


Nigeria HelloMama PY4 Summary & Results



Geographic Implementation Areas

Provinces

- 2/36 (5.5%)—Ebonyi, Cross River State

LGAs

- 30/774 (3.9%)

Facilities

- 142/216 (65.7%)

Population

Country

- 186,000,000

MCSP-supported areas

- 4,767,312

Technical Areas



Program Dates

October 1, 2015–September 30, 2018

Cumulative Spending through End of PY4



Demographic and Health Indicators

Indicator	# or %
Population growth rate ^[1]	2.6%
MMR (per 100,000 live births) ^[2]	576
IMR (per 1,000 live births) ^[2]	69
U5MR (per 1,000 live births) ^[2]	128
TFR ^[2]	5.5
CPR ^[2]	15%
SBA ^[2]	38%

Sources: (1) World Bank 2016; (2) Nigeria Demographic and Health Survey, 2013.

Strategic Objectives

- Establish an operational, nationally scalable platform at adequate coverage that makes age- and stage-based mobile messages available to the target population and linked to existing HISs.
- Complement supply side MNCH interventions by improving knowledge and adoption of healthy and safe MNCH practices.

Key Accomplishment Highlights

- Reached over 61,000 subscribers with HelloMama messages.
- Successfully supported 13,320 pregnant women from pregnancy through 1 year of child life and graduation from the HelloMama platform.
- Scaled up HelloMama services from 47 to 97 health facilities.
- Achieved government adoption and influenced national and subnational budget for digital health. Cross River State is committing \$100,000 to continue HelloMama SMS (text) and interactive voice response services.
- Attained status as a recognizable brand tailored to local needs, context, and languages. In Nigeria, HelloMama is known as “the phone doctor.”
- Developed a detailed implementation road map that will act as a guide for future programs implementing interactive voice response and SMS messaging systems similar to HelloMama.

Nigeria HelloMama

Key Accomplishments

In PY4, HelloMama expanded beyond the pilot sites to 142 facilities, ensuring wider coverage and access to services. MCSP continued to involve state actors in the transition plans to reinforce the principles behind the interventions so that state stakeholders will have management and technical knowledge to implement, advocate for, and sustain digital health interventions in Nigeria.

Knowledge to Health Services Available through SMS Messages

HelloMama scaled up in PY4 from 47 pilot sites to 97 implementation sites, reaching more than 60,000 subscribers (pregnant women, mothers, and gatekeepers); 14,803 are currently receiving prebirth messages, 36,385 clients graduated from pregnancy messages, 13,420 graduated from the platform, and 26 opted out (reasons for opting out were two miscarriages, one baby death, five stillbirths, one reported as not useful, and 17 said other reasons). HelloMama also attained status as a recognizable brand tailored to local needs, context, and languages. HelloMama is known in Nigeria as “the phone doctor.” Many mothers are now asking how they too can receive messages from “the phone doctor,” showing HelloMama’s ability to quickly expand and gain notoriety in MCSP’s catchment areas.

HelloMama introduced a callback feature in PY4 that allows registered users to trigger a callback with their last scheduled message in the event that they miss their call or the call is interrupted. This has resulted in mothers and gatekeepers receiving more HelloMama messages vital to improving the health outcomes for pregnant women, newborns, and families in Nigeria.

Government Adoption of eHealth Programming

HelloMama also achieved government adoption, influencing national and subnational budgets for digital health. Cross River State has committed \$100,000 to sustain the HelloMama SMS and voice message services, and the Ebonyi State MOH commitment is currently underway. These commitments and adoption by the Federal MOH demonstrate the improved capacity of the Federal and State MOHs to manage and ensure the sustainability of HelloMama technology and program implementation.

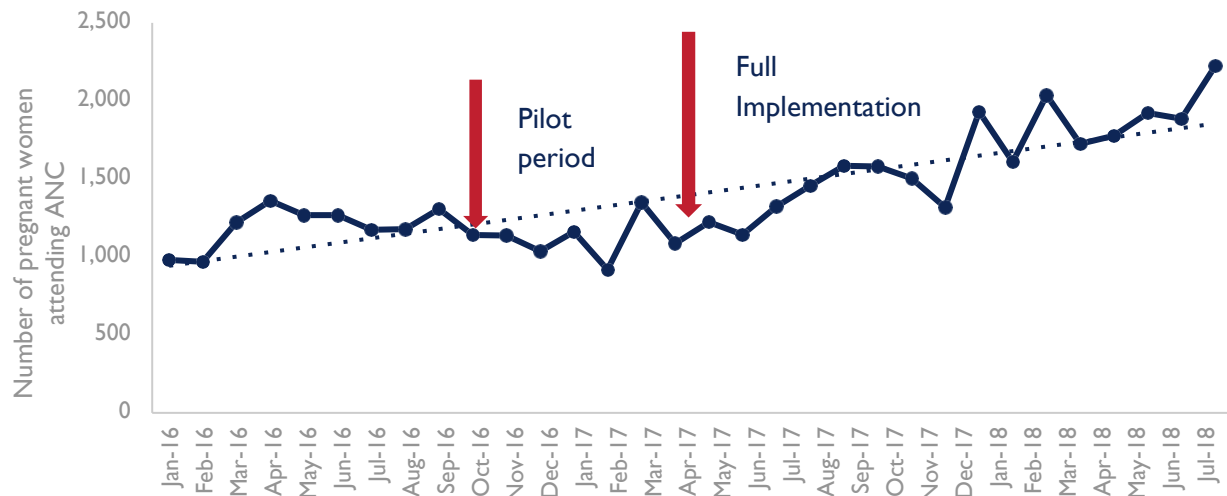
Uptake of Essential Maternal Health Services

HelloMama has sent more than 5.2 million messages via SMS and outbound dialer. These messages have facilitated positive behavior change and increased uptake of essential services. This can be seen in increasing trends in ANC attendance (Figure 1), pregnant women with four or more ANC visits, deliveries by SBAs (Figure 2), and number of children fully immunized in selected HelloMama-supported sites. HelloMama improved health-seeking behavior practices in PY4 and contributed to improved efficiency of service delivery. As a result of the HelloMama messages, pregnant women are more knowledgeable about the services available and know what to expect during pregnancy due to the health information received. Clients remind health workers about the supplements they need to receive based on the information they are provided via the HelloMama messages (e.g., IPTp with sulfadoxine-pyrimethamine and iron supplementation).

