equipment or supplies to serve them. The programme is judged on their ability to deliver and its progress is seriously compromised by this procurement delay. The PRRINN-MNCH staff have taken a proactive and intensive approach within Crown Agents. Fifteen month delays are untenable and DFID must act quickly to explore solutions or alternative providers.

7.6 Management by DFID

The relationship between PRRINN-MNCH staff and the DFID Nigeria continues to be a good one.

Britain and Norway. DFID and Government of Norway have a strong collaborative management approach to PRRINN MNCH. The Government of Norway has delegated routine project management responsibility to DFID. The two donors discuss progress on a quarterly basis and meet formally on an annual basis to agree on priorities and make recommendations.

PATHS2. Finally, the Review Team benefited from having two staff members from PATHS 2 on the team. PATHS 2 and PRRINN-MNCH will continue to have much to learn from each other. PRRINN-MNCH organizational partners generally move together in a coordinated step-wise fashion.

Annex 1: PRRINN-MNCH M & E Report: Progress against logframe and primary M&E indicators January to December 2010; and b) PRRINN M&E Report: Progress against logframe and primary indicators 2010.

Introduction

During the reporting year, a total of four quarterly M&E progress reports against 2010 programme milestones have been produced. Programme expansion within operational states and extension until 2013 has been approved. In line with the extension of the programme, the combined logframe and M&E framework have been revised.

This report highlights progress for the period of January to December against 2010 milestones established for the combined programme ending 2012 prior to extension agreement reached end October 2010. Most of reported HMIS data covers the period January to end of November. Data for the month of December will be included in the first quarter 2011 M&E progress report.

Detailed progress against annual milestones in the M&E framework is documented in the excel workbook Annexes to PRRINN-MNCH M&E progress report December 2010. The Annexes include a combined report for the programme and 4 state reports.

Goal and Purpose of the programme

Goal: To improve maternal, newborn and child health in Northern Nigeria
Purpose: To improve effective access to MNCH (including RI) services in four states

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

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

Immunisation coverage from the mini-survey conducted in the programme states was reported in the first quarter. The result indicated a three to four fold increase across the states. The draft report of NICS 2010 indicated that there has been remarkable progress across all the programme states compared to NICS 2006. The *average programme coverage by card for fully immunised infants is 20.52%* (compared to only 3% recorded by NICS 2006) while the *valid coverage both by card and history is 47.31%* (milestone 2010 before review 38%). The coverage in Jigawa and Zamfara exceeded both the zonal and national averages. *The % of women aged 15 – 49 yrs who had appropriate TT doses was 57%* (NICS 2010) compared to 15% (NICS 2006).

Table 1 below illustrates key results for NICS 2006 and 2010 in all PRRINN-MNCH states

Table 1: Comparison of NICS 2006 and 2010 key results for PRRINN-MNCH states

INDICATORS	Jigawa		Katsina		Yobe		Zamfara	
	NICS 2006	NICS 2010	NICS 2006	NICS 2010	NICS 2006	NICS 2010	NICS 2006	NICS 2010
Fully immunized - any (by either history or card)	15.5	76.76	21.30	22.22	12.90	35.27	11.00	61.28
Fully immunized card	4.4	63.10	2.20	0.46	5.70	6.25	0.00	9.88
MCV (routine) - any (by either history or card)	47.9	85.12	60.70	41.20	56.00	49.26	51.20	65.48
MCV (routine) – card	23.1	66.67	12.60	5.56	13.20	8.33	5.50	9.62
DPT3 Any	28.9	88.69	42.90	49.07	22.10	64.38	27.4	64.40
DPT3 – card	15.9	68.45	10.60	7.87	5.10	9.69	2.80	10.85
OPV3 – Any	44.8	88.10	40.60	61.11	48.80	64.38	66.10	80.47
OPV3 – Card	14.7	69.05	0.20	4.17	3.00	9.69	2.40	10.52
BCG Any	31.30	92.86	52.10	66.20	30.90	61.96	26.30	64.17
BCG Card	25.40	76.19	43.40	5.56	18.50	0.89	21.40	12.24
Drop-out DTP1-DTP3	47.70	5.95	34.80	1.39	62.90	5.51	50.4	0.30
TT 2 Coverage	39.00	88.69	46.00	11.25	67.00	67.26	23.00	60.18
TT 5 Coverage	15.00	39.88	14.00	43.98	24.00	48.96	7.00	44.29

In 2010, *17,473 measles cases were reported* (the annual milestone 11,125) out of which 17,366 cases (99%) were from Jigawa and Zamfara where there was an outbreak. The number of reported cases is very high compared to 2009 (only 355 cases). *In 2010, 9 polio cases reported (*6 cases from Zamfara and 1 case each from the other states). The number of cases dramatically reduced compared to 2009 (119 cases reported).

In 2010 *39,272 mothers attended ANC first visit* (milestone 19,365) and *22,170 deliveries were attended by skilled birth attendants* (milestone 10,886) in targeted clusters. Both ANC and delivery milestones were under estimated. They have been adjusted in the revised M&E framework. The *number of maternal complications transferred to health facilities via emergency transport scheme was 1,114* which is more than six-fold of the annual milestone (150). *A total of 919 caesarean section (CS) cases were reported with an average CS rate of 0.5 %* (milestone 0.5%).

11.73% of births attended by a skilled birth attendant (SBA) in targeted CEOC clusters (milestone 21%) while 31% of pregnant mothers attended ANC first visit (milestone 30%).

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

Output 1 Logframe Indicators
State government staff leads annual review and health planning process in all states.
Number of states with their State Health Plan incorporated into their State Development Plan.
State health plans reflect project data from 2010.
Number of donor PHC programmes reflected in State and LGA annual health plans.
SIACCs support for RI through PHC system in all states.
No donor field missions and reviews done jointly.
All states successfully access new Federally managed health funds.
Availability of PHC budget and expenditure reports for LGAs/Gundumas.

Progress against the logframe and primary indicators includes:

- In all states the programme has supported mid-year review of 2010 plans and annual planning and budgeting for the year 2011 in line with the states' health sector development plans. Some data generated from the programme reflected in states' annual plans.
- In Jigawa, the programme worked closely with SPARC and PATHS2 in development of MTT based on the finalised SEEDSII document. In Zamfara and Katsina programme supported the states to review the health component of SEEDS documents which further reflected into the states vision 2020 draft documents. In Yobe state development plan YOSERA is under-review with the programme supporting incorporation of the state health development plan.
- Al least 2 donor PHC programmes are reflected in each State and LGA annual plans.
- All the 14 LGAs in Zamfara, the 9 Gunduma Councils in Jigawa and 3 cluster LGAs each from Katsina and Yobe have been implementing at least 5 MNCH & RI activities in line with their annual operational plan.
- Costing of MSP completed in Yobe, Zamfara and Katsina, while costing of free MNCH completed in Yobe and Katsina. In Zamfara, costing of free MNCH is ongoing. The final document of costed free MNCH shared with other DFID programme working in the health sector. Inclusion of costed MSP and MNCH in states plan is yet to be done.
- Progress towards establishment of State Primary Health Care Boards is encouraging. Both in Yobe and Zamfara, the bills passed and signed into law. In Yobe, state appointed Board Chairman and members including Executive Secretary of the state primary health care board. At Federal level, Policy document and implementation guideline were endorsed by the NPHCDA Board who will now take them to the next National Council of Health for ratification
- SIACC and State Task Forces are regularly met and support RI and PEI.
- The programme actively participated in PATHS2, HERFON annual OPR as well as TSHIP Programme review.
- In Yobe, partnership agreement signed between the Governor of the State and Head of DFID-Nigeria. A monitoring and evaluation team represented from the state, DFID and the programme has been established. In Zamfara and Katsina, agreement reached with DFID on modalities signing the finalised

partnership agreement at the state level. Change matrix agreements signed with all LGAs in the first clusters.

- Implementation of advocacy plan ongoing in Jigawa and Zamfara. In All the states, capacity building of state HERFON members is ongoing.
- Three states accessed fund from NHIS and all states accessed the second instalment of GAVI fund, as well as MDG funds. States are also supported to retire GAVI funds.
- In all states PHC annual budgets at LGAs level is available but not yet the expenditure. State and LGA levels expenditure review meetings conducted in Katsina, Yobe and Zamfara.

Output 2: Improved human resource policies and practices for PHC

Output 2 Logframe Indicators
Status of HR policies and plans in each state.
Number of health professionals trained annually.
% of professional staff given in-service training in MNCH in targeted PHC facilities.
% of targeted facilities with at least one health worker trained in LSS.

Progress against the logframe and primary indicators includes:

- State HRH policies based on the national HRH strategic plan, have been developed in Jigawa, Yobe and Katsina. In Zamfara, support is currently ongoing.
- In Jigawa, the Gunduma Health System Board (GHSB) utilised the person to post matching report to rationalise distribution of staff transferred from LGAs to the Gunduma Health Councils.
- All state HR coordinating committees initiated utilisation of the Human Resource Information System (HRIS) reports and meet regularly on quarterly basis.
- A total of 40 HR managers and supervisors have been trained on application of HRIS software.
- HRAdmin software has been installed and training on use conducted in all states. It has been piloted in all states since the beginning of the second quarter. A paper based system commenced in 20 LGAs (milestone 10).
- 1,467 final year students in three states are awaiting final exam results and graduation at health training institutes.
- 54% professional health workers were given in-service training in MNCH in targeted PHC facilities (milestone 25%). This resulted in 650 professional staff being training in MNCH, out of which 188 trained were on Life Saving Skills (LSS) and 98 trained on Modified LSS. An additional 1,021 health workers were trained on routine immunisation.
- 62% of targeted facilities (milestone 40%) have at least one health worker trained in LSS. A total of 72 health facilities (milestone 78) have at least one health worker trained in LSS. 87 health facilities have at least one health worker trained in IMCI (milestone 104).

- The total of 134 new trainers on RI/MNCH were trained (milestone-70). This report did not include the state wide training. A total of 26 driver trainers trained (milestone 12).
- Two training institutions in Katsina got accreditation to courses (milestone 5)

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

Output 3 Logframe Indicators
% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%.
Systems for effective supervision in each state.
Number of PHC facilities providing BEOC.
% of PHC facilities with tracer drugs available.
Number of 1-year-old children immunised against measles.
% of health facilities providing RI experiencing vaccine stock-outs of TT.

Progress against the logframe and primary indicators includes:

Facilitate PHC system development and capacity building

- Annual PPRHAA exercise completed in all states. 29% of LGAs reached performance ranking score >75% (milestone 40%). The highest score was in Jigawa (67%) while Katsina and Yobe scored 6%.
- Systems for effective supervision have been established in all states and teams are visiting with technical and financial support from programme. A total of 31 quarterly integrated supportive supervisions were facilitated in LGAs of the targeted clusters.
- 15 targeted EOC facilities (100%) and 24 targeted PHC facilities (100%) in the first clusters achieved the minimum building status score.
- Jigawa, Yobe and Zamfara states have approved transport guidelines. In Katsina, the policy is ready for approval. The total number of drivers trained on emergency transport of pregnant mothers, including drivers from the National Union of Road Transport Workers (NURTW), reached 247 (milestone100).

Strengthen maternal care

- SBA attended 12% of births in targeted CEOC clusters. The coverage is far below the annual milestone (21%) as expected. Progress against the milestone on births attended by a SBA is lower than expected probably due to several factors including delay in drugs and medical equipment, low level of SBA and low demand for facility based deliveries.
- A total of 919 caesarean sections were reported with CS rate of 0.5 % (milestone 0.5%)
- 31% of women received ANC first visit in targeted clusters, which is just above the annual milestone of 30%.

- In the targeted clusters, 18 PHC facilities provide BEOC (milestone 12) and 7 facilities provide CEOC (milestone 3). All targeted 24 PHC facilities are providing basic MNCH services.
- 24 targeted EOC facilities are showing an increase in the number of signal functions provided (milestone 20) while 36 targeted PHC facilities providing MNCH services show an increase in the number of signal functions provided (milestone 32)
- A total of 41 PHC facilities (including BEOCs) reported providing 24/7 EOC services (milestone 8).
- A total of 22,170 deliveries (milestone 10,896) were reported from targeted facilities (CEOC/BEOC/PHC), while a total 39,272 ANC first visits (milestone 19,365) were reported from all targeted health facilities. 20,492 postnatal visits in targeted PHC facilities were reported from Katsina and Yobe (milestone 4,147). (The milestones were initially underestimated but have been adjusted in the M&E framework for the expansion of the project as of 2011.)
- 14 targeted BEOC and CEOC facilities regularly conduct maternal death audits (milestone15), while only 1 CEOC in Yobe is regularly conducting perinatal death audits (milestone 15). Perinatal audit training was only initiated late in 2010.
- 6 targeted CEOCs have at least 6 nurse-midwives (milestone 3) and 17 targeted BEOC facilities have at least 2 nurse-midwives (milestone 12). 18 targeted PHC facilities have at least 1 midwife (milestone 24).

Strengthen neonatal and child health

- 16 CEOC/BEOC facilities in the clusters have at least 3 health workers trained in Kangaroo Mother Care (KMC) (milestone 15).
- 5 CEOC facilities (milestone 3) and 15 BEOC facilities (milestone 12) in the clusters are practicing KMC.
- 18 BEOC and CEOC facilities have at least 2 health workers trained in Integrated Management of Newborn and Child Illness (milestone 15)
- 5 targeted CEOC facilities (milestone 3) and 12 targeted BEOC facilities (milestone 2) have at least 4 and 2 health workers trained in competency-based LSS-EONC respectively.

Strengthen sustainable drug supply

- 101 PHC facilities (29%), out of 345 PHC facilities appraised by PPRHAA in the four states, with tracer drugs available (milestone 40%).
- In all targeted first cluster facilities (45), sustainable drug supply system developed for roll out; drugs have arrived and ready for distribution.

Strengthen immunisation systems

- 64% of the health facilities providing RI experienced vaccine stock-outs of TT (milestone 29%). In Yobe 100% of the health facilities and in Katsina 35% of the facilities experienced stock-outs of TT.
- Only 12.5% of the LGAs had one-month stock of all antigens for previous 3 months (milestone 66%). None of the LGAs in Jigawa, Yobe and Zamfara

had one-month stock of all antigens for the previous 3 months. In Katsina, 50% of LGAs reported to have one-month stock.

- Available states HMIS data on RI indicated that: A total of 539,521 < 1-year-old children immunised against measles (milestone 299,957). The number of under one year children received OPV3 was 330,765 and the number of children received DPT3 was 370, 388 (milestone for both 278,828)
- Out of 345 PHC facilities appraised by PPRHAA, 92% of health facilities (milestone 45%) had up to date micro-plan while 86% health facilities (milestone 50%) had up to date immunisation monitoring charts.
- 298 facilities out of 345 facilities conduct weekly RI sessions (milestone 288)
- Average drop- out rate (DPT1 to DPT3) was 18% (milestone 36%).

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

Output 4 Logframe Indicators
State plans reflect OR results.
Number of pieces of OR into supply & demand aspects of MNCH which feed into programme.

Progress against the logframe and primary indicators includes:

- State plans reflect OR pre-intervention results as follows:

  1. In Katsina, SPHCDA plans to institute a bi-annual monitoring and supervision of the mobile ambulance scheme (MAS) and improve procurement and distribution of drugs and also conduct a follow up study.
  2. In Jigawa, the state plans to extend NHIS to the study PHC facilities to ensure availability of drugs since the free MNCH services do not include PHC facilities. Jigawa state will also introduce ETS and CE activities into CBSD pilot communities.
  3. In Yobe, study on clustering of child mortality has led to plans to train CHEWs operating in communities to recognise high-risk families and respond appropriately.
  4. In Zamfara, formation of women groups included in 2011 plans

- Institutional arrangements for OR established. All Operational Research Advisory Committees functional. Ahmad Bello University provides technical assistance and INDEPTH supported IT systems development in Health Demographic Surveillance Site (HDSS). Navrongo Health Research Centre continues to support HDSS development, West African Bioethics Committee has supported training of Ethics Committees,
- Baseline studies and qualitative studies field data collection completed.

  1. Jigawa has completed 8 out of total of 11 mini studies.
  2. Katsina completed all 5 mini studies.
  3. Zamfara completed 1 out of 2 mini studies for the TICK study and 2 out of 3 for the WISH study.