Data for Decision-Making at State Level

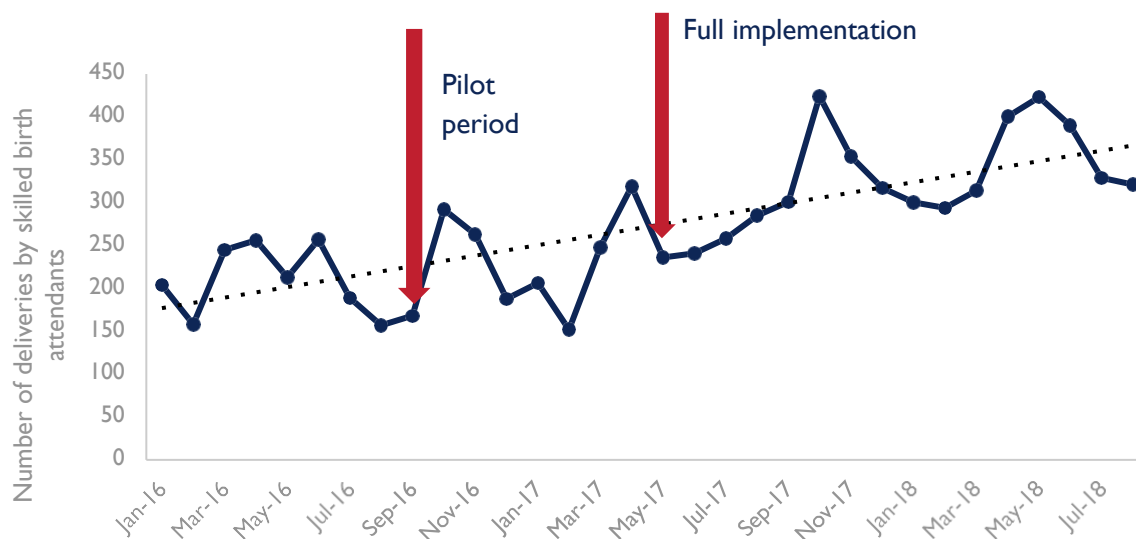
Finally, HelloMama developed a program, technical, and executive dashboard to foster program management for decision-making at project and state levels, and achieved full integration with all four major mobile network operators in Nigeria. This dashboard is fostering government ownership of digital health programming through training and mentorship to help decision-makers implement informed, impactful programs.

Figure 1. Total antenatal care attendance in selected facilities in Cross River and Ebonyi



Source: Nigeria DHIS2, N=7 facilities.

Figure 2. Deliveries by skilled birth attendants in selected facilities in Cross River and Ebonyi



Source: Nigeria DHIS2, N=10 facilities.


Way Forward

In PY5, HelloMama will focus on documenting and sharing lessons learned. The HelloMama team will work closely with key stakeholders to outline strategic options for service provision sustainability. MCSP will also continue its engagement with the national government to foster government ownership of digital health programming through training and mentorship to help decision-makers implement informed, impactful programs. Ebonyi and Cross River state governments have pledged support to continue health messages to pregnant women by including digital health resource allocation in their 2019 state budgets to sustain HelloMama messages and other digital health initiatives.

Additionally, a detailed implementation road map currently in development with key stakeholders from the Federal and State MOHs will guide future programs implementing interactive voice response and SMS messaging systems. The MCSP team has proposed the development of a telegram bot that providers can use to send pregnant women existing HelloMama text messages. By using this bot, providers will be able to continue to reach pregnant women with maternal and newborn care messages beyond the life of the program.

Selected Performance Indicators for PY4	
MCSP Global or Country PMP Indicators	Achievement
Number of subscribers newly registered in the HelloMama service	33,864 (target: 36,121, 94% achieved)
Number of HelloMama subscribers who are currently registered to receive HelloMama messages	48,430 (34,738 pregnant women/mothers and 13,692 gatekeepers, no target)
Number of health facilities registering subscribes in the HelloMama service	128 (target: 135, 95% achieved)
Number of health workers trained to register subscribers to receive HelloMama services	184 (target: 172, >100% achieved)

Nigeria HTS PY4 Summary & Results



Geographic Implementation Areas

States

- 7/37 (19%), including Federal Capital Territory

Districts

- 32/774 local government areas (LGAs) (4%)

Facilities

- Approximately 850 health facilities and community-based HIV testing sites

Population

Country

- 184,000,000

MCSP-supported areas

- 27,230,378

Technical Areas



Program Dates

October 1, 2017–January 31, 2019

Cumulative Spending through End of PY4



Demographic and Health Indicators

Indicator	# or %
People living with HIV (PLHIV) (2016) ^[1]	3,200,000
PLHIV who know their HIV status ^[1]	1,100,000
PLHIV who are on treatment ^[1]	970,000
PLHIV on treatment who are virally suppressed ^[1]	780,000
New HIV infections per year (2016) ^[1]	220,000
HIV incidence per 1,000 population (2016) ^[1]	1.23
AIDS-related deaths (2016) ^[1]	160,000
Last published national HIV testing guidelines	2011
Percentage of women aged 15-49 who have experienced physical violence at least once since age 15 (2013) ^[2]	28%

Sources: ^[1]UN-AIDS Data 2017, ^[2]DHS 2013

Strategic Objectives

- Provide technical assistance to US Government-funded HIV Testing and Services (HTS) implementing partners to improve yield in scale-up LGAs in Nigeria through partner notification services (PNS) and HIV self-testing (HIVST) approaches.
- Develop and disseminate an LRP for standardizing PNS and HIVST in Nigeria. LRP may include implementation materials; M&E tools; standard operating procedures; information, education, and communication materials; and tools to support ongoing mentorship.
- Provide support for inclusion of PNS and HIVST in national policies and guidelines.
- Evaluate expansion of PNS and HIVST in scale-up LGAs in Nigeria to determine impact on HIV testing yield, successes, and challenges with PNS and HIVST implementation; provide technical inputs for evaluation of screening tool to test children of index clients and other at-risk children in facility and community-based settings.

Key Accomplishment Highlights

- Disseminated the PNS evaluation report to the Federal MOH, US Government agencies, National AIDS Control Organization, and other stakeholders.
- Finalized the national guidelines for HTS and scale-up plan in coordination with the Federal MOH.
- Drafted and shared the PNS LRP with implementing partners.

Nigeria HIV Testing Services

Key Accomplishments

In PY4, MCSP shared results of the PNS evaluation with the US Government HTS TWG, implementing partners, and the Federal MOH in Nigeria at a dissemination meeting held in June 2018. The report highlights the important work of seven HIV implementing partners in introducing and scaling up PNS, and demonstrates the opportunities this approach presents for HIV case finding in Nigeria. The finalization of the national guidelines for HTS and the associated scale-up plan provide the necessary policy support for expanding work in this technical area, and the PNS LRP provides essential tools for training HIV providers to deliver, monitor, and strengthen PNS in Nigeria.

PNS Evaluation

MCSP hosted a 1-day meeting with implementing partners, US Government agencies, the Federal MOH, National AIDS Control Organization, and other key stakeholders to disseminate the final results of the PNS evaluation and discuss recent implementation successes and challenges. Among the key findings is that HTS program yields increased from 1.6% before the PNS technical assistance period to 2% during the implementation period. PNS is a key strategy for case finding and reaching partners of PLHIV. The report was officially disseminated with implementing partners, the US President's Emergency Plan for AIDS Relief, and Federal MOH colleagues in June 2018 along with PNS data tools. The results of the evaluation emphasize the importance of PNS and the opportunities for scaling up this approach in Nigeria.

National Guidelines for HTS and Scale-Up Plan

MCSP worked closely with the Federal MOH to finalize the National HTS Guidelines and National HTS Scale-Up Plan in June, 2018. These guidelines provide essential updates on new HTS approaches, including PNS, HIVST, and recency testing. They provide standards for HTS providers to ensure implementation of high-quality HTS. MCSP supported the Federal MOH with printing copies of the National HTS Guidelines and the National HTS Scale-Up Plan, and hosted a national dissemination meeting in September 2018. Supporting the Federal MOH to develop and refine favorable policy, strategy, and governance structures for quality and priority technical areas is key to establishing self-reliance.

Partner Notification Services Learning Resource Package

MCSP developed and shared an LRP for PNS that implementing partners used for step-down trainings to other providers. Feedback received from the pilot and step-down trainings will be incorporated into a final training package that will be used to train Federal MOH trainers in November 2018. The final LRP will be handed off to the Federal MOH and adopted as a standardized training package for future trainings in Nigeria. Strengthening the capacity of the health workforce is key in scaling up interventions/approaches beyond the zone of implementation.


Way Forward

The Nigeria HTS program has received an extension through December 31, 2018. Four key activities have been prioritized to ensure sustainability of program efforts to date. MCSP plans to harmonize the PNS LRP with US President's Emergency Plan for AIDS Relief-updated standard operating procedures and develop additional implementation materials (training videos, posters/information, education, and communication materials) for adoption by the Federal MOH after a training in November 2018. Implementing partners will further be supported to review and disseminate program data, and MCSP will provide recommendations about finalization of a pediatric screening tool. Finally, MCSP will finalize national operational guidance on HIVST and conduct trainings with national HTS trainers from the Federal MOH.

Selected Performance Indicators for PY4	
MCSP Global or Country PMP Indicators	Achievement
Number of meetings/technical assistance visits held with US Government-funded implementing partners	2 (target: 2, 100% achieved)
Number of LRPs developed for PNS in Nigeria	0 (target: 1, 0% achieved) ¹
Number of (national) policies drafted with US Government/MCSP support	1 (target: 1, 100% achieved)
Number of studies completed	1 (target: 1, 100% achieved)
Number of technical reports/papers, policy/research/program briefs, and fact sheets produced and disseminated	2 (target: 2, 100% achieved)

[1] To be completed in PY5 Q1

Nigeria MNCH PY4 Summary & Results



Geographic Implementation Areas

States

- 2/36 states (5.5%)

LGAs

- Kogi: 21/21 (100%)
- Ebonyi: 13/13 (100%)
- Total: 34/774 (4.4% of country total)

Facilities

- 321 (24%)

Population


Country

- 186,000,000

MCSP-supported areas

- 5,451,987

Technical Areas



Program Dates
October 1, 2014–December 30, 2018

Cumulative Spending through End of PY4
██████████

Demographic and Health Indicators

Indicator	# or %
MMR (per 100,000 live births) ^[1]	576
IMR (per 1,000 live births) ^[1]	69
U5MR (per 1,000 live births) ^[1]	128
TFR (births per woman) ^[1]	5.5
SBA ^[1]	38%
CPR (all methods) ^[1]	15%
HIV prevalence ^[1]	3.1%

Sources: ^[1] NDHS 2013.

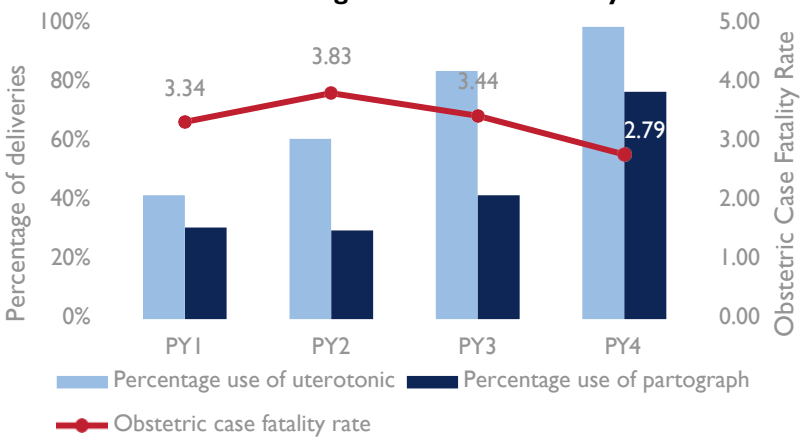
Strategic Objectives

- Improve quality of facility-based MNH services and community facility-based child health services.
- Improve HISs to monitor service delivery and health outcomes.
- Increase use of lifesaving innovations.

Key Accomplishment Highlights

- Empowered over 3,800 health care workers with lifesaving skills to deliver quality MNCH services.
- Steadily increased uptake of PFP in MCSP-supported facilities—from 5% in 2016 to 21% in 2017 to 42% in 2018—allowing several women who delivered in these facilities to choose a contraceptive method before leaving the facility after delivery.
- Established QI processes and teams in 91 health facilities with marked improvements in QI indicators, such as use of uterotonic and partograph.