4. Katsina, Jigawa, and Yobe have started setting up PBF schemes.

- Five pieces of OR into supply and demand aspects of MNCH have fed into the programme (milestone 2):

1. Rapid demand side assessment of barriers to MNCH services formed the basis of the design of demand side approach in all states.
2. Political economy assessment in all states informed the PRRINN MNCH change management approach in all states.
3. Findings of the study on clustering of child mortality has led to plans to train CHEWs operating in communities to recognise high risk families and respond appropriately and revised training of community volunteers.
4. An appraisal of sustainable drug supply system in 2009 led to a design of a new sustainable drug supply system with stakeholder participation in all states.
5. Findings from the preliminary pre-interventions OR studies have led to PRRINN MNCH program plans to support Katsina state to development of M&E plans for the MAS program, PRRINN MNCH Jigawa state to introduce ETS and CE activities into CBSD pilot communities, and PRRINN MNCH Yobe state to plan to support workshops on interpersonal communication for health staff.

- Demographic survey data available. Pilot census data collection activities were completed earlier in the year yielding a total of 1,440 individual data records from 196 households in four clusters within Nahuche Keku district. The full baseline census was completed in the fourth quarter of 2010.

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

Output 5 Logframe Indicators
State plans increasingly built on evidence from HMIS.
Demonstrated level of understanding in use of information by trained HMIS officers in each state.
% of LGAs with HMIS MNCH data collated at state level on a monthly basis.

Strengthen HMIS in all states

Progress against logframe and primary indicators includes:

- State plans are increasingly built on evidence from HMIS:

1. Jigawa - 2011 operational plan developed with input from ISS, PPRHAA and HMIS data.
2. Katsina - Immunisation data informed plans to establish daily RI in general hospitals
3. Yobe - Low immunization coverage, low facility based delivery data used for state community based outreach service delivery operational research.
4. Zamfara - Results framework for the State Health Development Plan is based on HMIS as appropriate.

- HMIS officers in each state show an increased level of understanding and application of information. In Jigawa, Katsina and Zamfara all the State and Gunduma HMIS officers are proficient in the use of the DHIS and information use. They routinely prepare presentations of data for the Health Data Co-coordinating Committees and have also developed state health profiles to be used as a standard source of reference data. In Yobe, HMIS information used in mid-year review for policy decisions. HMIS officers from all states participated in interstate data review meetings.
- 80% of LGAs in the four states collated (milestone 40%) HMIS MNCH data at state level on a monthly basis. The range varies from 100 % (Yobe & Zamfara) to 50% (Katsina).
- 80% of PHC facilities submitted (milestone 40%) monthly HMIS returns for RI within the designated period. Reporting rate ranges from 50% in Katsina to 96% in Zamfara.
- 63.5% of PHC facilities (milestone 40%) submitted monthly HMIS returns for MNCH within the designated period. Reporting rate ranges from 21% in Yobe to 96% in Zamfara.
- 52% of PHC facilities (milestone 40%) submitted monthly HMIS returns for IDSR within the designated period. Reporting rate ranges from 28% in Yobe to 62% in Zamfara.
- 63% of PMS sites (milestone 40%) had an accuracy ratio of between 0.85-1.15 for OPV3. Accuracy varies from 50% in Katsina to 90% in Jigawa.

Knowledge management and M&E for PRRINN-MNCH

Progress against the logframe and primary indicators includes:

- Programme website is live and functional.
- Potential articles (clustering study on child mortality and clinic assessment tools on high and low performing facilities) for peer-reviewed journals identified and draft abstracts submitted for review.
- 15 success stories documented in the four states.
- 9 technical briefs on demand and supply side produced.
- Programme introductory brochure developed. Strategy on how to raise the profile of the programme designed.
- Video documentation of Yobe state programme interventions finalised.
- Mid-year programme review and annual planning conducted
- Training on application of life saving tools conducted
- Programme and state specific quarterly Q1, Q2 & Q3 M&E report produced.

Output 6 Increased demand for RI and MNCH services

Output 6 Logframe Indicators
% of women in targeted areas who have standing permission to take their child to a health facility.
% of never immunised children < 2 in targeted areas.
% of women in targeted areas who know at least 4 of the maternal danger signs.
% of mothers of children < 2 in targeted areas who know the childhood vaccination schedule.
Increased political support for MNCH (including RI) evidenced by high level public events.
% of wards with a development committee and/or health partnership implementing a community action plan.
% of facility health committees for intervention facilities in targeted areas actively monitoring drugs.

Progress against indicators reported based on the follow-up KAP survey conducted in Jigawa, the mini-cluster EPI survey conducted in all the states and routine programme data collection. Unfortunately the KAP study in Katsina, Yobe and Zamfara will only be completed in first quarter of 2011. Progress against the logframe and primary indicators includes:

- 90% of women in Jigawa (milestone-65%) had standing permission to take their child to a health facility.
- EPI cluster survey indicated that the % of never immunised children < 2 in targeted areas dropped to 15 % (milestone 16%).
- Increased political support for MNCH (including RI) evidenced by high level public events both at state and LGAs level.

    1. In Jigawa - State Governor also made pronouncements in respect of his support for MNCH programmes and asked traditional and political leaders to impress on their respective communities to demand for routine immunization
    2. In Katsina- Advocacy visit to the wife of the Governor and the Emir of Daura
    3. In Zamfara- Launch of ETS and SDSS by Deputy Governor. Meeting with HCs and PS of 4 Min in Kaduna. Meetings with all LGA chairmen.
    4. In Yobe - State Governor signed partnership agreement with DFID.
    5. The MNCH Week was supported in all states

- In Jigawa, 53% of mothers of children < 2 (milestone 25%) in targeted areas know the childhood vaccination schedule.
- 31% of wards (milestone 15%) have a development committee and/or health partnership implementing a community action plan. A total of 300 community engagement intervention sites (milestone 146) have active community response systems to MNCH barriers, including RI.
- A total of 1,414 maternal complications transferred to health facility via emergency safe motherhood transport scheme.

- A total of 7 State ministries/ departments/ agencies (MDAs) have included funds for MNCH demand-side issues in their budgets and partially led community engagement activities (milestone 4).
- 88% of PHC facilities appraised by PPRHAA had IEC materials on immunisation.
- 17 tutors from all 11 health training institutions trained in new IPCC coursework focusing on family planning.
- On average, 4 health promotion jingles, songs or spots aired per day for 45 weeks in 4 states.
- 31% of facility health committees for intervention facilities in targeted areas are actively monitoring drugs (milestone 25%).
- 54 facility health committees for intervention facilities actively lobbying for an improvement in services (other than monitoring drugs) compared to milestone 39.
- Equity related information captured through health management information system informs management and policy decision-making in all states to some extent and includes:

  1. Consultation with stakeholders initiated to develop and implement health safety nets for the poor following the clustering studies.
  2. Findings of financial burden study provided entry point to get states to consider reviewing Free MNCH package from equity perspectives.
  3. HR gender information used in HRH planning
  4. HMIS now disaggregated by gender

- States supported to develop and implement health safety nets for the poor including CE establishing savings schemes for emergency maternal care, consultation with stakeholders initiated following clustering studies and OR on women's saving group.

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

Output 7 Logframe Indicators
Formal systems for leveraging, accessing and utilising additional PHC funding.
Agreed strategies to improve efficiency of RI.
Federal level delivers X% vaccines and supplies to states on time.
Number of state cold stores with adequate safe vaccines.

Progress against the logframe and primary indicators includes:

- GAVI fund flow system established and operational.
- Agreed strategies to improve efficiency of RI owned by federal stakeholders and partners:

  1. REW strategy implemented nation wide
  2. Guideline for traditional Leaders committee for RI & PHC developed
  3. National immunisation communication strategy developed

4. Study on PEI to identify reasons for unimmunized and zero dose children with support from programme conducted
5. Rapid assessment for National Cold Chain and Logistics systems transformation conducted

- NICS 2010 conducted and draft report circulated.
- PHC Management Information System of the NPHCDA strengthened
- FMOH HMIS policy and strategies revised to harmonize various datasets
- Concept note and implementation guideline on PHC under one roof endorsed by NPHCDA and ready for presentation to the National Council for Health in 2011.
- Polio-RI- sensitization training DVD has been integrated into the national majiki-DVD.
- A total of 580 midwives deployed to the programme states by midwife scheme in the first and second batch. 288 CHEWs deployed to the programme states along with the second batch of midwives.
- Baseline survey and ISS tools for Midwifery Service Scheme developed.
- Quarterly zonal cold-chain audit in Kano indicated that there was shortage of TT vaccine. (PPRHAA identified 64% of facilities providing RI had stock outs of TT.)
- State vaccines in all 4 state cold stores. Stock out of TT and BCG experienced

PRRINN M & E Report – Progress against logframe and primary M & E indicators

January to December 2010

Introduction

During the reporting year, a total of four quarterly M&E progress reports against 2010 programme milestones have been produced. PRRINN project extension until 2013 has been approved. In line with the extension of the programme, the logframe and M&E framework have been revised.

This report highlights progress for the period of January to December against 2010 milestones established for the combined programme ending 2012 prior to extension agreement reached end October 2010. Most of reported HMIS data covers the period January to end of November. Data for the month of December will be included in the first quarter 2011 M&E progress report.

Goal and Purpose of the programme

Goal: Progress towards achievement of MDGs 4 & 5 in Nigeria
Purpose: To improve delivery of routine immunisation for children and women of reproductive age via the primary health care system in 4 to 6 low-coverage states in northern Nigeria

Goal Indicators
MDG4, Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.

Purpose Indicators
% of infants fully immunised by first birthday.
% of women aged 15-49 have appropriate TT doses.
% of women receiving ANC.
Measles incidence reduced by 80%.
Polio incidence reduced to near zero.

Immunisation coverage from the mini-survey conducted in the programme states was reported in the first quarter. The result indicated three to four fold increase across the states. Draft report of NICS 2010 indicated that there has been remarkable progress across all the programme states compared to NICS 2006. The *average programme coverage by card for fully immunised infants is 20.52%* (compared to only 3% recorded by NICS 2006) while the *valid coverage both by card and history is 47.31%* (milestone 2010 before review 38%). The coverage in Jigawa and Zamfara exceeded both the zonal and national averages. *The % of women aged 15 – 49 yrs who had appropriate TT doses was 57%* (NICS 2010) compared to 15% (NICS 2006).

Table 1 below illustrates key results for NICS 2006 and 2010 in all PRRINN-MNCH states

Table 1. Comparison of NICS 2006 and 2010 key results for PRRINN-MNCH states

INDICATORS	Jigawa		Katsina		Yobe		Zamfara	
	NICS 2006	NICS 2010	NICS 2006	NICS 2010	NICS 2006	NICS 2010	NICS 2006	NICS 2010
Fully immunized - any (by either history or card)	15.5	76.76	21.30	22.22	12.90	35.27	11.00	61.28
Fully immunized card	4.4	63.10	2.20	0.46	5.70	6.25	0.00	9.88
MCV (routine) - any (by either history or card)	47.9	85.12	60.70	41.20	56.00	49.26	51.20	65.48
MCV (routine) – card	23.1	66.67	12.60	5.56	13.20	8.33	5.50	9.62
DPT3 Any	28.9	88.69	42.90	49.07	22.10	64.38	27.4	64.40
DPT3 – card	15.9	68.45	10.60	7.87	5.10	9.69	2.80	10.85
OPV3 – Any	44.8	88.10	40.60	61.11	48.80	64.38	66.10	80.47
OPV3 – Card	14.7	69.05	0.20	4.17	3.00	9.69	2.40	10.52
BCG Any	31.30	92.86	52.10	66.20	30.90	61.96	26.30	64.17
BCG Card	25.40	76.19	43.40	5.56	18.50	0.89	21.40	12.24
Drop-out DTP1-DTP3	47.70	5.95	34.80	1.39	62.90	5.51	50.4	0.30
TT 2 Coverage	39.00	88.69	46.00	11.25	67.00	67.26	23.00	60.18
TT 5 Coverage	15.00	39.88	14.00	43.98	24.00	48.96	7.00	44.29

In 2010, *17,473 measles cases were reported* (the annual milestone 11,125) out of which 17,366 cases (99%) were from Jigawa and Zamfara where there was an

outbreak. The number of reported cases is very high compared to 2009 (only 355 cases). In 2010, 9 polio cases reported (6 cases from Zamfara and 1 case each from the other states). The number of cases dramatically reduced compared to 2009 (119 cases reported).

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

Output 1 Logframe Indicators
No donor field missions and reviews done jointly.
Number of donor PHC programmes reflected in State and LGA annual health plans.
SIACCs support for RI through PHC system in all states.

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

The programme participated in the annual review of PATHS2 and HERFON as well as strategic review of TSHIP programme. The number of donor field missions and reviews done jointly are subject to frequency of donor field missions and reviews.
All states have at least 2 donor PHC programmes reflected in their State and LGA annual health plans. UNICEF and WHO in all state programmes and PATHS2 in Jigawa and SUNmap in Kastina reflected their plan into state plans. The number of donors reflected in state health plans depends on availability of decentralised donor programmes per state. In all the states, the PRRINN-MNCH programme plan for 2011 reflected in the state and LGA/Gunduma plans. .

In all the states, SIACC or equivalent coordination committees have provided some support to RI through the PHC system. In Jigawa, quarterly SIACC meeting approved release of final instalment of first tranche of GAVI fund to 9 Gunduma councils while in Zamfara State Task Force on PHC and immunization has been championing the release of funds to the "Basket Fund" which is used in funding RI amongst other activities

Promote coordinated advocacy, institutional change and change Management

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

During the reporting period, advocacy plan fully implemented in all states. In Jigawa, advocacy on thematic areas coordinated with SLP and led by HERFON while in Zamfara, the Eminent Persons Group (EPG) established and led advocacy activities. In All the states, capacity building of state HERFON and EPG members is ongoing.
A *number of advocacy visits targeting high political leaders, traditional and religious leaders have been organised.* In Yobe and Zamfara, Advocacy visits to the Governors and the states assembly led to the passage of the bills on SPHCDA passed in to laws.

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

Output 2 Logframe Indicators

State government staff led annual review and health planning process in all states.
State health plans reflect project data from 2010.
All states successfully access new Federally managed health funds.
Availability of PHC budget and expenditure reports for LGAs/Gundumas. Number of states with Demonstrated level of understanding in use of information by trained HMIS officers in each state.
% of LGAs with HMIS MNCH data collated at state level on a monthly basis.

Support state Planning and policy development

State government staff led annual reviews and health planning processes in all states with technical and financial support from the programme. In all states the programme has supported mid-year review of 2010 plans and annual planning and budgeting for the year 2011 in line with the states' health sector development plans. Some data generated from the programme reflected in states' annual plans. A case study on minimising missed opportunity in secondary health facilities informed states' plan and led to introduction of daily RI in all secondary health facilities

Each state has 2 or more examples of evidence based planning that is reflected in their 2011 plans. States were encouraged to develop an evidence based plan for 2011 based on project data. Information from programme supported integrated supportive supervisions, annual PPRHAA exercises, and community engagement activities helped the states reflect a few examples of evidence based planning. In Jigawa, cold chain equipment and solar maintenance and roll-out community engagement plans were incorporated based on quarterly cold chain audit, ISS and health partnership interventions. In Zamfara, a result matrix has been developed for the State Health development Plan with targets set based on a baseline assessment. In Yobe, human resource information, OR pre-intervention findings on outreach services and study on clustering health problems informed state plan. In Katsina, quarterly review of health promotion is linked to community engagement activities while HR information fed in to the draft HR policy development.

All states established health milestones for inclusion in their State Development Plan. These were developed as part of their revised health sector strategic plans. Each state has a different timeframe for revision of SEEDs and development of new State Development Plan (SDP). In Jigawa, the programme worked closely with SPARC and PATHS2 in development of MTT based on the finalised SEEDSII document. In Zamfara and Katsina programme supported the states to review the health component of SEEDS documents which further reflected into the states vision 2020 draft documents. In Yobe state development plan YOSERA is under-review with the programme supporting incorporation of the state health development plan.

Support health financing, budgeting and public financial management for PHC

All states have made considerable progress in accessing new federally managed in 2010. The milestone of two successive years access for new federally managed health funds achieved in all states. All states accessed MDG and GAVI funds for successive years.

The milestone for *accessing of two federally managed funds in two states* has been achieved. Three states accessed fund from NHIS and all states accessed the second instalment of GAVI fund, as well as MDG funds. States are also supported to retire GAVI funds.

In all the states, annual PHC budgets were available both at state and LGAs/Gunduma levels, as the programme was also actively supported the development of costed plan for the year 2010 at state and LGA level. Release of funds for PHC activities has increased in all states.

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

All state plans reflect use of some HMIS data collected from ISS and PPRHAA. Some progress demonstrated in utilisation of routine HMIS data and information collected through ISS and PPRHAA for state plans. *All programme states have functional Health Data Consultative Committees* and organised quarterly review meetings.

State plans are increasingly built on evidence from HMIS: in Jigawa, 2011 operational plan developed with input from ISS, PPRHAA and HMIS data. In Katsina, Immunisation data informed plans to establish daily RI in general hospitals. In Yobe, low immunisation coverage, low facility based delivery data used for state community based outreach service delivery operational research. In Zamfara, results framework for the State Health Development Plan is based on HMIS as appropriate.

80% of LGAs in the four states collated (milestone 40%) HMIS MNCH data at state level on a monthly basis. The range varies from 100 % (Yobe & Zamfara) to 50% (Katsina).

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

Output 3 Logframe Indicators
% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%.
% of PHC facilities with tracer drugs available.
Number of 1-year-old children immunised against measles.
% of health facilities providing RI experiencing vaccine stock-outs of TT.
Number of health professionals trained annually.

Facilitate PHC system development and capacity building

Annual PPRHAA exercise completed in all states. *29% of LGAs reached performance ranking score >75% (milestone 40%)*. The highest score was in Jigawa (67%) while Katsina and Yobe scored 6%.

Systems for effective supervision have been established in all states and teams are visiting with technical and financial support from programme. A total of 31 quarterly integrated supportive supervisions were facilitated in LGAs of the targeted clusters.

Strengthen maternal care

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

Based on NICS 2010 draft report, 57% of women aged 15-49 have appropriate TT doses (milestone 60%). Distribution per state indicates that 89% in Jigawa, 11% in Katsina, 67% in Yobe and 60% in Zamfara.

State HMIS data indicated that 31% of women received ANC first visit, which is just above the annual milestone of 30%. ANC distribution in the states indicates that 60% in Jigawa, 23% in Zamfara, 18% in Yobe and 22% in Katsina. Implementation of NHIS and free MNCH contributed to high coverage in Jigawa state.

A total of 22,170 deliveries (milestone 10,896) were reported from targeted facilities (CEOC/BEOC/PHC), while a total 39,272 ANC first visits (milestone 19,365) were reported from all targeted health facilities. 20,492 postnatal visits in targeted PHC facilities were reported from Katsina and Yobe (milestone 4,147). (The milestones were initially underestimated but have been adjusted in the revised M&E framework for the expansion of the project)

Strengthen sustainable drug supply

Annual PPRHAA exercise indicated that *tracer drugs were available in 29% (*101 PHC facilities) out of 345 PHC facilities appraised by PPRHAA in the four states, (milestone 40%). Distribution per state indicated that 28% in Jigawa, 32% in Katsina, 26% in Yobe, and 43% in Zamfara.

In all targeted first cluster facilities (45), sustainable drug supply system developed for roll out; drugs have arrived and ready for distribution.

Strengthen immunisation systems

In 2010, *17,473 measles cases were reported* (the annual milestone 11,125) out of which 17,366 cases (99%) were from Jigawa and Zamfara where there was an outbreak. The number of reported cases is very high compared to 2009 (only 355 cases). In 2010, *9 polio cases reported* (6 cases from Zamfara and 1 case each from the other states). The number of cases dramatically reduced compared to 2009 (119 cases reported).

Annual PPRHAA exercise indicated that

- *64% of the health facilities providing RI experienced vaccine stock-outs of TT (milestone 29%)*. In Yobe 100% of the health facilities and in Katsina 35% of the facilities experienced stock-outs of TT.
- Only *12.5% of the LGAs had one-month stock of all antigens for previous 3 months (milestone 66%).* None of the LGAs in Jigawa, Yobe and Zamfara

had one-month stock of all antigens for the previous 3 months. In Katsina, 50% of LGAs reported to have one-month stock.

- Out of 345 PHC facilities appraised by PPRHAA, *92% of health facilities (milestone 45%) had up to date micro-plan* while 86% health facilities (milestone 50%) had up to date immunisation monitoring charts.
- *31 % of tracer medical supplies available at PHC facilities (milestone 58)*
- *298 facilities out of 345 facilities conduct weekly RI sessions* (milestone 288)
- *Average drop- out rate (DPT1 to DPT3) was 18%* (milestone 36%).

Available states HMIS data on RI indicated that: A total of 539,521 < 1-year-old children immunised against measles (milestone 299,957). The number of under one year children received OPV3 was 330,765 and the number of children received DPT3 was 370, 388 (milestone for both 278,828).

Strengthen HR planning and development

1,467 final year students in four states are awaiting final exam results and graduation at health training institutes *Distribution per state indicates that:-*

Katsina 701: Nurse 25 (13 male and 12 female), Midwives 49 (all females), CHEWS 343 (25 male and 138 female) and paramedical 284 (194 male and 90 female).
Zamfara 119: Nurse 16 (4 male and 12 female, Midwives 18 (all females), CHEWs 85 (48 males and 37 females).
Yobe 314: Nurse 68 (23 male and 45 female) CHEWs 246 (106 male and 140 female)

Aggregated data for Jigawa not available

A total of 134 new trainers on RI/MNCH trained (milestone=70); 55 in 2009 and 79 in 2010. *A total of 26 driver trainers trained* (milestone=12).

Progress has been made in strengthening of human resource policy development and management as well as work force planning:-

- State HRH policies based on the national HRH strategic plan, have been developed in Jigawa, Yobe and Katsina. In Zamfara, support is currently ongoing.
- In Jigawa, the Gunduma Health System Board (GHSB) utilised the person to post matching report to rationalise distribution of staff transferred from LGAs to the Gunduma Health Councils.
- All state HR coordinating committees initiated utilisation of the Human Resource Information System (HRIS) reports and meet regularly on quarterly basis.
- A total of 40 HR managers and supervisors have been trained on application of HRIS software.
- HRAdmin software has been installed and training on use conducted in all states. It has been piloted in all states since the beginning of the second quarter. A paper based system commenced in 20 LGAs.

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

creation

Progress against the logframe and primary indicators includes:

- *State plans reflect OR pre-intervention results* as follows:

  5. In Katsina, SPHCDA plans to institute a bi-annual monitoring and supervision of the mobile ambulance scheme (MAS) and improve procurement and distribution of drugs and also conduct a follow up study.
  6. In Jigawa, the state plans to extend NHIS to the study PHC facilities to ensure availability of drugs since the free MNCH services do not include PHC facilities. Jigawa state will also introduce ETS and CE activities into CBSD pilot communities.
  7. In Yobe, study on clustering of child mortality has led to plans to train CHEWs operating in communities to recognise high-risk families and respond appropriately.
  8. In Zamfara, formation of women groups included in 2011 plans

- Institutional arrangements for OR established. All Operational Research Advisory Committees functional. Ahmad Bello University provides technical assistance and INDEPTH supported IT systems development in Health Demographic Surveillance Site (HDSS). Navrongo Health Research Centre continues to support HDSS development, West African Bioethics Committee has supported training of Ethics Committees,
- Baseline studies and qualitative studies field data collection completed.

  5. Jigawa has completed 8 out of total of 11 mini studies.
  6. Katsina completed all 5 mini studies.
  7. Zamfara completed 1 out of 2 mini studies for the TICK study and 2 out of 3 for the WISH study.
  8. Katsina, Jigawa, and Yobe have started setting up PBF schemes.

- *Five pieces of OR into supply and demand aspects of MNCH have fed into the programme* (milestone 2):

  6. Rapid demand side assessment of barriers to MNCH services formed the basis of the design of demand side approach in all states.
  7. Political economy assessment in all states informed the PRRINN MNCH change management approach in all states.
  8. Findings of the study on clustering of child mortality has led to plans to train CHEWs operating in communities to recognise high risk families and respond appropriately and revised training of community volunteers.
  9. An appraisal of sustainable drug supply system in 2009 led to a design of a new sustainable drug supply system with stakeholder participation in all states.
  10. Findings from the preliminary pre-interventions OR studies have led to PRRINN MNCH program plans to support Katsina state to development of M&E plans for the MAS program, PRRINN MNCH Jigawa state to introduce ETS and CE activities into CBSD pilot communities, and

PRRINN MNCH Yobe state to plan to support workshops on interpersonal communication for health staff.

- Demographic survey data available. Pilot census data collection activities were completed earlier in the year yielding a total of 1,440 individual data records from 196 households in four clusters within Nahuche Keku district. The full baseline census was completed in the fourth quarter of 2010.

Support capacity building of a sustainable HMIS system

HMIS officers in each state show an increased level of understanding and application of information. In Jigawa, Katsina and Zamfara all the State and Gunduma HMIS officers are proficient in the use of the DHIS and information use. They routinely prepare presentations of data for the Health Data Co-ordinating Committees and have also developed state health profiles to be used as a standard source of reference data. In Yobe, HMIS information used in mid-year review for policy decisions. HMIS officers from all states participated in interstate data review meetings.

Monitoring of timely data reporting at all level and accuracy of data indicated that:-

- 80% of PHC facilities submitted (milestone 40%) monthly HMIS returns for RI within the designated period. Reporting rate ranges from 50% in Katsina to 96% in Zamfara.
- 63.5% of PHC facilities (milestone 40%) submitted monthly HMIS returns for MNCH within the designated period. Reporting rate ranges from 21% in Yobe to 96% in Zamfara.
- 52% of PHC facilities (milestone 40%) submitted monthly HMIS returns for IDSR within the designated period. Reporting rate ranges from 28% in Yobe to 62% in Zamfara.
- 63% of PMS sites (milestone 40%) had an accuracy ratio of between 0.85-1.15 for OPV3. Accuracy varies from 50% in Katsina to 90% in Jigawa.

Establish knowledge management for PRRINN

Progress against logframe indicators indicates that:-

- Programme website is live and functional.
- 1 article published in peer review journal in 2009 (on Household Survey). Potential articles (clustering study on child mortality and clinic assessment tools on high and low performing facilities) for peer-reviewed journals identified and draft abstracts submitted for review.
- 15 success stories documented in the four states.
- 9 technical briefs on demand and supply side produced.
- Programme introductory brochure developed. Strategy on how to raise the profile of the programme designed.
- Video documentation of Yobe state programme interventions finalised.
- Mid-year programme review and annual planning conducted
- Training on application of life saving tools conducted

Establish monitoring and evaluation for PRRINN-MNCH

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

Output 4: Increased demand for routine immunisation

Output 4 Logframe Indicators
Increased political support for MNCH (including RI) evidenced by high level public events.
% of mothers of children < 2 in targeted areas who know the childhood vaccination schedule.
% of never immunised children < 2 in targeted areas.
% of wards with a development committee and/or health partnership implementing a community action plan.

Progress against indicators reported based on the follow-up KAP survey conducted in Jigawa, the mini-cluster EPI survey conducted in all the states and routine programme data collection. Unfortunately the KAP study in Katsina, Yobe and Zamfara will only be completed in first quarter of 2011. Progress against the logframe and primary indicators includes:

- *90% of women in Jigawa (milestone 65%) had standing permission to take their child to a health facility*.
- EPI cluster survey indicated that the *% of never immunised children < 2 in targeted areas dropped to 15 %* (milestone 16%).
- Increased political support for MNCH (including RI) evidenced by high level public events both at state and LGAs level.

  6. In Jigawa - State Governor also made pronouncements in respect of his support for MNCH programmes and asked traditional and political leaders to impress on their respective communities to demand for routine immunization
  7. In Katsina- Advocacy visit to the wife of the Governor and the Emir of Daura
  8. In Zamfara- Launch of ETS and SDSS by Deputy Governor. Meeting with HCs and PS of 4 Min in Kaduna. Meetings with all LGA chairmen.
  9. In Yobe - State Governor signed partnership agreement with DFID.
  10. The MNCH Week was supported in all states

- In Jigawa, 53% of mothers of children < 2 (milestone 25%) in targeted areas know the childhood vaccination schedule.

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

Progress against logframe and primary indicators indicates that:-

- 31% of wards (milestone 15%) have a development committee and/or health partnership implementing a community action plan. A total of 300 community

engagement intervention sites (milestone 146) have active community response systems to MNCH barriers, including RI.

- A total of 7 State ministries/ departments/ agencies (MDAs) have included funds for MNCH demand-side issues in their budgets and partially led community engagement activities (milestone 4).

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

Progress against indicators:-

- *88% of PHC facilities appraised by PPRHAA had IEC materials on immunisation*.
- 17 tutors from all 11 health training institutions trained in new IPCC coursework focussing on family planning.
- On average, 4 health promotion jingles, songs or spots aired per day for 45 weeks in 4 states.

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

Strategies for establishment of facility health committees and monitoring of drugs for intervention facilities have been developed and implemented. A series of trainings for the FHC at the PHC and Secondary facility levels conducted. 31% of facility health committees for intervention facilities in targeted areas are actively monitoring drugs (milestone 25%). 54 facility health committees for intervention facilities actively lobbying for an improvement in services (other than monitoring drugs) compared to milestone 39.

Promote mainstreaming of equity and social inclusion in policy and programmes

Equity related information captured through health management information system informs management and policy decision-making in all states to some extent and includes:

5. Consultation with stakeholders initiated to develop and implement health safety nets for the poor following the clustering studies.
6. Findings of financial burden study provided entry point to get states to consider reviewing Free MNCH package from equity perspectives.
7. HR gender information used in HRH planning
8. HMIS now disaggregated by gender

Study supported by the programme on the Role and Impact of Gender in the Use of Immunisation Services in Jigawa and Lagos identified steps that should be taken in order to address the gender-related constraints to accessing immunization for children.

States supported to develop and implement health safety nets for the poor including CE establishing savings schemes for emergency maternal care, consultation with stakeholders initiated following clustering studies and OR on women's saving group.

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

Output 5 Logframe Indicators
Formal systems for leveraging, accessing and utilising additional PHC funding.
Agreed strategies to improve efficiency of RI.
Federal level delivers X% vaccines and supplies to states on time.

Support co-ordination and harmonisation at federal level

Progress in 2010 includes:-

- GAVI fund flow system established and operational.
- Agreed strategies to improve efficiency of RI owned by federal stakeholders and partners:

  6. REW strategy implemented nation wide
  7. Guideline for traditional Leaders committee for RI & PHC developed
  8. National immunisation communication strategy developed
  9. Study on PEI to identify reasons for unimmunized and zero dose children with support from programme conducted
  10. Rapid assessment for National Cold Chain and Logistics systems transformation conducted

- NICS 2010 conducted and draft report circulated.
- PHC Management Information System of the NPHCDA strengthened
- FMOH HMIS policy and strategies revised to harmonize various datasets
- Concept note and implementation guideline on PHC under one roof endorsed by NPHCDA and ready for presentation to the National Council for Health in 2011.
- Polio-RI- sensitization training DVD has been integrated into the national majiki-DVD.
- Quarterly zonal cold-chain audit in Kano indicated that there was shortage of TT vaccine. (PPRHAA identified 64% of facilities providing RI had stock outs of TT.)
- State vaccines in all 4 state cold stores. Stock out of TT and BCG experienced

Contribute to securing Dependable RI Supplies and Leveraging Extra Resources

Federal level delivery of vaccines and supplies to states on time during 2010 was 75% because there was shortage of DPT in the third quarter due to anticipation of introducing pentavalent vaccine. A system has been established and monitoring of deliveries of vaccines and supplies conducted at zonal and states stores on quarterly basis.

Annex 2: Jigawa State Report

The Review Team met with the PRRINN-MNCH Jigawa state team and were well briefed with a clear high level of expertise. (There is no MNCH programme in Jigawa as **PATHS 2** does MNCH; unfortunately there has been a long delay due to the PATHS 2 approval structure to support programme implementation. This delay was noted by the Gunduma Board when the Review Team met with them.)

Relationships with stakeholders. The team found that the PRRINN team had a good relationship with UNICEF and WHO and that there has been huge progress with the partnership process and having the routine immunisation agenda owned by WHO.

Gunduma system. While the Gunduma system is an excellent innovation, the system cannot afford to rest on its laurels. The system should be driving the SMOH to feel budgetary pressure and make changes accordingly.

Human Resources policy level. There were several opportunities to evaluate PRRINN-MNCH's progress (in combination with PATHS 2) in human resources. (It is difficult to differentiate the specific contribution of PRRINN and PATHS 2 as they are harmonising their agendas. PRRINN-MNCH primarily works with the Gunduma system to support RI while PATHS 2 works closer with state ministry officials.)

The Director of Human Resources for the Gunduma Health System board provided an excellent overview of the Jigawa HR policy and strategic plan. There has been significant progress on audits and providing baseline figures with a significant focus on quality of care (largely through training and professional development) and the number of female health workers. The HRIS system has been useful at a policy level to estimate need. However, due to the shortage of workers and lack of female staff throughout the whole state, this exercise has not yet had significant impact on re-adjusting staff at the facility level. It appears that HRIS is used at a practice level as many of the PHC and secondary facility staff have been trained. Whether or not it informs decision making and the impact of the training would require further assessment. Two further issues came to light on the team's visit:

> **All Jigawa is rural.** There is an allowance and renumeration uplift for health workers who live in rural areas. However, Jigawa, as a state is rural. The implications are that nurses and CHEWS who come from a town area, such as Dutse, are paid the same a CHEW who works in remote villages with no power, no cellphone coverage and living long distances from his/her family. This may require rethinking.
>
> **MSS renumeration**. The team met with the Commissioner for Health who stated that MSS midwives are given 30,000 N salary and a 30,000 renumeration from the state. However, there is a cohort of some of those midwives who have not received the renumeration for over three months.