Figure 1. Improved quality and labor and delivery care and decreasing obstetric case fatality rate



Year	Percentage use of uterotonic	Percentage use of partograph	Obstetric case fatality rate
PY1	40%	30%	3.34
PY2	60%	30%	3.83
PY3	80%	40%	3.44
PY4	100%	75%	2.79

Nigeria MNCH

Key Accomplishments

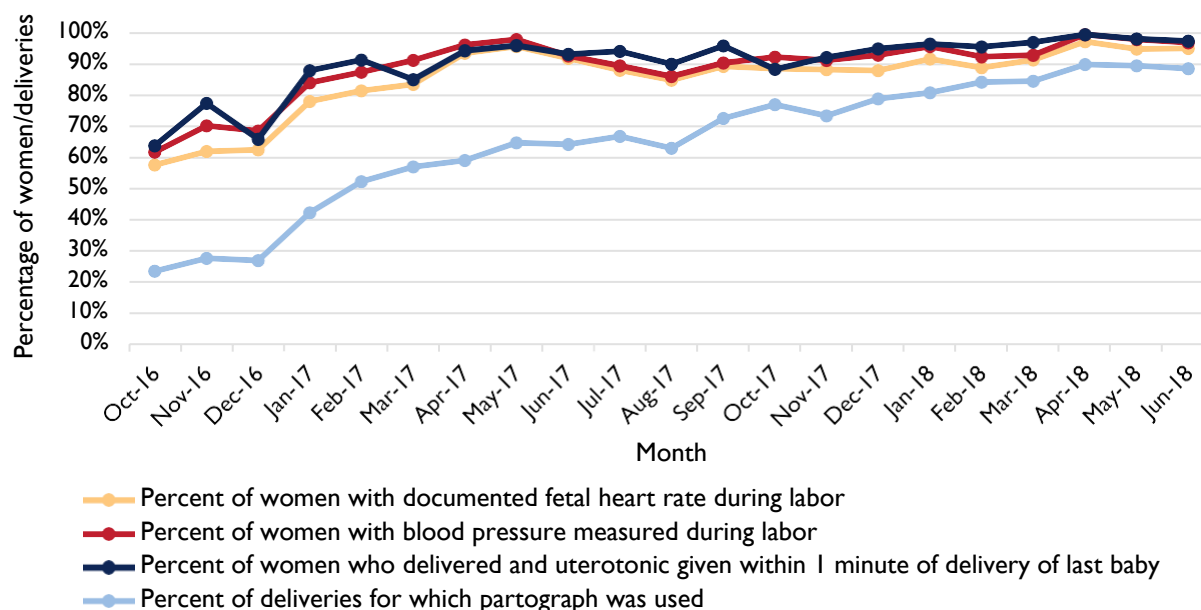
PY4 of the MCSP implementation in Nigeria provided opportunities to strengthen the program’s various ongoing interventions and consolidate the gains achieved so far. Although a few new interventions were also introduced, focus was on increasing access to and use of these lifesaving interventions by building capacity of more health care workers and refreshing the skills of those already trained. Additional tools and equipment were also provided to complement health worker training. MCSP further prioritized building strong health systems and institutions that will sustain the interventions after the program ends. MCSP also fostered more learning during PY4 by completing several learning products and sharing key findings with RMNCAH stakeholders at national and global levels.

Health Care Workers Delivering Quality Maternal and Newborn Care

In PY4, more than 600 health workers (including doctors, nurses, midwives, and community health extension workers across 321 facilities) were trained in MNH. Thus, MCSP has empowered a total of 3,584 health workers in Ebonyi and Kogi states over the life of the project to provide basic and emergency obstetric and essential newborn care. These skilled health workers have attended more than 65,000 deliveries and offer lifesaving services, such as provision of immediate postpartum uterotonic drugs for active management of the third stage of labor. They also successfully resuscitated 1,638 of 1,720 newborns (95%) who did not breathe at birth, promoted use of CHX gel for cord care, which led to 91% uptake in Ebonyi KMC approach.

Additionally, MCSP conducted a 1-day IPC management training on critical IPC behaviors and roles of managers in enforcing behavior compliance. Information, education, and communication materials were also designed and provided to 30 facilities across both states to motivate health care providers to comply with IPC protocols. To obtain a complete picture of current conditions and practices in the 30 targeted facilities, MCSP conducted an initial assessment of those facilities before rolling out the interventions mentioned earlier and will conduct an endline assessment across those facilities in PY5 Q1.

Figure 2. Improving quality of labor, delivery, and immediate postpartum care (N=27,643 total deliveries in 91 facilities)

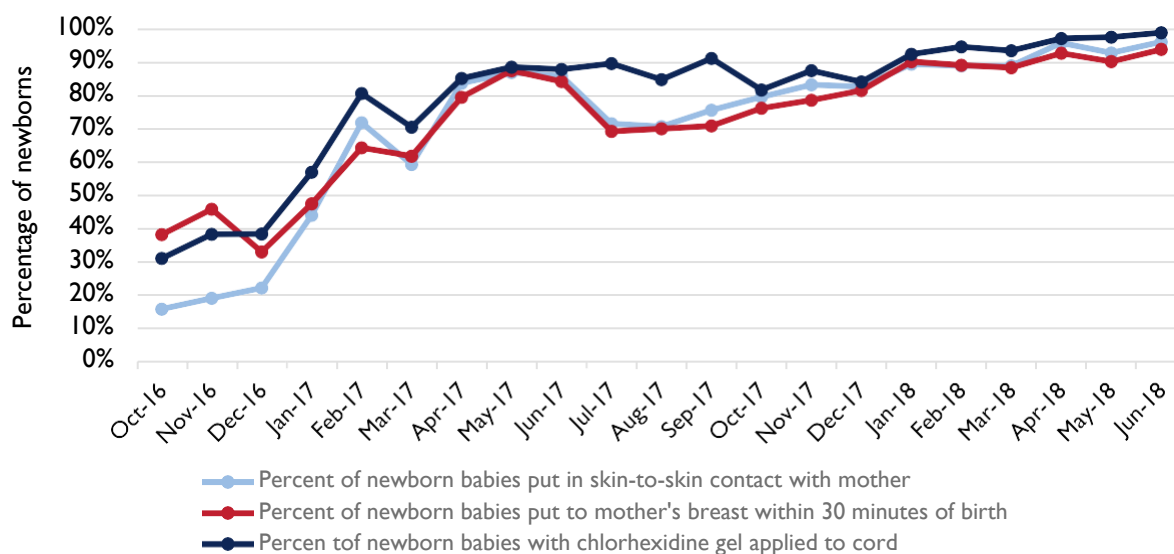


Source: MCSP quality of care dashboard (DHIS and additional data).