Human Resource Practice. The team interviewed nurses and midwives at Jahun Hospital, Kafin Gana PHC, and the Tsakuwawa community LGA. In aspects of routine immunisation, health workers, in general, are trained and knowledgeable. There are large variations in staff to patient ratios, levels of skill-mix and support. For example, staff in Jahun Hospital seem to be highly trained, adequately resourced and supported with sufficient stocks of drugs and specialist equipment. The medical director and director of nursing discussed the need for more female staff--however

this site is better staffed than most (largely due to the intensive investment from Medicine Sans Frontiers). At Kafin Gana PHC, there were two female CHEWs who were delivering RI services to a busy clinic. This was a NHIS site and the staffing ratios appeared to be adequate. At Tsakuwawa clinic, there were five clinic staff members serving a very large rural community with multiple health issues. The CHEWs there appeared well trained but with limited exposure and experience in such a rural isolated setting. The huge demands of the clinic meant that staff had little time for breaks; they performed community outreach as well as clinic outpatient care and seemed to be very stretched.

Routine Immunisation. The team is to be congratulated on its excellent NICs results! Let Jigawa continue to lead the way in improvements. There is still work to do, however, as logistics and supply are still hampering the state to some extent. For example, it was observed that the State is still using a temporary cold store with poor and dilapidated storage facilities, whereas the permanent site has been completed awaiting connection to national grid on electricity and other utilities.

Operations Research. The Tsakuwawa clinic is a pilot OR site and has only recently been functioning. It appears to be off to a very good start with strong community buy in. In this OR model there were two female CHEWS included and they were positive and proud of their work. They had training and support from the programme but were somewhat isolated in many aspects: there was no generator and very limited cellphone coverage.

HMIS. The review team found a well functioning HMIS with good data that was circulating through the system. The next step is to notice that a facility has, for example, high drop-out rates. The facility head should be noticing this data and determining who is dropping out and why.

Community volunteer (CV) initiative. The use of women in doing house-to-house mobilisation of female caregivers to health facilities means that access to immunisation information is made easy for women and more children are vaccinated against childhood killer diseases. Full involvement of the Gunduma council in the work and supervision of the CV initiative has created a sense of government ownership. A challenge remains that the polio campaign has created a culture of female caregivers waiting for health services to be provided for them at home rather than going down to health facilities for RI services.

Voice and accountability. Through its CE strategy, PRRINN is creating the precondition for voice and accountability whereby communities are able to hold service providers accountable. DFID should consider coordinating the work that SLPs and PRRINN are doing on V & A. As it stands now, there is no linkage of V & A work that PRRINN is doing with what the other SLPs are doing at the state level. Monitoring of local government spending is not within the remit of SPARC and SAVI so it is important for DFID to consider giving this responsibility to one of these SLPs or empower PRRINN to take up this task. What is happening at the LGA level? Who is working here? There is a real opportunity to work with PATHS 2 and SAVI to make a difference.

Annex 3: Katsina State Report

The PRRINN-MNCH team in Katsina seem hardworking and dedicated. Dr Sani as State Team Leader for PRRINN-MNCH has grown well into his role and can be commended. Overall the team saw progress from 2010 in all output areas. It is important to note that this review came with a backdrop of the recent National Immunisation Coverage Survey which showed progress across Nigeria – and particularly in all the PRRINN-MNCH states--except Katsina where very little progress has been seen.

Governance. PRRINN-MNCH has an excellent relationship with key stakeholders: Ministry of Health; SPHCDA; Ministry of Women's Affairs and Local Government. Katsina has a health strategic plan and operational plans which have been costed. However, the health budget is not linked to the plan as historical budgeting is the norm. Weak budget allocation and non-strategic financial allocation reflects poor political will…and a lack of sense of urgency. Current politics around the election are further reducing health prioritisation as the government has just built a 200 bed orthopaedic hospital when the state does not have an orthopaedic surgeon. The State Ministry of Health consider they are doing a good job and blame the poor statistics on lower levels of the health system (i.e. local government and SPHCDA). There is no formal forum for the health sector to meet and the last state council on health was five years ago.

However PRRINN-MNCH do have some good people to work with; for example, the SPHCDA. There has been new leadership in SPHCDA which PRRINN-MNCH has found to be an opportunity for more change. Changes are needed to the Bill that created the Primary Health Care Agency to enable the vision of PHC under one roof to be realised. There are opportunities for more advocacy – and different advocacy – particularly around more difficult high level political and budget related issues. At present, most advocacy stops at the level of SPHCDA.

There needs to be more formal collaboration between DFID programmes in Katsina state – it would be of benefit to all (namely Water, Girls Education, Malaria and PRRINN-MNCH).

Human Resources. PRRINN-MNCH is clearly working on MSS and the policy work is high up on the agenda. Mapping is being updated regularly. There is need for a 'step change' in health staff behaviour as the review team saw little sense of urgency at the health facilities. The two MSS midwives in the clinic the team visited had not had their local government 'top-up' for 3 months. Integrated service supervision took place more as peer reviews from facility to facility. Some concerns regarding the quality of clinical practice calls to question whether peer to peer review is adequate.

Service delivery. Family planning is increasing which is great news and the team found family planning commodities were available. The CEOC visited in Katsina had very good supplies with virtually a full range of methods available. The register at CEOC level showed up to 14 women being supplied family planning per day. At the same facility, all nurses in the female ward had trained to perform Manual Vacuum aspiration and the equipment looked good. According to the MVA register, all patients were offered family planning which is best practice. The team saw evidence of stock outs of most essential drugs. The 'Free MNCH' policy is not being followed up with budget release to match the demand. (During a maternal death audit, one of the critical factors was delays created by the patient having to pay for a blood transfusion.)

The greatest set back to the delivery of services is the significant delay by the supplier 'Crown Agents' on the delivery of essential equipment for facilities (now 15 months behind schedule). This has had numerous repercussions for the programme among which are: inability of trained health staff to put knowledge into practice following the huge gains made in training over the last year; inability for EOC facilities to meet the signal functions at any level; and pressure on the poorest to pay for drugs and supplies from the private market. At the time of the review the first containers of drugs had arrived at the state medical stores and a part of the equipment (this was one container of the eight expected).

It was noted by the review team in Katsina that there was a very large response to the Nutrition outreach day (UNICEF and SCF) at BEOC level with large numbers of women attending with young children. This was seen as a good opportunity for integrating other activities such as promotion of family planning and health education. It also provides an opportunity for immunisation, including Tetanus Toxoid for women of reproductive age. It appears that women are not targeted for TT1 prior to pregnancy which means those not attending ANC will be missed.

Operations research. The SPHCDA specifically brought up the importance of Operations Research and they are clearly being involved. The team heard about OR in the presentation (mainly process issues – such as formation of an ethics committee) but little about the research. Asset transfer (i.e. a gift bag) if delivery at a facility is a great idea that could be started and monitored. PRRINN-MNCH should keep all informed on the progress with this initiative.

Information systems. In all facilities there is some data being collected – and often presented on the clinic office walls. Overall the team had concern about how data is being used. There was no evidence of feedback to health facilities from the data they 'send up' or evidence that facility data is being used by local government or the state in planning and budgeting. Disaggregated data on Katsina may be a powerful advocacy tool – such as maternal mortality. Finally, ANC records and delivery records need to be thoroughly reviewed in Katsina. Women held records were written in exercise books.

At the CEOC level in Katsina, the review team tried to track data from delivery registers at the maternity unit and registers kept in hospital's register unit down to actual CS cases and maternal deaths. In general clinical data is not available after patients have left the hospital and referrals cannot be traced.

Demand generation. The team saw excellent work with the Emir. Demand side work seems good (all women community volunteers knew danger signs) but this component of PRRINN-MNCH's work will need more emphasis as the supply side improves. ANC and deliveries figures are going up – but need to go up much more – and the team was concerned over the slow rate of increase in facility births (over the previous month there had been 300 women attending ANC and only 15 delivered in the facility.) On the other hand, family planning demand is rising.

PRRINN-MNCH seems stronger in community mobilisation than V&A. Facility committees are working more with communities – and much less on advocacy with LGAs and facility committees are not working with other facility committees so the coalitions are not happening. The public / facility committee / civil society voice are still quite quiet in Katsina state.

Annex 4: Yobe State Report

Overall, this is a state where a few years ago, little was expected to be achieved. Now, at the midterm stage, in most output areas, the Yobe state programme has exceeded expectations. The majority of the milestones are on track and the NICS survey presents an improving picture of immunisation.

Staff and leadership. Eric Amuah is an outstanding team leader--he is knowledgeable about his state and his priority areas and has a clear vision for the future. He is also empowering to his staff and gives them much of the credit for the success. It is also encouraging to see such strong assertive female staff who are highly skilled and strong advocates for women's health. There was also excellent cross-working with other state teams (particularly with Zamfara).

Working with Government. The team saw evidence of excellent networking with State Ministry officials who are supportive of PRRINN-MNCH. It is the view of the Review Team that, previous to PRRINN-MNCH, these officials have had limited budget, limited interest and limited support. PRRINN-MNCH has been catalytic in making them "proud" of the progress they have achieved in health and this progress has been jointly owned. Yobe state has made interesting links with the Ministry of Religious Affairs and the director of Sharia who are also supportive of PRRINN-MNCH work. They feel that it is harmonious with their religious principles and they see various mechanisms (Hisbah) which can support PRRINN-MNCH.

Working with other Partners. WHO, MDG and UNICEF appreciate the work and support of PRRINN-MNCH. They see this as a strong partnership with PRRINN-MNCH providing expertise and some specialist support. It is likely there will be significant spill-over benefits to the Ministry and other partners as a result of the PRRINN-MNCH programme in Yobe (particularly in the area of immunisation). There is close working on IPDs and this is one aspect which also seems to have good linkages with LGAs.

YSPHCMB. The meeting with the YSPHCMB was the highlight of the visit. There is strong direction and excellent political and technical links with key stakeholders in the State and LGA. This mechanism has the greatest chance of success, but it is still in its infancy and there are many uncertainties. It is likely to take a few more years until the structures are strongly embedded, the resourcing solid, and there is evidence of clear health impact.

There are still areas which will require further work including:

- **Support needs proving.** The Health commissioner was supportive of new YSPHCMB but did not give details on how he would support the board and ensure its success and what he felt were the potential risks. It is a concern that he didn't give a detailed articulation of what he expects from this and how he will ensure it happens.

- **Little progress on M&E Framework.** The MOU has been signed nearly a year ago and the M&E framework has still not been agreed. (The Health Commissioner has agreed to have the framework agreed by end of March.)

- **Budget tracking still needs work**. Lots of excellent work with Ministry officials and technocrats but still unclear on how well budget flows tracking

and working. Clear progress has been made in just understanding how to make a realistic budget and agree it.

Human Resources. There is also strong leadership on human resources and the Yobe HR forum seems to be a particular channel for further development. The M&E work is responsive and there was an increased emphasis on the collection of data and use by ministry officials (particularly in HR areas). Knowledge management, particularly strong in HR, is addressing a very critical weakness in the system. The team saw excellent networks with the nursing school and school of health technology; all are working to address these issues. (However, the state does remain seriously constrained by a lack of health workers.)

Service delivery. Yobe has particular challenges due to the terrain and the long distances and this makes close supervision a real challenge for members of the project team. However, the team members have done an excellent job of supporting and supervising this, despite the logistical and geographical challenges. The Review Team saw clear issues with delays in supplies due to Crown Agents constraints.

HMIS and Knowledge Management. The Review Team would like to see a clearer linkage of data used to inform practice and improve quality as in Zamfara. It appears that data is being used but the team was less clear if it was used outside of the programme to inform and to guide service practice and performance. The data presented was detailed (including denominators and baselines), accurate (as much as possible in weak systems) and timely.

Demand Generation. In the one cluster visited, demand generation remained an issue. The site has been operational for one year but delivers approximately 13 births per month. Some team members went to the radio station in Yobe and there was a lengthy debate about how and when the messages would be broadcast in Kanuri. There was little articulation about how best to reach the target audience, (e.g.: what times, what messages) and who is the target (there was the assumption that all people listen to the radio in the morning? Is this also true for women?) On the other hand, there were great examples of radio jingles that are popular.

Annex 5: Zamfara State Report

The Review Team travelled to Gusau from Kano and arrived at the PRRINN-MNCH office for meetings with the STM Dr. Ahmad Abdulwahab and his staff. The team received a fine presentation which set the stage for the visit.

Meeting with Development Partners. A meeting was held with development partners including the WHO Coordinator, UNICEF representative and MCHIP. It was observed that PRRINN-MNCH has established good working relationships with the partners and plays a leading role in partner's coordination with stakeholders. The partners commended PRRINN-MNCH on the Basket Funds initiative for routine immunizations, supplementary immunizations activities (SIAs) and surveillance. PRRINN-MNCH was also commended on the development of the State Strategic Health Development Plan (SSHDP).

Meeting with the SMOH and other MDAs. The meeting was held in the office of the State Commissioner of Health who had invited all the Directors from the various departments and related MDAs such as Budget, Women Affairs, the State PHC Agency and the NPHCDA State Coordinator. The Commissioner expressed appreciation for the various support provided by the PRRINN-MNCH and noted that this has necessitated the State Governor to go to DFID Country Office in Abuja where he signed the MOU. In Zamfara, this mechanism is clearly working very well so far.

Training. Of all facilities visited it was clear that training coverage was high and included IMCI, KMC, ENC, LSS EOC and NC and FANC. Staff also confirmed that they had received one follow up visit by trainers (LATH) and ongoing supervision through integrated supportive supervision. ISS has been integrated into quarterly performance reviews at state and LGA level in Zamfara.

Routine Immunisation. The PRRINN-MNCH team in Zamfara is to be highly commended for putting in place the core building blocks of an immunization system in Zamfara State. The team is to be further commended for raising the profile and importance of routine immunization and engaging substantively at State level and among the partners on all aspects of immunization. Zamfara State and PRRINN-MNCH should be exceedingly proud of the 2010 NICS results which indicate that Zamfara's DTP3 coverage has increased from 22% in 2006 to 64.4% in 2010 (the 2008 DHS survey (based on 2006 data) put Zamfara's DTP3 coverage at 9%). No expired vaccine was found in any health facility.

RI challenges remain, however, and more work is required. There was a DTP stock out from July – September 2010 which was attributed to Nigeria anticipating the introduction of pentavalent through GAVI; there were also shortages of TT and BCG. The State Cold Chain manager seemed to have rather a passive approach to vaccine deliveries, relying exclusively on Abuja for quarterly deliveries and didn't feel he had any role in forecasting or requesting additional vaccine from Abuja or other States if there were shortages. Nahuche has a solar fridge but there was no temperature monitoring chart. The other two facilities relied on vaccines being provided from LGA stores on the immunization day in cold boxes. Attention to freezing as well as heat should be considered in the supply chain and more attention needs to be paid to vaccine storage and handling. The TT vaccine (Nahuche) was frozen, having been stored next to ice packs and was being thawed for administration to pregnant women. (Frozen TT cannot be used and must be discarded.) TT being used in the ANC in Bundugu was properly stored. Almost all health workers (mostly

CHEWS) knew how to read the vaccine vile monitor (VVMs) accurately and knew the shake test–all good practices. The CHEWS in training did not know what VVMs were, but perhaps they hadn't reached this stage of their education? In terms of waste management, 2/3 facilities had properly constructed incinerators but only one (Nahuche) was being used, so in effect 2/3 facilities are using open burning (one at least in a pit) but Bundugu is just open burning –and given that there is a newly constructed incinerator, it should be used.

Facility visits. The review team visited the Furfure PHC facility about 20KM from Gusau. The facility was recently renovated by PRRINN-MNCH and is headed by a Senior Community Health Extension Worker (CHEW). It has 4 Midwives posted by the NPHDA on the Midwifery Service Scheme (MSS). The team visited the Nahuche Comprehensive PHC (BEOC) as well as the Comprehensive PHC and Nahuche community health centre. The SDSS store had been renovated by the community and they had provided a refrigerator, an air conditioner and shelves for the drugs. The health care workers who spoke with the team were knowledgeable about their communities and catchment area. The challenge will be to get the staff to understand the importance of how to reach the unreached, the defaulters, and the non-users. ANC records and delivery records were in pre-printed records in Zamfara, making information easier to trace and also guiding health providers in accurate record entries.