QI Process and Teams in Facilities

The number of MCSP-supported health facilities with established QI teams and a systematic approach to track quality of care measures increased from 40 in 2017 to 91 in 2018. These facilities can effectively plan, implement, and monitor QI processes, while the other 240 MCSP-supported facilities have been sensitized on quality of care and appreciate the importance of requirements and standards for delivering quality services to pregnant women, new mothers, and children. MCSP's QI interventions have promoted effective leadership and governance for health, and contributed to significant improvement in service delivery in the supported facilities, which serve about 1.7 million women of reproductive age and their children in Ebonyi and Kogi. As a result of these interventions, the total obstetric case fatality rate decreased from 4.0 in 2016 to 2.7 in 2018. At the national level, MCSP and other MNCH partners supported the Federal MOH to develop a road map for implementing QI learning sites in Nigeria.

Figure 3. Improving quality of early postnatal care for newborns



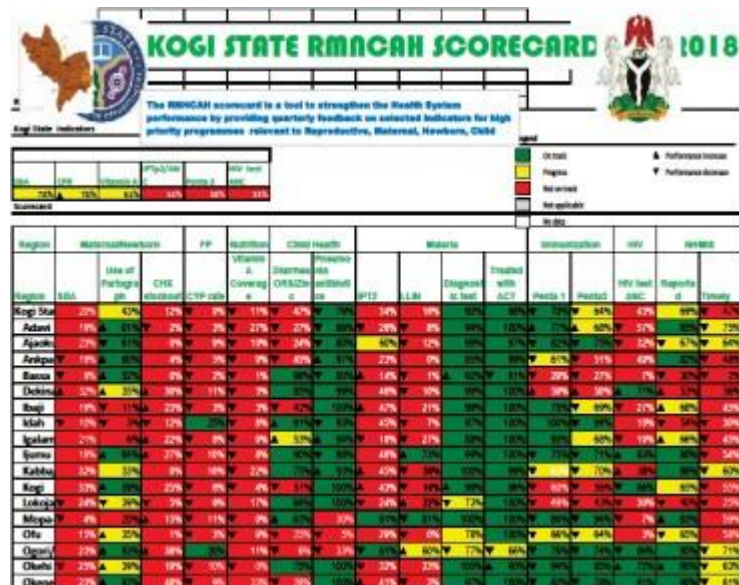
Source: MCSP quality of care dashboard (DHIS and additional data).

Similarly, integrated supportive supervision has been institutionalized in both states. Each quarter, teams from the state MOHs and LGAs, covering all LGAs or districts in Ebonyi and Kogi, visited an average of 220 facilities to provide integrated supportive supervision. This intervention built capacity within the state and LGA health teams to monitor facility performance and to identify challenges and the resources needed to resolve them. In addition, these visits improved health care workers' clinical skills as well as their attitudes toward work and their clients. Overall, the integrated supportive supervision visits have contributed to the MNCH outputs and outcomes.

Data for Decision-Making and Reporting Rates

As a result of MCSP's support for enhancing the capacity of health officials at facility, district, and state levels to monitor, visualize, and use routine data for decision-making, use of monthly facility summary forms to report and submit routine data increased: from 53% and 65% of supported facilities in Ebony and Kogi, respectively, in July 2015, to 86% and 70%, respectively, in June 2018. MCSP also recently introduced the use of data/dashboards at health facilities and scorecards at the state level in Ebonyi and Kogi, which is expected to improve the content and use of RMNCH data for decision-making, and to improve health outcomes in the states.

Figure 4. Sample RMNCAH scorecard from Kogi



Source: MCSP quality of care dashboard (DHIS and additional data).

Access to Health Care through Affordable Financing and Transport System

Under the emergency transport scheme introduced by MCSP in Ebonyi and Kogi, volunteer drivers transported 539 pregnant women and 315 children with emergency medical conditions to health facilities for treatment between 2017 and 2018, thereby helping to prevent maternal and child morbidity and mortality in the states. Similarly, the 73 mothers' savings and loans clubs established in both states with support from MCSP raised NGN 3,263,680 (USD 8,990). These clubs provided 21 female members no-interest loans of NGN 99,710 (USD 277), enabling them to access health care services, especially during emergencies, when they or their families could not pay. In addition, more than 2,000 club members used soft loans of up to NGN 1.2 million (USD 3,500) to enhance their livelihoods.

Gender Integration in RMNCH

More men are becoming involved in seeking quality care for their partners and children, especially in FP discussions, ANC, labor and delivery, and childhood immunizations. In MCSP-supported facilities, the number of women accompanied by their male partners for FP counseling, ANC, and labor and delivery increased from 1,479 in June 2017, to 4,625 in December 2017, to 5,627 in September 2018. MCSP interventions contributing to this development include capacity-building of state facilitators on male engagement in RMNCAH. This training equipped them with gender-sensitive counseling skills and the capability to provide basic first-line support to survivors of GBV. MCSP also helped develop male engagement job aids for service providers and informative flyers for clients, and supported the Federal MOH in developing Nigeria's first Gender and Health Policy.

Access to Reproductive Health Care for Adolescents

MCSP's interventions also expanded reproductive health care to cover adolescents and first-time mothers and young parents in selected areas (four health facilities in the two states). As a result, 5,938 young mothers (under 25 years old) voluntarily accepted their FP method of choice. Before this development, MCSP supported strengthening the availability and quality of health care tailored to the needs of first-time young parents through whole-site training on adolescent-responsive health care. MCSP also provided technical support to develop, pre-test, and finalize the age and life stage counseling tool and Our First Baby guide, which help providers tailor appropriate counseling based on adolescent clients' age and life stage (including youth and adolescents ages 10–14 and 15–19, and married/parenting adolescents and youth). In addition,

MCSP established first-time mothers' savings and loans clubs to promote sustainability of health care by increasing access and making care more affordable for young mothers.

FP Uptake among Postpartum Women

PPFP services have been initiated in 233 facilities (including faith-based hospitals) across Ebonyi and Kogi, and trained service providers counseled 60,804 women as of June 2018. Almost half (41%) of women who delivered in these facilities received the contraceptive method of their choice before leaving the facility. These FP interventions averted an estimated 25,000 pregnancies.⁷ MCSP also introduced minilaparotomy under local anesthesia—a simple, safe, modern, and affordable permanent FP method—in Ebonyi and Kogi, increasing contraceptive options and methods for women who desire to limit their family size. MCSP was instrumental in building the capacity of the first set of health care workers (20 doctors and nurse attendants) to ever perform the procedure in both states.

Services for Children under Age 5

Access to and use of quality child health services also increased in 119 health facilities in Ebonyi and Kogi following MCSP's training of 246 health workers in IMCI and PSBI guidelines. The trained health workers effectively treated 12,205 children under age 5 with amoxicillin DT for pneumonia and 5,881 children under age 5 for diarrhea using 119 oral rehydration therapy corners established by MCSP. MCSP also enhanced the capacity of 862 patent and proprietary medicine vendors on management of uncomplicated childhood illnesses, enabling the proprietary and patent medicine vendors across 682 outlets to assess, classify, and treat uncomplicated childhood illnesses and refer sick children to primary health care facilities for further care. A midline quality of care evaluation conducted in PY4 Q3 showed remarkable improvement in patent and proprietary medicine vendor stocking of essential childhood medicines and appropriate treatment of sick children from the baseline conducted in PY4 Q2. An endline quality of care study will take place in PY5 Q1.

In response to findings from a qualitative study of barriers and drivers of care seeking for childhood illness, MCSP supported community-based organizations to conduct community mobilization activities. Within 3 months of community-based organization-driven community mobilization, more than 163,000 caregivers and community members were reached, and 5,065 sick children under age 5 were referred to primary health centers and patent and proprietary medicine vendors for care.

Way Forward


In PY5 Q1, MCSP's priorities will be the completion of activities and transition to the state government, and continued documentation of results and lessons learned. MCSP directly supported 321 health facilities in Kogi and Ebonyi, representing about one-quarter of the health facilities in both states. Scaling up the program interventions across the states is therefore a critical next step that should be prioritized, especially by state actors. This ensures that key stakeholders, such as health care workers, federal and state MOH officials, professional associations, and patent and proprietary medicine vendors have already been engaged to serve as effective champions, advocates, mentors, and trainers. MNCH core technical committees in both states have also been revitalized to mirror the committees at national level and champion the cause of MNCH. Both states are also leveraging Saving One Million Lives to build on MCSP's gains so interventions continue beyond the life of the project. Although these important steps have been taken to sustain the gains, to achieve the overall goal of reducing maternal and child deaths in the states, going forward, state actors must show serious political will to drive scale-up of these gains, and communities must continue to demand quality services.

⁷ Pregnancy averted was calculated using the total couple-years protection generated from FP methods dispensed over the reporting period after considering the failure rates for each of the methods.

Selected Performance Indicators for PY4	
MCSP Global or Country PMP Indicators	Achievement
Number of people trained in MNH through US Government-supported programs	619 (target: 540, >100% achieved)
Number of people trained on FP/reproductive health with US Government funds	144 (target: 240, 60% achieved)
Number of people trained through US Government-supported programs on IMCI and iCCM	1,723 (target: 1,320, >100% achieved)
Number of MCSP-supported health facilities that have a systematic approach to track and display priority RMNCH indicators	91 (target: 91, 100% achieved)
Number of facilities with maternal and perinatal death reviews conducted	33 (target: 40, 83% achieved)
Couple-years of protection in US Government-supported programs	86,710 (target: 65,000, >100% achieved)
Number of pregnant women that attended antenatal clinic for at least four times	18,188 (target: 30,000, 61% achieved)
Number of deliveries by skilled birth attendants	23,257 (target: 25,000, 93% achieved)
Percentage of babies for whom CHX was applied to the umbilical cord at birth	88% (21,228 / 24,156, target: 80%, >100% achieved)
Percentage of newborns not breathing at birth who were resuscitated in US Government-supported programs	95% (1,117 / 1,166, target: 97%, 98% achieved)
Number of children under 5 referred to a high-level health facility by patent and proprietary medicine vendors for treatment of severe diarrhea, pneumonia, malaria, or danger signs in US Government (MCSP)-supported programs	255 (target: 1,505, 17% achieved) ¹
Number/percentage of patent and proprietary medicine vendors that received quarterly supportive supervision	80% of 682 (target: 100%, 80% achieved)

[1] Due to requested changes to the child health program's PPMV activities, implementation was delayed, limiting the number of referrals provided. Also, targets may have been overestimated, as no similar work had been done in the past, so no baseline data was available.

Nigeria RI PY4 Summary & Results



Geographic Implementation Areas

States

- 2/36 (6%)—Sokoto, Bauchi

LGAs

- 53/53 (100%) (in 2 states)

Wards

- 567/567 (100%)—323 in Bauchi, 244 in Sokoto

Facilities

- 1,542/1,844 (84%) (in 2 states)

Population

Country

- 186,000,000

MCSP-supported areas

- 1,364,487

Technical Areas



Program Dates

September 1, 2014–
December 31, 2018

Cumulative Spending through End of PY4



Demographic and Health Indicators

Indicator	# or %
Live births/year ^[1]	7.133 million
National DTP3 ^[2]	36%
Bauchi State DTP3	12.5%
Sokoto State DTP3	2.6%
IMR (per 1,000 live births) ^[2]	64
USMR (per 1,000 live births) ^[2]	128

Sources: ^[1]UNICEF *State of the World's Children 2015*, ^[2]NDHS 2013.

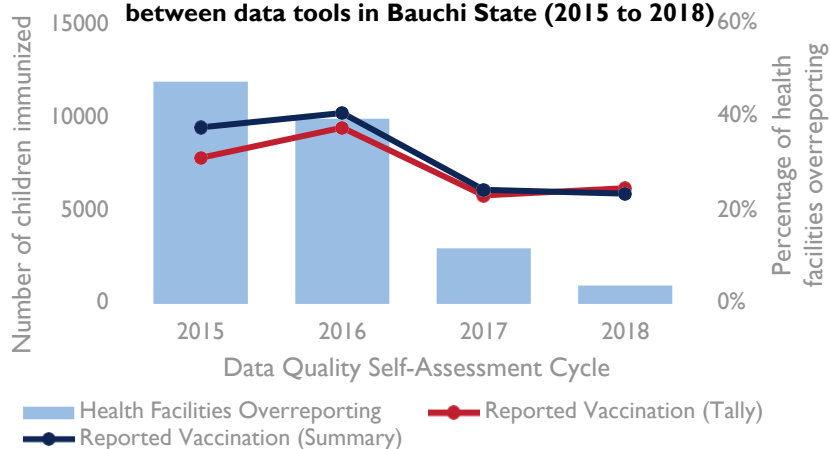
Strategic Objectives

- Support state-led and state-owned efforts to achieve over 80% RI coverage in every ward of Bauchi and Sokoto state by the end of December 2018.
- Support state-led and state-owned efforts to expand the availability and quality of RI services by providing technical assistance in the areas of capacity-building and training, supportive supervision, monitoring and use of data, supply/cold chain, and community engagement.
- Promote the transition of all responsibility for sustaining and building on these gains to Bauchi and Sokoto state by January 2018 by improving capacity to promote, deliver and monitor RI services at state, LGA, health facility, and community levels.