At a CEOC in Zamfara there was no acceptable provision of an area in or around the operating theatre for staff to prepare, including changing and hand washing. Whilst the Review Team acknowledges that it is the state that leads the activity, the programme staff have themselves acknowledged the need to be vigilant in monitoring activity at this early stage to ensure the minimum standard is sufficient and to check that refurbishment has been carried out as planned prior to the scale up of the programme.

Operations Research. The PRRINN-MNCH team has piloted an innovative TICK sheet in Furfuri to improve the tally system. The team looks forward to seeing how this will be used.

HDSS centre. The Health and Demographic Surveillance Site is located at Nahuche community of Bungudu Local Government Area (LGA), 32KM away from Gusau the state capital. It is designed to monitor health and population changes in the community that will have an impact on health and livelihood interventions. The progress at the centre in just one year was impressive as the centre went from an empty building last year to a fully functional facility.

HMIS. This output is performing extraordinarily well and the Zamfara state staff and the PRRINN-MNCH team have achieved impressing results in establishing an integrated and harmonized HMIS system. The system is comprehensive and includes IDSR, Immunization, ANC, FP, and MNCH. Computerized Data Warehouses (using the Software DHIS) are established and functional at LGA and State Level. The databanks contain comprehensive registries of monthly collected facility based data. Submission rates from facilities for MNCH and RI are over 95%. Facilities transfer monthly summary forms to LGAs and LGA transfer to state. The State HMIS office was well equipped and fully operational with very competent staff. Data Quality Audits are institutionalized and show very promising results. The team saw successful collaboration with USAID-MCHIP on HMIS and tools and forms have been jointly developed. The next step is to continue working on analysis of data for problem solving and improving coverage, as well as effective dissemination and policy work. To document maternal and newborn deaths, the system must extend to

collect information from the community. At state level policy dialogue, the team got the impression that data on maternal deaths are still not being systematically used and analyzed due to underreporting and challenged related to the interpretation of the numbers.

Community Engagement at Furfure Community. The female members of the review team held a meeting with the community women while the male counterparts had discussions with the men outside. The community demonstrated appreciation of the PRRINN-MNCH support and their unreserved commitment in mobilizing their members particularly women to seek for health care participate in the maintenance of their health facility. In addition, the community members we spoke to are well aware of when routine immunizations are offered and when children should be brought for their vaccines.

Annex 6: TERMS OF REFERENCE

Mid Term Review

21 February – 4 March 2011

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

1. Objective

1.1 The aim is to undertake a Mid Term Review of DFID's Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative (PRRINN-MNCH).

1.2 Specific outputs are:

i. Assessment of progress of PRRINN MNCH against the log frame purpose, outputs and OVIs over the last year;

ii. Completed standard DFID Annual Review template for PRRINN;

iii. A Midterm Review that objectively assesses the status of the programme in light of the original vision and plans; also looking at forward at the last half of the programme and its sustainability;

iv. Production of draft and final report to include findings, conclusions and recommendations and expected outcomes and results until the programme completion date; and a

v. Short report on VFM conclusions and recommendations [4 pages max] Dan Kress to write with support from DFID Results Advisor.

2. The Recipient

2.1 The Recipient of this work is DFID Nigeria.

3. Scope of Work

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

- Quantitative and qualitative progress and achievements against programme purpose and outputs over the previous 3 years;
- Output 3 (service delivery including strengthened maternal care) in particular;
- Follow-up on recommendations in the 2009 annual review report;
- Risk analysis and mitigation;
- Management and reporting arrangements;
- Linkages with Government of Nigeria institutions, policy, other programmes;
- Assess the objectives and the joint partnership of donor and Government of Nigeria, and structural, organisational and institutional issues deriving and comment on effectiveness and or need for change;

- Economic, financial and budget processes; in particular, specific Value for Money (VfM) recommendations and issues as suggested below:

1. *Break down input and output costs to show how money is being spent,*
2. *Develop benchmarks and compare costs of different inputs and outputs, (for, both service provider costs and commodities),*
3. *Identify efficiency savings by service providers,*
4. *What are the trends in efficiency over time?*
5. *Examine the efficacy of different outputs in contributing to project purpose and goals,*
6. *Is there evidence of spin off? Broader benefits? Possible longer-term impacts?*
7. *In scoping positive and negative project scenarios, assess how they affect the risk of achieving good VfM for the project?*
8. *Specify any considered contractual changes needed and set out specific recommendations on improving VfM.*

- *Each donor priorities (Norway—big-picture look and post-programme sustainability); (DFID—VFM) Both: scale up within states.*

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

4. Method

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

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

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

4.4 Activities will include:

- Read and analyse background information on: Nigerian Federal and State policies and strategies particularly for MNCH and routine immunisation; the current status of MNCH in Nigeria; PRRINN-MNCH documentation including programme memoranda and reports;
- Agree on responsibilities for addressing particular aspects of the review;
- Hold discussions with DFID and members of the PRRINN-MNCH consortium;
- Meet and include specific recommendations from Government of Norway Partners.
- Hold discussions with Federal and State Government officials and other national and international partners active in immunisation e.g. USAID, WHO, UNICEF.
- Review the status of immunisation and primary health care services in the field in at least 1 health facility per state;

- Review family planning aspects including: State level forecasts and unmet need for contraceptives; assess the provision of modern family planning services in PHC facilities.
- Review one MNCH cluster per state to assess quality and MNCH continuum of care.
- Hold a Midterm Review discussion with the full team;
- Hold a wrap-up meeting with PRRINN-MNCH staff and key stakeholders to discuss key findings and recommendations;
- Hold discussions in Abuja: List to be determined.

5. Reporting

5.1 The Team Leader will be responsible for writing the combined report (Annual Review and Midterm Review) with specified inputs from some other team members including recommendations, and for completing the internal DFID annual reviews template for PRRINN.

5.2 A draft narrative report of the Mid Term Review with key findings and recommendations will be completed by Monday 14th March. Comments will be provided by DFID by Monday 21st. The final report should be submitted by Thursday 31st March.

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

6. Timeframe

6.1 Essential background reading for the review will be supplied to team members by end of January and this reading should be undertaken before the start of the main review mission on 21 February.

6.2 The team leader will provide inputs to the preparation of the review in January 2011.

6.2 The review mission will be undertaken from 21 February to 4 March 2011 with finalisation of the reports by 31st March.

7. DFID Coordination

7.1 The overall coordinator will be Mick McGill, Programme Manager with Susan Elden DFID Health Adviser providing professional and technical advice.

8. Review Team

8.1 The proposed Review Team members are listed below. .

- Team Leader: Carol Bradford
- Health Economist: Dan Kress -, Procurement/ Results (VfM aspects)
- Violaine Mitchell: Routine Immunization
- Sarah Dobson MNCH Consultant
- Jane Miller DFID Senior Health Adviser

- Mick McGill and Edward Idenu: DFID Programme Managers
- Health Adviser from Norway: Solvi Taraldsen. Leone Lothe
- Norway Deputy Ambassador, Nigeria: Jan Erik Rasmussen
- SPARC/SAVI
- Paths2
- GATES Foundation

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

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

9. Background

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

9.2 *MNCH in Nigeria*
Nigeria is not on target to reach MDGs 4 and 5. Maternal, newborn and child health mortalities in northern Nigeria are amongst the highest in the world.
While the national under-five mortality is 157 per 1000 live births in the 2008 DHS the figures for the North West and North East zones are 217 and 222 respectively. Immunisation coverage in Nigeria has fallen since the 1990s to become one of the lowest in the world. The 2008 DHS suggests full immunisation coverage in the 4 PRRINN States to be between 0 and 5%, with measles coverage between 8 and 25%.

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

9.3 *PRRINN- MNCH*

DFID-funded PRRINN was originally a 5-year programme supporting the strengthening of routine immunisation and was extended by a year as a result of the findings of the OPR of 2009. The programme is now due to end on 31st December 2013 coinciding with the MNCH completion date. The programme's outputs include capacity building of governmental partners, increasing community demand for immunisation, and harmonisation of donors' inputs in order to revitalise routine immunisation. It has been operational in four states (Jigawa, Katsina, Yobe and Zamfara) in Northern Nigeria since early 2007. In 2008 the Norway-funded MNCH programme was added, designed to augment and strengthen PRRINN by deepening the governance components of PRRINN, strengthen the broader PHC system with focus on maternal and child health and creating a larger operational research component. DFID is managing the programme on behalf of Norway through a delegated cooperation arrangement.

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

and combined workplan. However, annual reporting requirements are still separate. The narrative report of the annual review of the combined logframe and workplan was requested by DFID and Norway. DFID requires a separate assessment of progress against the purpose and outputs of the PRRINN logframe, with the information being derived from the combined review.

The combined annual review of PRRINN and Inception Review of MNCH in February 2010 showed that: PRRINN was making good progress against most outputs at state level especially Output 4 on the demand side for immunization. On the other hand it was too soon for Output 3 on strengthening primary healthcare systems to demonstrate progress.

10. Relevant Documentation

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

PRRINN programme memorandum (2007)
MNCH programme memorandum (2008)
PRRINN-MNCH combined logframe
PRRINN logframe
PRRINN-MNCH annual report 2009
PRRINN-MNCH workplan and budgets for 2010 and 2011
PRRINN and MNCH Extension reports
Relevant consultants' reports

10.2 Additional relevant material includes:

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

3 February 2011

Annex 7:Review Team

PRRINN-MNCH Review Team (2011): additional information			
Name	**Affiliation**	**Expertise**	**Timing**
Joe Abah	SPARC	Governance	First week
Jummai Alhamdu	SAVI	Governance	Second week
Carol Bradford	Team Leader, Consultant	Reproductive Health, Evaluation	Both weeks
Daniel Carter	DFID	Health and nutrition	Second week
Sarah Dobson	MNCH Consultant	Maternal and newborn health	Both weeks
Susan Elden	DFID	Health Adviser	Both Weeks
Steve Fraser	SAVI	Governance	Second week
Kulchumi Hammanyero	DFID	Social Development	Second week
Edward Idenu	DFID Programme Officer	Logistics	First week
Abubakar Kende	Paths2	State Team Leader, Jigawa	Both weeks
Dan Kress	Gates Foundation	Health economist, VFM	First week
Lene Lothe	NORAD Senior Advisor	Health	First week
Mick McGill	DFID Programme Manager	Logistics	Second week
Jane Miller	DFID Health/Education	Health	Second week
Violaine Mitchell	Gates Foundation	Routine immunisation	Both weeks
Saul Morris	Gates Foundation	Community engagement	First week
Lawal Aliyu Rabe	SPHCDA, Katsina	State Government Representative	Second week
Bulama Umar Suleiman	SMOH, Yobe	State Government Representative	First week
Usman Tahir	SMOH, Jigawa	State Government Representative	Second week
Solvi Taraldsen	NORAD consultant	Obstetrician/Gynaecologist	Both weeks
Samuel Usman	Paths2	Service delivery adviser	First week
Kevin Gager & Adam Suleiman	SAVI		Joined team for key meetings

Annex 8: Team Itinerary (by State)

22 February 2011 – 4 March 2011

Jigawa State Midterm Review Schedule 28th February 2010

S/N	Time	ACTIVITY	LOCATION	Persons and activity to see	Remark
1	9:00am	Arrive Dutse, Jigawa State	Dutse	PRRINN-MNCH Dutse team	
2	9:00 am – 10 am	Briefing by PRRINN-MNCH Dutse team	Dutse	PRRINN-MNCH Dutse team	
3	10:00am -2:00pm	Field visit to OR site and Jahun Gunduma Council	Jahun and OR site	OR: Takalafiya CHEWs in the Community	
4	2:00pm – 3:00pm	Lunch	Dutse/Jahun		
5	3:00 pm – 4:00pm	Visit to community engagement site	Dutse	Tsakuwawa community, Miga LGA	
6	4:00pm – 5:00pm	Debrief with PRRINN-MNCH state team	Dutse	PRRINN-MNCH team	

DAY 2

S/N	Time	ACTIVITY	LOCATION	Persons and activity to see	Remark
1	9:00am – 11:00am	Visit to Kafin Gana PHC	Kafin Gana, Birnin Kudu LGA	RI service delivery	
2	11:00 am – 12:00 noon	Meeting with SMOH	Dutse	Health sector policy makers	
3	12:00 13:30pm	Meeting with Gunduma Health System board	Dutse	Health care under one roof implementation agency	
4	2:00pm – 3:00pm	Lunch	Dutse	Dutse	
5	3:00 pm – 4:00pm	Meeting with partners	Dutse	Key partners: WHO, UNICEF, PATH2	
6	4:00pm – 5:00pm	Debriefing at PRRINN-MNCH	Dutse	PRRINN-MNCH Team	

Katsina State Midterm Review Schedule 28th February 2010

MEETINGS: 28 FEBRUARY
10.00 – 11.30 – STATE TEAM
11.30 – 12.00 – State Ministry of Health
12.05 – 12.35 – State Ministry of Finance & Budget
12.40 – 1.10 – State Ministry of Women's Affairs
1.10 – 1.50 – LUNCH
2.00 -2.30 – State Primary Healthcare Development Agency
2.40 – 3.10 – State Ministry of Local Government
3.30 – 4.30 – PARTNERS (WHO; UNICEF; SuNMaP; SCUK; ACCESS; GEP)

FIELD VISITS: 01 MARCH
08.00 ---------- DEPART KATSINA
09.00 – 10.00 – DAURA CEOC
10.40 – 11.10 – BAURE BEOC
11.25 – 11.40 – FASKI PHC
11.45 – 12.15 – FASKI COMMUNITY
01.30 – 02.00 – HRH EMIR OF DAURA (IN COMPANY OF 3 CLUSTER LGAs CHAIRMEN)
02.00 – 02.30 – HISTORICAL MONUMENTS
02.30 – 03.30 – LGA TEAMS (CHAIRMEN & PHC DIRECTORS; 3 LGAs)
03.30 ---------- DEPART DAURA
04.30 ---------- ARRIVE KATSINA

DEBRIEFING MEETINGS: 02 MARCH
09.30 - 11.00 – STATE TEAM
11.15 ---------- DEPART FOR KANO

Yobe State Midterm Review Schedule 28th February 2010

Date	Time	Activity
Tuesday 22/02	4.00 pm	Arrival of the Team
Tuesday 22/02	4.00 pm – 5.00 pm	Welcome and presentation in office
Wednesday 23/02	Whole day	Team A trip to Yunusari
Wednesday 23/02	8.00 am – 10am	Review of documents in office.
	11.00 am – 12 am	SMOH management at SMOH office
	12 noon -1.00pm	SPHCMB
	2.00pm – 3.00 pm	HRH Forum Chairman + 2 Principals at SSG office
	3.00 pm – 4.00 pm	Partners in WHO office
Thursday 24/02	9am – 10am	Meeting with Director Sharia (MORA) in Director's office
Thursday 24/02	10 am – 11 am	Meeting with Ministry of Women Affairs in their Office
Thursday 24/02	12noon – 1.00pm	Meeting with Perm Sec MoBEP
Thursday 24/02	4pm – 5pm	Feedback in the office.