Key Accomplishment Highlights

- Expanded daily RI services in Sokoto from 512 health facilities in PY3 to 551 in PY4, and to 43 secondary health facilities across Sokoto and Bauchi states.
- Supported the training of 300 LGA primary health care staff in all 43 LGAs of Bauchi and Sokoto states, who in turn trained 1,500 health facility providers and RI in-charges on the updated *Basic Guide for RI Service Providers*.

Figure I. Fewer health facilities overreporting Penta3 immunization per DQS and improved consistency between data tools in Bauchi State (2015 to 2018)



Nigeria Routine Immunization

Key Accomplishments

USAID, the Bill & Melinda Gates Foundation, the Dangote Foundation, and state primary health care development agencies (SPHCDA) in Bauchi and Sokoto states are signatories to groundbreaking MOUs for RI strengthening, referred to hereafter as RI MOUs. The SPHCDA provide staff, infrastructure, commodities, and funding that is pooled with funding and technical support from the two foundations for implementation of each state's MOU. USAID has provided technical assistance through MCSP since early 2015 to the Bauchi MOU and since the end of that same year to the Sokoto MOU. Along with other RI MOU implementing partners in the states, MCSP supports activities to improve monitoring and use of immunization data, supportive supervision, community partnership and demand generation, and capacity-building and training of health workers. MCSP also provides technical support to the National Primary Health Care Development Agency and Nigeria's Federal MOH to strengthen coordination, planning, and review mechanisms; improve RI coverage; and ensure stronger and more resilient national RI and primary health care systems.

National Policy Development and Implementation

MCSP's national-level RI technical support during PY4 included continued sharing of experiences and lessons learned from MOU implementation in Bauchi and Sokoto, contributions to quarterly EPI reviews, and technical input for a series of national policies and plans. MCSP supported the National Primary Health Care Development Agency to update the National Immunization Policy to reflect several important changes, including introduction of the National Emergency for RI Coordination Center and the Optimized Integrated RI Sessions approach. Also during PY4, MCSP supported finalization of standard operating procedures for RI supportive supervision and mentoring, an RI job aid for health care providers, national training guidelines for the National Primary Health Care Development Agency, the *Basic Guide for RI Service Providers*, and the National Measles Elimination Plan 2018–2028. Finally, MCSP is proud to have contributed to the development and submission of the National Strategic Plan to Strengthen RI and Primary Health Care 2018–2018, which was recently approved for multiyear support by Gavi.

Strengthening of and Expansion of RI Services in Bauchi and Sokoto

A central focus of MCSP's technical support has been expansion of access to RI services. In PY4, both states continued to show improvements in the number of health facilities providing RI services each month, the number of immunization sessions conducted (both fixed and outreach), and the reliability of the vaccine supply to individual health facilities. In the past year, MCSP supported both states to evaluate and build the capacity to provide daily RI sessions at an additional 33 secondary and three tertiary health facilities (16 in Bauchi and 20 in Sokoto). In Bauchi, the percentage of fixed RI sessions conducted as planned continued to increase (from 91% in Q1 to 99% in Q4), and the percentage of planned outreach sessions conducted increased from 89% to 100%. In Sokoto, the percentage of fixed RI sessions conducted as planned remained steady at 98%, with 98% of planned outreach sessions conducted as well. Consistent monitoring and follow-up of RI through quarterly review of microplans, monthly LGA-level review meetings, and supportive supervision visits contributed to the increased percentage of fixed and outreach sessions conducted in both states. The regular disbursement of RI MOU funds to dedicated health facility bank accounts has also helped to ensure that health facilities consistently have the funds needed for outreach. All of these improvements bode well not only for coverage but also for RI service quality and system strengthening. Caregivers are now consistently returning to complete their remaining RI doses, as seen in dropout rates of less than 10% in both states, compared to the national average of 14% (2017 estimate from WHO and UNICEF). Overall, 377,719 children in the two states received DPT3 in the past year.

Vaccine Supply Chain and Logistics

MCSP supports the coordination of activities that are critical to vaccine security, cold chain strengthening, and RI logistics in both of the MOU states. In PY4, along with other partners, MCSP helped both SPHCDAAs to monitor vaccine stocks and the functionality of cold chain equipment by intensifying spot checks and providing onsite coaching of LGA and health facility staff. Stock-outs continued to be tracked and addressed using LGA-level dashboards and public-private partnerships that “push” vaccine delivery to health facilities in need. The reduction in vaccine stock-outs in Bauchi health facilities has been dramatic. In June 2015, 28% of health facilities in Bauchi had experienced a recent vaccine stock-out; by December 2017, after the introduction of vaccine direct delivery and more aggressive monitoring and coaching/mentoring of staff, the rate of stock-out had fallen to 4%. In PY4, 96% of facilities with cold chain capacity in Bauchi (289 facilities) and 91% of facilities with cold chain capacity in Sokoto (221 facilities) experienced no stock-outs of vaccines during the preceding month. By building the capacity of service providers and EPI managers in vaccine forecasting, microplanning, RI session planning, cold chain equipment maintenance, and use of performance dashboards, vaccine data consistency has improved in the zonal cold stores and across all of the Bauchi and Sokoto LGAs.