Zamfara State Midterm Review Schedule 22nd February 2010

Time	Activity	Contact person	Venue
Tuesday 22/02/2011			
Afternoon	Arrival of Team		
13.00hr – 13.30hr	Briefing by the review team	Team Leader	PRRINN-MNCH Office
13.30hr – 14.30hr	Lunch/Prayers		
14.30hr – 17.00hr	Meeting with the PRRINN-MNCH team Review of documents	STM, PRRINN-MNCH	PRRINN-MNCH Office
Wednesday 23/02/2011			
08.00hr-9.30hr	Meeting with Partners (WHO, UNICEF, MCHIP)	WHO SC, Alpha	WHO office
9.30hr – 10.00hr	Tea Break		
10.15hr-11.15hr	Meeting with Stakeholders (MOH, MBEP, MFLG and NPHCDA)	Hon. Commissioner, MOH	Office of the Hon. Commissioner, MOH
11:15hr – 11.30hr	Travel to Furfuri		
11.30hr -12.30hr	Visit to Furfuri Health facility (MCH services)	OIC Furfuri PHC, Abubakar Mande	Furfuri PHC
12.30 – 13.00hr	Travel to Nahuche		
13.00hr-13.30hr	Visit to Nahuche PHC (MCH services)	OIC Nahuche PHC, Salisu	Nahuche PHC
13.30hr – 14.15hr	Lunch/Prayers		Nahuche HDSS
14.15hr- 15.00hr	Visit to HDSS centre Nahuche	HDSS Manager, Alabi	HDSS Center
15.00hr- 15.30hr	Travel to Bungudu		
15.30hr- 16.00hr	Visit to Bungudu Cold store and HMIS unit (immunization services)	LIO, Usman Kado,	Bungudu cold store
16.00hr- 16.30hr	Visit to Furfuri Community (community Engagement services)	Chairman Health committee	Furfuri village
16.30hr- 17.00hr	Travel to Gusau		
Thursday 24/02/2011			
8.30hr- 9.15hr	Visit to State Cold Store (Immunization services)	State CCO	State Cold Chain Offiice
09.15hr- 10.00hr	Visit to State Medical stores (SDSS services)	Director PS, Pharm Isah Gusau	Central medical stores
10.30hr- 11.30hr	Visit to Bungudu GH (CEOC services)	PMO, Dr Gambo	GH Bungudu
11.30hr- 12.00hr	De briefing by the MTR team	Team Leader	PRRINN-MNCH Office Conference room
12.00hr – 13.00hr	Lunch		
	Departure to Kano		

Schedule of Visit of the Midterm Review Team to Abuja

Date: Thursday March 03, 2011
MTR Team Members: Carol Bradford & Sarah Dobson

Time	Location
0900hrs – 0930hrs	PRRINN-MNCH, Abuja Office
O945hrs – 1030hrs	Federal Ministry of Health – Family Health Department (FMOH)
1045hrs – 1145hrs	National Primary Healthcare Development Agency (NPHCDA)
1200hrs – 1245hrs	PATHS 2
1300hrs – 1330hrs	USAID
1330hr – 1415hrs	Lunch
1430hrs – 1500hrs	WHO
1500hrs – 1530hrs	UNICEF
1530hrs	Departure to Airport

Annex 9: Persons and Organisations Consulted

STATE: YOBE

Meeting with Director Sharia (MARA)

Name	Position
Mohammad Tanko	Director, Sharia
Moher Haji Kurugu	Director, Planning/Research
Mohammad Tela	Director, Kakat and Andomat
Mr Lawala	Director of Enlightment
M Kagi	
M Shuwadiskam	Director of Supplies

State Ministry of Health

Alhaji Yahn Barde	Permanent Secretary
Lawan Mustafa Kaka	Director, K E Services
Sulemain Shaiby	YBC
Alli Ahmed Isa Nguru	YBC
Alluaji Umar Geidan	
Ibrahim Bulama Dachin	General Manager

HRH Forum Chairman

Baba Mallam Wali	Permanent Secretary

Partner collaboration: WHO, Damaturu

Dr M. I. Adamu	WHO/SC
Hassome Ig-Dahonen	TBHSDP
Bawakil Hassan	MDG Office
Jatau, S.S.	UNICEF
Pharm David Mshelbwala	UNICEF, USLC
Abdullahi Shehu	MOH (NHIS)

Ministry of Budget and Planning

Alhaji K.K. Amishi

STATE: ZAMFARA

State Ministry of Health

Isah Mohdgusau	DPS
Rilwann Moh'd Anka	DHIS
Moh'd Malami	DNS
Mahammad IBN Mahmud	NPHCDA
Hassan N Kuryf	PHRS
Baliusu A. Amica I	DFS
Alhaji Halilu Aliyu Anka	Permanent Secretary
Dr Sa'ad Uidrisu	Honourable Commissioner
Alh. Maiean Mahlar	DG
Ahmed Ibrahim	DDHR
Abdullha Mosikauru	SMOH
Bello Liman	PHCMB Exec Sec
Hamila Salihu	MBEP
Haluhi H. Bakuna	Minister for Local Govt
Dr K. A. Naabba	DPHS

Amina A Modibbo	Ministry of Women's Affairs

Cold Chain Officer

Abdullah Kanoma	SMOH/SCCO
Nasim Yakusu	SMOH/ASCCO
Bello Umaru Jabaks	SMOH/ASCCO

BEOC Bungudu

Ummu Abdullah	ACNO
Hadiza Shikai	ACNO
Rashida Mohid	SVC

Partners Meeting

Name	**Organisation**
Amina Bale	MCHIP
Giwa Abdulganiyu	UNICEF
Alpha Njie	WHO
Shittu Abour-Agune	MCHIP
Jones Mpakateni	UNICEF

STATE: JIGAWA

Gunduma Health System meeting

Dr Hassana H Adamu	Director General
Alh Aminu DanMallam	Director PHC
Dr Bello I M	Director HR
Muhammed B Muhammed	Director Admin & Finance

Partners Meeting

Dr Sani Maiwada	State coordinator WHO
Dr Umar Hussaini	PATHS 2
Abubakar Imam K	UNICEF

Jigawa State Ministry of Health

Dr I Nashabaru	Health Commissioner
Bala I Abubakar	Permanent Secretary

Hassan Abdullahi	Director Admissions and Finance
Lawal Bal	DPS

STATE: ABUJA

National Primary Health Care Development Agency (NPHCDA)

Name	**Position**
Dr. M.A. Pate	Executive Director
Dr Ugo Okoli	Project Advisor MSS
Dr.O.Ogbe	TA/ED/NPHCDA
Dr.E.I. Odu	Director, PRS
Dr Nnenna Ihebuzor	Director,CHS
Abdulfafah S	Deputy special duties
A.L Abubaker	Director
Dr.E.A Abanida	Director/DCI

Meeting with Family Health Department. FMOH

Dr. P Momah	Director FHD
Dr.B Adeniran	H/RHD
Bajomo Remi	CPO,FDH,
A.E Omory	AD/ Nut
Ajoko J.K	HEO
Dr.Dawodu A.A	RH
Adama Abdul	CH
Dr Aderinola O.M	CH
Njoku C.E	Nut
Tomouro Fadyeyhfe	CHD

Meeting with USAID

Sharon Epstein Gabra	Team Leader, Health /Population/Nutrition

Meeting with UNICEF

Dr Boubacar Dieng	EPI Team Leader
Esther Obinja	Health Specialist (MNCH)
Emmanuel Gemade	UNICEF MNCH

PATHS 2

Mike Egboh	Director

Annex 10: Risk Assessment March 2011

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

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

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

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

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

Annex 11: PRRINN Logframe 2007-2011

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

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

[5] Extrapolated from Demographic Health Survey (DHS) 2008 Under Five Mortality of 157

	Measles incidence reduced by 80%	22,250	16,687	11,125	4,450	
		Source				
		Integrated Disease Surveillance and Response (IDSR) 2008, formerly DSN,				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
	Polio incidence reduced to near zero	237	178	119	0	
		Source				
		DSN 2008				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	19,000,000					
INPUTS (HR)	**DFID (FTEs)**					

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

	1,900.000				
INPUTS (HR)	**DFID (FTEs)**				

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

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

OUTPUT 3	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	**Assumptions**
Primary health care systems strengthened to support routine immunisation	% of health facilities providing RI experiencing vaccine stock-outs of TT	38%	34%	29%	19%	Global and national initiatives do not disrupt planning and implementation of PHC and RI at State and LGA levels States continues to provide drugs on a sustainable basis
		Source				
		Stock records or PPRHAA				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
	% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%	7%	29%	40%	50%	
		Source				
		PPRHAA reports				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
	Number of 1-year-old	109,464	204,711	299,957	403,556	

	children immunised against measles	**Source**				
		NICS 2006; PRRINN Household Survey 2007, MNCH Household Survey 2009; DHS				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
	Number of health professionals trained annually	904 (M=552; F=352)	Number	Number	Number	
		Source				
		Survey of Health Training Institutions 2009, Annual Reports of Health Training Institutions. *Baseline, milestones and target should be disaggregated by sex*				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
30%	Percentage of PHC facilities with tracer drugs available	41%	54%	58%	62%	
		Source				**RISK RATING**
		Stock records or PPRHAA				High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	8,360,000					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 4	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	**Assumptions**
Increased demand for routine immunisation	Increased political support for RI evidenced by high level public events	None	1 at state level; 1 at LGA level	1 at state level; 2 at LGA level	1 at state level; 2 at LGA level	MNCH programme and other partners provide additional complementary support
		Source				
		Media reports; project reports				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
	%of wards with a development committee and/or health partnership implementing a community action plan	None	7%	15%	30%	
		Source				
		Community monitoring process				

	Indicator	Baseline	Milestone 1	Milestone 2	Target	
	% of mothers of children <2 in targeted areas who know the childhood vaccination schedule	10%	25%	35%	50%	
		Source				
		PRRINN Household Survey 2007, MNCH Household Survey 2010; MNCH Rapid Household Survey 2011.				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
25%	% of never immunised children <2 reduced in targeted areas	25%	20%	16%	13%	
		Source				**RISK RATING**
		NICS 2006, 2009; PRRINN Household Survey; *Baseline, milestones and target should be disaggregated by sex*				Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	4,180,000					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 5	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	**Assumptions**
Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities	Formal system established for leveraging, accessing and utilising additional PHC funding	None	1 system designed	1 system implemented	2 systems implemented	All donors and partners provide common support and advocate for common strategy Sufficient funds allocated and released at Federal level for national immunisation supplies
		Source				
		System reports				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
	Federal level delivers X% vaccines and supplies to states on time	*<80%*	90%	100%	100%	
		Source				
		Stock records of zonal and state stores				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
10%	Agreed strategies to improve efficiency of RI	None	Strategies developed	Strategies owned	Strategies implemented	
		Source				**RISK RATING**

		Federal level reports			Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**
	760,000				
INPUTS (HR)	**DFID (FTEs)**				

PRRINN-MNCH Combined Logframe 2009-2012

PROJECT NAME	PRRINN-MNCH in Northern Nigeria, 2009-2012					
GOAL	**Indicator**	**Baseline (2009)**	**Milestone 1 (2010)**	**Milestone 2 (2011)**	**Target (2012)**	
To improve maternal, newborn and child health in Northern Nigeria	MDG4, Target 5 Reduce by two thirds, between 1990 and 2015, the under five mortality rate	153[6]	149	144	140	
		Source				
		National Demographic Health Survey (DHS) 2008.[7] [8]				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target**	
	MDG5, Target 6 % of births attended by a skilled birth attendant (SBA) in targeted CEOC clusters	38.9%			50%[9]	
		Source				
		NDHS 2008				

PURPOSE	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Assumptions
To improve effective access to MNCH (including RI) services in four states	% of infants fully immunised by first birthday	16%	38%	60% (PRRINN Target)	65%	Maintenance of Federal allocations to State and LGA health budgets Continued political stability and absence of civil strife
		Source				
		NICS 2006, 2009, 2012, MNCH Household Surveys 09, 10, 12, Mini Household Survey 2011, HMIS/PMS				

[6] Extrapolated from Demographic Health Survey (DHS) 2008 Under Five Mortality of 157

[7] Target is based on 2 thirds reduction of 1990 U5MR

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

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

		Baseline, milestones and target should be disaggregated by sex				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (1012)**	
	% of women aged 15-49 have appropriate TT doses	15% 2006	60%	70%	75%	
		Source				
		NICS 2006, 2009, 2012, MNCH Household Surveys 09, 10, 12, Mini Household Survey 2011.				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Caesarean section rates (in targeted CEOC clusters)	0.5%	>0.5%	1%	>1%	
		Source				
		MNCH Services Survey 2009, PMS, MNCH Household Survey				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Percentage of women receiving ANC	21%	30%	38%	45%	
		Source				
		MNCH Household Surveys, HMIS/PMS				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Measles incidence reduced by 80%	22,250	11,125	4,450	2,225	
		Source				
		Integrated Disease Surveillance and Response (IDSR) previously DSN.				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Polio incidence reduced to near zero	237	119	0	0	
		Source				
		IDSR; WHO monitoring system				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**		**DFID SHARE (%)**
	22,700,000					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 1	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Assumption
Strengthened state and LGA governance of PHC systems geared to RI and MNCH	State government staff lead annual review and health planning process in all states	Planning process facilitated and supported by the programme	Process led by state teams with technical and financial support from the programme	Process led by state teams with limited support from the programme	Process led by state teams with no support from the programme	Federal, State and LGAs willing open up planning, budgeting and financial records to public scrutiny Draft Health Bill enacted and effectively applied at Federal, State and LGA level Federal funds are released to States for PHC services Donors want to harmonise and align with state priorities Federally managed funds agree to allocate resources to PRRINN-MNCH states
		Source				
		State health plans and budgets				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	All states successfully access new Federally managed health funds	One year in all states	Two years in all states	Three years in all states	Four years in all states	
		Source				
		State financial statements or federal level statements (e.g. NPHCDA for GAVI and possibly the PHC fund)				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Availability of PHC budget and expenditure reports for LGAs /Gundumas.	Limited data available in 3 states	Annual PHC budgets available for all targeted LGAs/ Gundumas	Annual expenditure reports available for all targeted LGAs/ Gundumas	Annual PHC budget and expenditure reports available for 80% of all LGAs/Gundumas	
		Source				
		State and LGA financial statements				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Number of states with their State Health Plan incorporated into their State Development Plan	Some linkage to SEEDs in 2 states	2 States	3 States	4 States	
		Source				
		State development plan document				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	State health plans reflect	Few examples of	Each state plan	Each state plan	Each state plan	

	project data from 2010	evidence based planning	has at least 3 examples of evidence based planning	has at least 5 examples of evidence based planning	has at least 7 examples of evidence based planning	
		Source				
		State health plans				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Number of donor PHC programmes reflected in State and LGA annual health plans	1 per state	2 per state	3 per state	3 or more per state	
		Source				
		State and LGA health plans				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	SIACCs support for RI through PHC system in all states	Little	Some	More	RI fully integrated	
		Source				
		Meeting records				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
15	Number of donor field missions and reviews done jointly	2	At least 2	At least 2	At least 2 (8 in total)	
		Source				**RISK RATING**
		Mission and review reports				High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	2,514,000					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 2	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumptions**
Improved human resource policies and practices for	% of targeted facilities with at least one health	5%	40%	70%	100%	Increased commitment to PHC at State and LGA level
		Source				

PHC	worker trained in LSS	Facility and staff monitoring reports, PMS, HRIS linked to DHIS			
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**
	HR policies and plans developed, operationalised, and implemented in each state	Some	Developed	Operationalised	Implemented
		Source			
		State Human Resource policy documents			
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**
	Number of health professionals trained annually	904 (M=552; F=352)	Number	Number	Number
		Source			
		Survey of Health Training Institutions 2009, Annual Reports of Health Training Institutions. *Baseline, milestones and target should be disaggregated by sex*			
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**
15	% of professional staff given in-service training in MNCH in targeted PHC facilities	0%	33%	66%	100%
		Source			**RISK RATING**
		MNCH services survey, In service training schedules, PMS, HRIS			High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**
	2,794,000				
INPUTS (HR)	**DFID (FTEs)**				

OUTPUT 3	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumptions**
Improved delivery of MNCH services (including RI) via the PHC system	% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%	18%	40%	50%	60%	Global and national initiatives do not disrupt planning and implementation of PHC, MNCH and RI at State and LGA levels States continues to provide
		Source				
		PPRHAA reports				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Number of PHC facilities	1	12 BEOCs	24 BEOCs	36 BEOCs	

	providing basic emergency obstetric care	**Source**				drugs on a sustainable basis
		MNCH services survey, PMS				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Systems for effective supervision in each State	Designed	Teams visiting with technical and financial support from the programme	Visits planned and implemented with limited technical and financial support from the programme	Visits planned, financed and implemented by each state	
		Source				
		Facility and staff monitoring reports, PMS				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	Number of 1-year-old children immunised against measles	126,439	299,957	403,556	485,624	
		Source				
		MNCH Household Survey; NICS, PMS *Baseline, milestones and target should be disaggregated by sex*				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	% of health facilities providing RI experiencing vaccine stock-outs of TT	38%	29%	19%	15%	
		Source				
		Stock records or PPRHAA, PMS				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
25	% of PHC facilities with tracer drugs available	50%	58%	62%	66%	
		Source				**RISK RATING**
		Stock records or PPRHAA, PMS				High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	9,169,000					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 4	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Assumptions
Operational research providing evidence for PHC stewardship, RI and MNCH policy and planning, service delivery, and effective demand creation	Number of pieces of OR into supply & demand aspects of MNCH feed into programme	None	2	2	2 (6 in total)	Results of operational research acceptable to government RISK RATING Low
		Source				
		Project reports				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
10	State plans reflect OR results	None	1 example per state	1 example per state	1 example per state (12 in total)	
		Source				
		State plans				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	2,960,000					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 5	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	Assumptions
Improved information generation with knowledge being used in policy and practice	Demonstrated level of understanding in use of information by trained HMIS officers in each state	Some	Basic	Moderate	Substantial understanding	
		Source				
		HMIS data and reports, HR performance indicators				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
	State plans increasingly built on evidence from HMIS	None	Some	Moderate	Substantial	
		Source				
		State plans, Evidence based planning guidelines				

IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Target (2012)	
10	% of LGAs with HMIS MNCH data collated at State level on a monthly basis	<10%	40%	75%	85%	
		Source				**RISK RATING**
		HMIS Reports, PMS				Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	1,404,000					
INPUTS (HR)	**DFID (FTEs)**					

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

	areas	MNCH Household Survey;			
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**
	% of facility health committees for intervention facilities in targeted areas actively monitoring drugs	0%	25%	50%	75%
		Source			
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**
	% of mothers of children <2 in targeted areas who know the childhood vaccination schedule	10%	35%	50%	60%
		Source			
		Household survey 2007, MNCH Household Survey 2010, 2012; MNCH Rapid Household Survey 2011.			
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**
20	% of never immunised children <2 reduced in targeted areas	25%	16%	13%	11%
		Source			
		NICS 2006, 2009, 2012; MNCH Rapid Household Survey 2011. *Baseline, milestones and target should be disaggregated by sex*			
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**
	3,366,000				
INPUTS (HR)	**DFID (FTEs)**				

OUTPUT 7	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	**Assumptions**
Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities	Formal systems for leveraging, accessing and utilising additional PHC funding	None	1 System implemented	2 Systems implemented	Systems functioning	All donors and partners provide common support and advocate for common strategy
		Source				
		System reports				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	Sufficient funds allocated and

	Federal level delivers X% vaccines and supplies to states on time	TBD	90%	100%	100%	released at Federal level for national immunisation supplies Federal government willing and have capacity to do
		Source				
		Stock records of zonal and state stores				
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target (2012)**	
5	Agreed strategies to improve efficiency of RI	Some strategies developed	Strategies owned	Strategies implemented	Strategies implemented	
		Source				**RISK RATING**
		Federal level reports				Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	493,000					
INPUTS (HR)	**DFID (FTEs)**					

Annex 12: PRRINN-MNCH Midterm Review Meeting

AGENDA (final)

25 February 2011

Kano DFID office 11am-5pm

Facilitator: Carol Bradford, Team Leader

11am Introductions

11:15 Zamfara and Yobe debrief –form draft joint recommendations

11:45 PRRINN-MNCH Big 4 x 3 questions: Discuss

12:15 Group Discussion with working lunch

Discussion Questions:

What would we call PRRINN-MNCH's approach?

Could anything they have done been missed out? What are the gaps?

Could this approach be used:

-in another state?

-in another country?

How long will what PRRINN-MNCH has started take? (in four states)

Define our ideal exit strategy

LOOKING BACK:

- Since startup, has the programme obtained what it originally was set up to do?
- How far have we come over these last three years according to plans?

LOOKING FORWARD:

- Will we be able to achieve our programme goals after 5/6 years?
- What are the likely outcomes (discuss by output)?
- What are our recommendations to facilitate the programme achieving its goals?

LESSONS LEARNED:

- What has been learned from way the programme was set up? (e.g. Use of an NGO Consortium, Provision of TA, Capacity Building, Governance and Ownership, Service Delivery, Cluster Approach, Learning LGAs, Community Engagement).
- Is the approach right (efficient? cost effective?) or does it need to be modified?
- What might be PRRINN-MNCH biggest achievements?
- Is the programme seen as Nigerian or as donor driven?
- Has the programme done enough to ensure its accomplishments are known?

POST PROGRAMME:

- What is the likelihood of post-programme sustainability? What are the main risks? Is there scope for a follow-on project or projects?
- What are the possibilities for scale up? What advice would we give to others?

Annex 13: Perspectives on Value for Money

Daniel Kress, Deputy Director, Finance and Policy,
Bill and Melinda Gates Foundation

February 26, 2011

I. Some Important Limitations

This report is based on work done during a one week visit to Nigeria during which most of the time was spent in the field as part of the Assessment team for the PRRINN-MNCH Mid Term Review team. The available documents were provided only upon arrival and little time was available during the trip to do an in-depth review. Time was insufficient to collect and analyze any original data.

Consequently, much of the information in this report will reference two documents: 1) PRRINN-MNCH Value for Money Report, 2) a spreadsheet on State level financing and expenditures provided by PRRINN-MNCH.

Finally, DFID may have their own framework for analyzing VfM that may differ from how I have analyzed the issues. Lacking any Value for Money Framework coming into this work, I used my own construct.

II. Preliminary Observations:

- Very positive that PRRINN-MNCH (hereafter "the project") is focusing on V4M issues. The team prepared and provided a Value for Money report. The team is focusing on VfM issues in terms of financing and leveraging Govt of Nigeria (GON) and partner funding and the team is focused on issues of project effectiveness and efficiency.
- There are potentially several dimensions to a VfM perspective
    - Opportunities for cost savings to the project (and by extension to DFID): Cost of the project and opportunities to reduce the cost of the project via reduction in the price of inputs, using fewer inputs, etc.
    - How the project achieves results at scale not only in the focus areas of the project but also how the project facilitates scale up and increased coverage (and results) outside the project area, ie how the project produces results in each of the focus states.
    - The first dimension is clearly important but in my view, the more important V4M issue is the second one, ie what is the impact of the project on outputs in the States in and beyond the focus clusters for the project.
    - For DFID, there may be another VfM dimension which is could the same results be achieved at equal or lower cost via another approach? This is an important question for any donor but is beyond the scope of the remit for this assignment and so will be left unanswered.

III. Cost savings and efficiencies realized by the project:

The project VfM report outlines a number of ways the project has achieved cost savings through such measures as reducing per diem rates, reducing air travel costs, increasing the use of national consultants. These are all to be applauded.

The report also notes that the project is promoting the increased use of interventions that are cost effective and some that are highly cost effective (immunization). This is true but does not really answer the question of how the project resources are allocated to particular interventions or if it might be possible to reallocate resources to achieve greater DALY gains for the same resources.

The report provides details on how the project has been able to produce outputs (ie renovating a health facility) at lower cost relative to other DFID funded projects. I am insufficiently familiar with the other projects mentioned (or the quality of the renovations undertaken) to render a judgement if the cost per health facility renovated is truly less costly in the project relative to another DFID project.

See a later section for more detailed observations on the PRRINN-MNCH Value for Money report.

IV. How the Project produces results at scale in the focus areas and in the States more broadly

As noted above, a fundamental value proposition in a project like this is the premise that by virtue of the project's activities, capacities are created, models are developed and proven and government commitment and financing realized so that the project catalyzes a benefits stream much larger than that produced in the few intervention areas where the project is active. Thus, Value for Money is clearly a multidimensional construct.

However, one lens that can be applied to understand how effectively the project is creating value for money is understanding how the project is leveraging financing from GON and partners to facilitate implementation and scale up. Conceptually, if the project is successful, the GON will adopt the approaches proposed and use it own funding to scale and sustain the project. And we know that even for the project to be successful in the early stages, funding from the GON is critical. Much of the activities that are required for the project to be successful require financing (eg training of health personnel, provision of drugs, vaccines and equipment, etc. The greater the ability of the project to mobilize the commitment and thus the financing necessary to scale and sustain the project activities, the more likely a larger impact in terms of results from the project.

How much GON financial commitment do we see in each of the focus states? Ideally, we would have detailed analyses of health spending by state at sufficient detail to understand resources going to the priority interventions of the project and those that are going to other areas. These data are lacking but we do have two tables we can use.

Yobe State Approved Budget for 2010, in Million Naira[10]

budget head	organization	Personnel cost	Overhead Cost	Total Recurrent	Capital Expenditure	Total budget
3100	Ministry of Health	1570	90.08	1660.78	3133	4793.78
	Total budget	9006.32	10559.25	19565.58	45571.62	65137.2
Health as a % of total				8.49%	6.87%	7.36%

[10] From Yobe State Government, Approved Budget 2010, page 14.

This table shows the Ministry of Health budget for Yobe State in 2010 as well as the total amount of the Yobe State budget. We can see from the table that spending on health accounts for about 7.36% of the total budget. This is below the 15% guideline established by the Abuja Declaration. It should be noted that this does not include the LGA spending on health, which as you will see later is in some states can be as much as half of state spending. However, LGAs also allocate resources across health and other sectors so presumably, we would hope to see LGA spending on health as a share of total LGA spending at the 15% level or thereabouts.[11]

Another way to understand financial commitment to health that is necessary for project and program success is to look at the trend in state level health budgets. The table below shows the trends in state level health budgets and actual realized levels of spending for several years (though many data are missing).

Summary of health budgets and expenditure in Katsina, Yobe, Zamfara, Jigawa Nigeria (Naira)[12]

	Funding source	2009		2010		2011	
		Budget	Actual	Budget	Actual	Budget	Actual
Katsina	State Ministry of Health	6,087,860,305	4,133,196,672	6,718,093,565	5,999,476,829	6,349,660,880	
	State Ministry of Local Government	8,123,273,279	4,755,917,269	6,275,510,390	4,660,531,561		
Yobe	State Ministry of Health	3,609,200,000	2,805,100,000	4,388,160,000	496,024,409	3,112,080,000	
	State Ministry of Local Government			2,722,045,565			
Zamfara	State Ministry of Health	5,109,635,036	2,982,102,842	6,096,194,552	3,220,784,425	6,040,772,655	
	SMLGCA	4,315,740,310		4,369,120,140			
Jigawa	State Ministry of Health	4,288,144,000	3,132,660,759	4,483,030,000	-	4,900,000,000	
	Gunduma Health System Board	1,746,944,000	1,945,308,852	3,367,375,000	-	4,200,000,000	

Examination of the data above yield several interesting findings:

1. The trend in the level of spending on health in these four states is not uniformly increasing over these three years. Presumably, we would like to see increases in spending on health so that the project scale up does not encounter any financial constraints. In Katsina, State spending on health is relatively constant with LGA spending declining over time. In Yobe, State budgets for health go up in 2010 but apparently are headed back down in 2011. In Zamfara, State level spending increased but in 2010 but looks likely to be constant in 2011. In Jigawa, State level budgets are increasingly very slightly but LGA spending is increasing.
2. Perhaps even more importantly, there are significant differences between approved budgets for spending on health and what actually gets spent on health. Zamfara spent about 50% of its approved budget while in Yobe only 11% of the approved state budget for health was expended.
3. The LGAs provide significant resources for health and seem impacted by the same budget execution problems as the State (although data are missing so firm conclusions are difficult).

[11] Detailed budget data by State were only available in Yobe.

[12] Data in the table from PRRINN-MNCH Value for Money Report

V. How the project is addressing efficiency and effectiveness issues in the health sector in each state

There are many ways the project could be addressing issues of efficiency and effectiveness, both in the way resources within the project are allocated and used but also in how the project impacts on the health system in each state. Time was not sufficient for a detailed examination of efficiency and effectiveness but from discussions with the project team in Yobe they have made some commendable efforts to address efficiency and effectiveness issues.

One example pertains to the issue of "ghost" health workers. The team in Yobe noticed that many of the participants showing up for training were not health workers despite being on the payroll roster for health workers. The team then did an inventory of all health facilities in the State to ascertain the names of all health workers actually at post. For Nurse Mid-Wives the number reported to be in the State MOH was 432. When the team finished the inventory of actual NMWs at post the number was only 97. The other 335 persons are essentially "ghost" workers and while many undoubtedly collect a salary, none are active in the health facilities in the state. As a result of this inventory, the project was able to better target their training to the right individuals and reduce the overall training costs (by having to train fewer health staff).

This example raises some important policy questions for the project and the project funders. The expense of some many Ghost workers is likely considerable to the Yobe State Government and the realization that the true number of NMWs is only ¼ the true number is potentially a threat to the expected impact of the project. Moreover, these are likely politically sensitive issues that are beyond the remit of the project to address. The funders and principally DFID may wish to ask the project to investigate this issue more fully and if confirmed, take it up with the State Governments.

VI. Comments on PRINN-MNCH Value for Money Report

Overall, it's a solid first attempt to address cost and efficiency issues. As noted above, the discussion on cost savings strikes me as laudable. I have tried to point out in this analysis that while the cost of the project is important, of greater importance is the need for the project to attain a high degree of impact, something that can only be achieved if the project is successful at going to scale and sustained by the GON. To do this requires political and financial commitment by the GON.

A second comment on the report is that it downplays important questions about quality and impact tradeoffs. For example, the report suggest that the decision to add new clusters and increase the scale of the project interventions at a small additional cost is an example of value for money. What we saw in Yobe is some evidence to suggest that rapidly expanding the focus to new clusters may not be possible at the desired level of quality. Already, the quality is in need of strengthening. Thus, proposition that the project can add a large number of additional clusters at low incremental cost at the same level of quality seems a stretch.

Finally, I think the conclusions on GON and partner commitment require a much more careful analysis before any interpretations can be drawn. From looking at the underlying data on which the report findings are based, there are many missing values and so any findings on trends over time are suspect. Also, the categorization of what is partner often includes many sources that are GON-Federal (ie, NHIS,

MDG Fund etc) and so it would be useful to have a slightly different categorization of the funding data.

Annex 14: PRRINN-MNCH LOGFRAME 2009 to 2013

PROJECT NAME	Maternal, Newborn and Child health Initiative (MNCH) in Northern Nigeria						
GOAL	**Indicator**	**Baseline (2009)**	**Milestone 1 (2010)**	**Milestone 2 (2011)**	**Milestone 3 (2012)**	**Target (2013)**	
To improve maternal, newborn and child health in Northern Nigeria	MDG4, Target 5 Reduce by two thirds, between 1990 and 2015, the under five mortality rate	153[13]	149	144	140	138	
		Source					
		National Demographic Health Survey (DHS) 2008.[14] [15]					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target**	
	MDG5, Target 6 % of births attended by a skilled birth attendant (SBA) in targeted CEOC clusters	39%			50%	52%[16]	
		Source					
		NDHS 2008					

PURPOSE	Indicator	Baseline	Milestone 1	Milestone 2	Milestone 3	Target (2013)	Assumptions
To improve effective access to MNCH (including RI) services in four states	% of infants fully immunised by first birthday	16% (3%)	12%	18%	25%	32%	Maintenance of Federal allocations to State and LGA health budgets Continued political stability and absence of civil strife
		Source					
		NICS 2006, 2009, 2012, MNCH Household Surveys 09, 10, 12, Mini Household Survey 2011, HMIS/PMS *Baseline, milestones and target should be disaggregated by sex*					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	% of pregnant women have appropriate TT doses	15% 2006	25%	34%	42%	50%	
		Source					
		NICS 2006, 2009, 2012, MNCH Household Surveys 09, 10, 12, Mini Household Survey 2011.					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	

[13] Extrapolated from Demographic Health Survey (DHS) 2008 Under Five Mortality of 157

[14] Target is based on 2 thirds reduction of 1990 U5MR

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

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

	% of women aged 15-49 have access to modern family planning services	1.18	NA	2.18	3.18	4.18
		Source				
		DHS 2008, MNCH Household survey 2011, 2013				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**
	Caesarean section rates (in targeted CEOC clusters)	0.5%	>0.5%	0.75%	1%	1.25%
		Source				
		MNCH Services Survey 2009, PMS, MNCH Household Survey				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**
	Percentage of women receiving ANC	21%	25%	34%	42%	50%
		Source				
		MNCH Household Surveys, HMIS/PMS				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**
	Measles incidence reduced by 80%	22,250	11,125	4,450	2,225	1,112
		Source				
		Integrated Disease Surveillance and Response (IDSR) previously DSN.				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**
	Polio incidence reduced to near zero	237	119	0	0	0
		Source				
		IDSR; WHO monitoring system				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	33,791,702					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 1	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	**Assumptions**
Strengthened state and LGA governance of PHC systems geared to RI and MNCH	State government staff lead annual review and health planning process in all states	Planning process facilitated and supported by the programme	Process led by state teams with technical and financial support from the programme	Process led by state teams with limited support from the programme	Process led by state teams with no support from the programme	Process led by state teams with no support from the programme	Federal, State and LGAs willing open up planning, budgeting and financial records to public scrutiny Draft Health Bill enacted and effectively applied at Federal, State
		Source					
		State health plans and budgets					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	All states successfully access new Federally managed health funds	One year in all states	Two years in all states	Three years in all states	Three years in all states	Four years in all states	
		Source					
		State financial statements or federal level statements (e.g. NPHCDA for GAVI and possibly the PHC fund)					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	Availability of PHC	Limited data	Annual PHC	Annual expenditure	Annual PHC	Annual PHC	

	budget and expenditure reports for LGAs /Gundumas.	available in 3 states	budgets available for all targeted LGAs/ Gundumas	reports available in targeted LGAs/ Gundumas	budget and expenditure reports available for 80% of all LGAs/Gundumas	budget and expenditure reports available for 90% of all LGAs/Gundumas	and LGA level Federal funds are released to States for PHC services Donors want to harmonise and align with state priorities Federally managed funds agree to allocate resources to PRRINN-MNCH states
		Source					
		State and LGA financial statements					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	Number of states with their State Health Plan incorporated into their State Development Plan	Some linkage to SEEDs in 2 states	2 States	3 States	4 States	4 States	
		Source					
		State development plan document					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	State health plans reflect project data from 2010	Few examples of evidence based planning	Each state plan has at least 3 examples of evidence based planning	Each state plan has at least 5 examples of evidence based planning	Each state plan has at least 7 examples of evidence based planning	Each state plan has at least 9 examples of evidence based planning	
		Source					
		State health plans					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	Number of donor PHC programmes reflected in State and LGA annual health plans	1 per state	2 per state	3 per state	3 or more per state	4 or more per state	
		Source					
		State and LGA health plans					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	SIACCs support for RI through PHC system in all states	Little	Some	More	RI fully integrated	RI fully integrated	
		Source					
		Meeting records					
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
15	Number of donor field missions and reviews done jointly	2	At least 2	At least 2	At least 2 (8 in total)	At least 2 (10 in total)	
		Source					**RISK RATING**
		Mission and review reports					High

INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)
	3,365,287				
INPUTS (HR)	DFID (FTEs)				

OUTPUT 2	Indicator	Baseline	Milestone 1	Milestone 2	Milestone 3	Target (2013)	Assumptions
Improved human resource policies and practices for PHC	% of targeted facilities with at least one health worker trained in LSS	5%	40%	70%	100%	100%	Increased commitment to PHC at State and LGA level
		Source					
		Facility and staff monitoring reports, PMS, HRIS linked to DHIS, TMIS					
	Indicator	Baseline	Milestone 1	Milestone 2	Milestone 3	Target (2013)	
	HR policies and plans developed, operationalised, and implemented in each state	Some	Developed	Operationalised	Implemented	Implementation sustained	
		Source					
		State Human Resource policy documents					
	Indicator	Baseline	Milestone 1	Milestone 2	Milestone 3	Target (2013)	
	Number of health professionals trained annually	904 (M=552; F=352)	Number	Number	Number	Number	
		Source					
		Survey of Health Training Institutions 2009, Annual Reports of Health Training Institutions. *Baseline, milestones and target should be disaggregated by sex*					
IMPACT WEIGHTING	Indicator	Baseline	Milestone 1	Milestone 2	Milestone 3	Target (2013)	
15	% of professional staff given in-service training in MNCH in targeted PHC facilities	0%	25%	50%	At least 75%	At least 85%	
		Source					RISK RATING
		MNCH services survey, In service training schedules, PMS, HRIS					High
INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)		
	3,421,658						
INPUTS (HR)	DFID (FTEs)						

OUTPUT 3	Indicator	Baseline	Milestone 1	Milestone 2	Milestone 3	Target (2013)	Assumptions
Improved delivery of MNCH services (including RI) via the PHC system	% of LGAs reaching performance ranking tool (PPRHAA) scores	18%	40%	50%	60%	70%	Global and national initiatives do not disrupt
		Source					
		PPRHAA reports					

	over 75%	PPRHAA reports					planning and implementation of PHC, MNCH and RI at State and LGA levels States continues to provide drugs on a sustainable basis
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	Number of PHC facilities providing basic emergency obstetric care	1	12 BEOCs	24 BEOCs	36 BEOCs	58 BEOCs	
		Source					
		MNCH services survey, PMS					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	Number of PHC facilities providing Family Planning services	NA	8	36	54	72	
		Source					
		MNCH services survey, PMS					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	Systems for effective supervision in each State	Designed	Teams visiting with technical and financial support from the programme	Visits planned and implemented with limited technical and financial support from the programme	Visits planned, financed and implemented by each state	Visits planned, financed and implemented by each state	
		Source					
		Facility and staff monitoring reports, PMS					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	Number of 1-year-old children immunised against measles	126,439	299,957	403,556	485,624	544,710	
		Source					
		MNCH Household Survey; NICS, PMS *Baseline, milestones and target should be disaggregated by sex*					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	% of health facilities providing RI experiencing vaccine stock-outs of TT	38%	29%	19%	15%	10%	
		Source					
		Stock records or PPRHAA, PMS					
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
25	% of PHC facilities with tracer drugs available	50%	58%	62%	66%	70%	
		Source					**RISK RATING**
		Stock records or PPRHAA, PMS					High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**		

	15,156,831					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 4	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	**Assumptions**
Operational research providing evidence for PHC stewardship, RI and MNCH policy and planning, service delivery, and effective demand creation	Number of pieces of OR into supply & demand aspects of MNCH feed into programme	None	2	4	6	8	Results of operational research acceptable to government
		Source					
		Project reports					
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
10	State plans reflect OR results	None	1 example per state	1 example per state	1 example per state	1 example per state (16 in total)	
		Source					**RISK RATING**
		State plans					Low
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**		
	4,041,601						
INPUTS (HR)	**DFID (FTEs)**						

OUTPUT 5	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	**Assumptions**
Improved information generation with knowledge being used in policy and practice	Demonstrated level of understanding in use of information by trained HMIS officers in each state	Some	Basic	Moderate	Substantial	Proficient	
		Source					
		HMIS data and reports, HR performance indicators					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	State plans increasingly built on evidence from HMIS	None	Some	Moderate	Substantial	Substantial	
		Source					
		State plans, Evidence based planning guidelines					
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
10	% of LGAs with HMIS MNCH data collated at State level on a monthly basis	<10%	40%	75%	85%	85%	
		Source					**RISK RATING**
		HMIS Reports, PMS					Medium

INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID SHARE (%)
	2,360,753				
INPUTS (HR)	DFID (FTEs)				

OUTPUT 6	Indicator	Baseline	Milestone 1	Milestone 2	Milestone 3	Target (2013)	Assumptions
Increased demand for MNCH (including RI) services	Increased political support for MNCH (including RI) evidenced by high level public events	1 at state level; 1 at LGA level	1 at state level; 2 at LGA level	1 at state level; 2 at LGA level	1 at state level; 2 at LGA level	1 at state level; 3 at LGA level	
		Source					
		Media reports; project reports					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	%of wards with a development committee and/or health partnership implementing a community action plan	4%	15%	30%	40%	50%	
		Source					
		Community monitoring process					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	% of women in targeted areas who have standing permission to take their child to a health facility	55%	65%	74%	83%	90%	
		Source					**RISK RATING**
		MNCH Household Survey					Medium
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	% of women who know at least four of the maternal danger signs in targeted areas	1.4%	15%	30%	40%	55%	
		Source					
		MNCH Household Survey					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	% of facility health committees for intervention facilities in targeted areas actively monitoring drugs	0%	25%	34%	57%	66%	
		Source					
		Annual Reports, PMS					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	
	% of mothers of children <2 in targeted areas who know the childhood vaccination	10%	25%	40%	50%	65%	
		Source					
		Household survey 2007, MNCH Household Survey 2010; MNCH Rapid Household Survey 2011.					

	schedule					
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**
20	% of never immunised children <2 reduced in targeted areas	25%	16%	13%	11%	<10%
		Source				
		NICS 2006, 2009, 2012; MNCH Rapid Household Survey 2011. *Baseline, milestones and target should be disaggregated by sex*				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**	
	4,620,408					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 7	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	**Assumptions**
Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities	Formal systems for leveraging, accessing and utilising additional PHC funding	None	1 System implemented	2 Systems implemented	Systems functioning	Systems sustained	All donors and partners provide common support and advocate for common strategy
		Source					
		System reports					
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	Sufficient funds allocated and released at Federal level for national immunisation supplies
	Federal level delivers X% vaccines and supplies to states on time	TBD	90%	100%	100%	100%	
		Source					
		Stock records of zonal and state stores					
IMPACT WEIGHTING	**Indicator**	**Baseline**	**Milestone 1**	**Milestone 2**	**Milestone 3**	**Target (2013)**	Federal government willing and have capacity to do
5	Agreed strategies to improve efficiency of RI	Some strategies developed	Strategies owned	Strategies implemented	Strategies implemented	Strategies implemented	
		Source					**RISK RATING**
		Federal level reports					Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**		
	825,164						
INPUTS (HR)	**DFID (FTEs)**						

PRRINN LOGFRAME 2007-2013

PROJECT NAME	Partnership for Reviving Routine Immunisation in Northern Nigeria (PRRINN)						
GOAL	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**
Progress towards achievement of MDGs 4 & 5 in Nigeria	MDG4, Target 5 Reduce by two thirds, between 1990 and 2015, the under five mortality rate	161[17]	153	149	144	140	138
	Source						
	National figures based on Demographic Health Survey (DHS) 2008, MNCH Household Survey 2009 established <5 mortality in MNCH States (Yobe, Zamfara and Katsina) as 246.						

PURPOSE	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	**Assumptions**
To improve delivery of routine immunisation for children and women of reproductive age via the primary health care system in 4 to 6 low-coverage states in northern Nigeria	% of infants fully immunised by first birthday	3%	8%	12%	18%	25%	32%	Maintenance of Federal allocations to State and LGA health budgets Continued political stability and absence of civil strife
	Source							
	NICS 2006, 2009, 2012, MNCH Household Surveys 09, 10, 12, Mini Household Survey 2011, HMIS/PMS *Baseline, milestones and target should be disaggregated by sex*							
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	% of pregnant women have appropriate TT doses	15%	20%	25%	34%	42%	50%	
	Source							
	NICS 2006, 2009, 2012; MNCH Household Surveys 09, 10, 12; Mini Household Survey 2011, HMIS/PMS							
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	Percentage of women	19%	22%	25%	34%	42%	50%	

[17] Extrapolated from Demographic Health Survey (DHS) 2008 Under Five Mortality of 157

	receiving ANC	**Source**					
		DHS 2008, MNCH Household Surveys, HMIS/PMS					
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**
	Measles incidence reduced by 80%	22,250	16,687	11,125	4,450	2,225	1,112
		Source					
		Integrated Disease Surveillance and Response (IDSR) 2008, formerly DSN,					
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**
	Polio incidence reduced to near zero	237	178	119	0	0	0
		Source					
		DSN 2008					
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**		
	27,177,686						
INPUTS (HR)	**DFID (FTEs)**						

OUTPUT 1	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	**Assumptions**
Effective harmonization and alignment of all agencies' support for routine immunisation at State and LGA levels	Number of donor field missions and reviews done jointly	2	At least 2	At least 2	At least 2	At least 2 (8 in total)	At least 2 (10 in total)	All donors and partners provide common support and advocate for common strategy
		Source						
		Mission and review reports						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	Number of donor PHC programmes reflected in State and LGA annual health plans	None	1 per state	2 per state	3 per state	3 or more per state	4 or more per state	
		Source						
		State and LGA health plans						
IMPACT WEIGHTING	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	

15	SIACCs support for RI through PHC system in all states	None	Little	Some	More	RI fully integrated	RI fully integrated	
		Source						**RISK RATING**
		Meeting records						Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**			
	2,276,330							
INPUTS (HR)	**DFID (FTEs)**							

OUTPUT 2	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	**Assumptions**
Improved capacity at State and LGA levels for strategic analysis, policy development, planning and budgeting of routine immunisation	State government staff lead annual review and health planning process in all states	No	Planning process facilitated and supported by the programme	Process l led by state teams with technical and financial support from the programme	Process led by state teams with limited support from the programme	Process led by state teams with no technical or financial support from programme	Process led by state teams with no technical or financial support from programme	Draft Health Bill enacted and effectively applied at Federal, State and LGA levels and NPHCDA funds distributed FGN and academic authorities approve curriculum for intensive, practical short course Federal, State and LGAs willing open up planning, budgeting and financial records to public scrutiny (from MNCH)
		Source						
		State health plans and budgets						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	State health plans reflect project data from 2010	None	Each state has 1-2 examples of evidence based planning	Each state plan has at least 3 examples of evidence based planning	Each state plan has at least 5 examples of evidence based planning	Each state plan has at least 7 examples of evidence based planning	Each state plan has at least 9 examples of evidence based planning	
		Source						
		State health plans						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	All states successfully access new Federally	None	One year in all states	Two years in all states	Three years in all states	Three years in all states	Four years in all states	

	managed health funds	**Source**						Federal funds are released to States for PHC services (from MNCH) Federally managed funds agree to allocate resources to PRRINN-MNCH states (from MNCH)
		State financial statements or federal level statements (e.g. NPHCDA for GAVI and possibly the PHC fund)						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	Availability of PHC budget and expenditure reports for LGAs /Gundumas	Minimal data available in 2 states	Limited data available in 3 states	Annual PHC budgets available in targeted LGAs/ Gundumas	Annual expenditure reports available in targeted LGAs/ Gundumas	Annual budget and expenditure reports available for 80% of LGAs/ Gundumas	Annual budget and expenditure reports available for 90% of targeted LGAs/Gundmas	
		Source						
		State and LGA financial statements						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	Demonstrated level of understanding in use of information by trained HMIS officers in each state	Little	Some	Basic	Moderate	Substantial	Proficient	
		Source						
		HMIS data and reports, HR performance indicators						
IMPACT WEIGHTING	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
20%	% of LGAs with HMIS MNCH data collated at State level on a monthly basis	<5%	20%	40%	75%	85%	85%	
		Source						**RISK RATING**
		HMIS Reports, PMS						High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**			
	4,759,245							
INPUTS (HR)	**DFID (FTEs)**							

OUTPUT 3	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	**Assumptions**
Primary health care	% of health facilities	38%	34%	29%	19%	15%	10%	Global and

systems strengthened to support routine immunisation	providing RI experiencing vaccine stock-outs of TT	**Source**						national initiatives do not disrupt planning and implementation of PHC and RI at State and LGA levels States continues to provide drugs on a sustainable basis
		Stock records or PPRHAA						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	% of LGAs reaching performance ranking tool (PPRHAA) scores over 75%	7%	29%	40%	50%	60%	70%	
		Source						
		PPRHAA reports						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	Number of 1-year-old children immunised against measles	109,464	154,585	299,957	403,556	485,624	544,710	
		Source						
		NICS 2006; PRRINN Household Survey 2007, MNCH Household Survey 2009; DHS						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	Number of health professionals trained annually	904 (M=552; F=352)	Number	Number	Number	Number	Number	
		Source						
		Survey of Health Training Institutions 2009, Annual Reports of Health Training Institutions. *Baseline, milestones and target should be disaggregated by sex*						
IMPACT WEIGHTING	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
30%	Percentage of PHC facilities with tracer drugs available	41%	54%	58%	62%	66%	70%	
		Source						**RISK RATING**
		Stock records or PPRHAA						High
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**			
	13,333,838							
INPUTS (HR)	**DFID (FTEs)**							

OUTPUT 4	Indicator	Baseline (2007)	Milestone 1 (2009)	Milestone 2 (2010)	Milestone 3 (2011)	Milestone 4 (2012)	Target (2013)	Assumptions
Increased demand for routine immunisation	Increased political support for RI evidenced by high level public events	None	1 at state level; 1 at LGA level	1 at state & 2 at LGA level	1 at state & 2 at LGA level	1 at state & 2 at LGA level	1 at state & 3 at LGA level	MNCH programme and other partners provide additional complementary support
		Source						
		Media reports; project reports						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	%of wards with a development committee and/or health partnership implementing a community action plan	None	7%	15%	30%	40%	50%	
		Source						
		Community monitoring process						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	% of mothers of children <2 in targeted areas who know the childhood vaccination schedule	10%	15%	25%	40%	50%	65%	
		Source						
		PRRINN Household Survey 2007, MNCH Household Survey 2010; MNCH Rapid Household Survey 2011.						
IMPACT WEIGHTING	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
25%	% of never immunised children <2 reduced in targeted areas	25%	20%	16%	13%	11%	<10%	
		Source						**RISK RATING**
		NICS 2006, 2009; PRRINN Household Survey; *Baseline, milestones and target should be disaggregated by sex*						Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**			
	5,705,645							
INPUTS (HR)	**DFID (FTEs)**							

OUTPUT 5	**Indicator**	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	**Assumptions**
Improved capacity of Federal Ministry level to enable States' MNCH (including RI) activities	Formal system established for leveraging, accessing and utilising additional PHC funding	None	1 system designed	1 system implemented	2 systems implemented	Systems functioning	Systems sustained	All donors and partners provide common support and advocate for common strategy Sufficient funds allocated and released at Federal level for national immunisation supplies
		Source						
		System reports						
	Indicator	**Baseline (2007)**	**Milestone 1 (2009)**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
	Federal level delivers X% vaccines and supplies to states on time	*<80%*	80%	90%	100%	100%	100%	
		Source						
		Stock records of zonal and state stores						
IMPACT WEIGHTING	**Indicator**	**Baseline (2007)**	**Milestone 1**	**Milestone 2 (2010)**	**Milestone 3 (2011)**	**Milestone 4 (2012)**	**Target (2013)**	
10%	Agreed strategies to improve efficiency of RI	None	Strategies developed	Strategies owned	Strategies implemented	Strategies implemented	Strategies sustained	
		Source						**RISK RATING**
		Federal level reports						Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID SHARE (%)**			
	1,102,628							
INPUTS (HR)	**DFID (FTEs)**							

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