RI Data Quality

MCSP provided technical support to the SPHCDAAs in both states to review RI indicators, identify and address gaps in data management and quality, train staff, and monitor improvements. During the PY, MCSP and the state M&E working groups intensified supportive supervision visits and conducted routine data quality assessments to improve data quality in both states. In collaboration with other RI MOU partners, MCSP supported the coaching and mentoring of 523 service providers in Sokoto to improve the quality and timeliness of their reporting. As a result, timeliness of RI reporting had improved to 95% in Sokoto by the end of PY4. To further engage LGA counterparts and improve the quality of HMIS data, MCSP introduced directly observed data entry, which requires trainers to correct and provide guidance to data officers on site when data entry errors are observed. MCSP also supported the states to address persistent RI data quality issues at the LGA and health facility levels, including serious discrepancies and inconsistencies in reporting, falsification and over-reporting of data, and transcription errors. Results from a joint assessment in 112 randomly selected health facilities in Bauchi led the state and its partners to define more clearly the roles for LGA data working groups, revise their terms of reference, and adopt data quality assessment tools as part of their monthly routine data validation process. The trends in both states as a result of these efforts show improved data quality, reduced over-reporting, and more accurate coverage rates.

Linkages between Communities and Health Facilities

Both states further strengthened partnerships with community structures to improve RI uptake in PY4. MCSP participated in RI review meetings between health facilities and communities, and provided technical assistance and mentoring to service providers on how to share RI performance data with communities. MCSP also sensitized community leaders about the need to participate in RI and taught them to line-list children, track their vaccination status, and develop defaulters’ lists for future tracking and referral to health facilities and outreach sessions. Community leaders showed their commitment to this process by regularly attending meetings, updating the community name-based register, and developing lists of defaulters. With MCSP’s support, ward community focal people facilitated 2,587 community feedback and reconciliation meetings (1,685 in Sokoto and 902 in Bauchi) in PY4.

In PY4, MCSP’s technical support addressed issues that lead to missed opportunities for immunization and large numbers of unimmunized children, such as weak tracking mechanisms for newborns, and challenges with identifying and following up with children who are left out or who drop out of the RI system. MCSP’s newborn tracking activity has effectively leveraged trusted community members (trained traditional barbers) to track and refer newborns using color-coded cards and to educate caregivers on the benefits of immunization. Before beginning the newborn tracking activity in Sokoto, MCSP collected baseline data from a community assessment targeting women with children ages 0–23 months from the 10 LGAs. MCSP presented preliminary findings from the baseline assessment to the State Emergency RI Coordination Center

and at the social mobilization working group in January 2018. MCSP also supported the Bauchi SPHCDA to use qualitative evidence from this assessment to strengthen, document, and assess strategies for newborn identification, referral, and tracking. Findings revealed that traditional barbers who made house-to-house visits increased the acceptance of RI by improving caregivers' awareness of its importance and contributing to an increased number of immunized children in both fixed and outreach sessions in the pilot sites. As part of the newborn tracking activity, MCSP trained 2,858 traditional barbers in Bauchi (2,058) and Sokoto (800), who went on to track and refer 43,380 newborns in PY4; of these, 39,416 (91%) were reported to have received vaccination in both states. This is a significant increase from the 35,198 newborns tracked in these catchment areas in PY3. MCSP continues to work closely with the state community engagement working group to monitor and support child tracking activities. In PY4, MCSP also adapted the My Village My Home (in Nigeria, called Healthy Children, Community's Pride) visualization tool and used it in three wards of three LGAs in each state as a complementary approach to existing name-based records. Thus far, 3,200 children have been tracked using the Healthy Children, Community's Pride visualization tool in the six wards, and 78% of them were up-to-date with their vaccines at the end of the PY.

Building Capacity and Strengthening Partnerships to Ensure Quality RI Services

Skilled and knowledgeable health care providers are required to ensure high-quality RI services at health facilities and outreach sessions. In collaboration with Solina and the other RI MOU partners, MCSP used a combination of user-centered approaches—onsite, need-based mentoring; cross learning; monthly data review meetings; and supportive supervision—to build and reinforce health worker capacity. MCSP played a key role in integrating adult learning techniques into the Basic Guide for RI for Service Providers and its training approach. In PY4, 29,428 health workers in Bauchi and 9,759 health workers in Sokoto received training supported by MCSP on RI-related topics, including data management, Reaching Every Ward microplanning, newborn tracking, vaccine distribution, cold chain management and maintenance, direct delivery of vaccines, injection safety, vaccine management, new vaccine introduction, data quality assessment, PSE, data analysis, directly observed data entry, and interpersonal communication skills. MCSP assisted with the establishment of a mentoring component for follow-up supervision that is in line with the new national standard operating procedures. It is building a pool of “super mentors” in each state who will be able to continue providing onsite, need-based mentoring and building the capacity of other mentors to sustain the gains so far.

MCSP also made significant progress on the MOU documentation and startup guide in PY4, beginning with an MOU brief that summarizes the experience of Bauchi and Sokoto in implementing their RI MOUs. In collaboration with Solina, MCSP also conducted interviews with key informants in all six MOU states and drafted case studies for each state. The case studies are being reviewed and will be finalized in PY5 Q1. In addition, these individual state case studies will be used to generate a startup guide that summarizes the experiences of the six states and provides guidance to other states and partners on how to initiate, structure, and implement similar public-/private-sector MOUs.

Way Forward

In PY5 Q1, MCSP will continue to work closely and collaboratively with the National Primary Health Care Development Agency and its national, state, and LGA Emergency RI Coordination Centers to ensure effective RI management and delivery at all levels of the health system. During the short period remaining for MCSP implementation, the MCSP RI team will continue USAID's contribution to primary health care systems strengthening by providing capacity-building support to the chairs of the emergency committees and contributing technically to their planning, monitoring, and coordination of RI activities. Before project closeout in December 2018, certain RI activities implemented by MCSP in Nigeria will transition to new implementing partners, and others will be handed over to national and state entities in accordance with the program's approved closeout plan. Endline data collection and dissemination of key program documents and resources will be conducted at state and national level through existing platforms, including National Emergency for RI Coordination Center and State Emergency RI Coordination Center meetings. MCSP will take all possible steps to promote the sustainability and continued use of program learning and resources at national level and in the two states.

Selected Performance Indicators for PY4	Bauchi	Sokoto
MCSP Global or Country PMP Indicators	Achievement (Target ¹)	
Number of national policies drafted with US Government (MCSP) support	6 ²	
Percentage of children less than 12 months of age who received DPT 3 from USG-supported programs	84% (target: 70%, >100% achieved)	76% (target: 57%, >100% achieved)
DPT1 to DPT 3 dropout rate	11% (target: 10%)	9% (target: 10%)
Number of people trained in child health (immunization) and nutrition through US Government-supported health area programs	29,428 (target: 832, >100% achieved)	6,610 (target: 400, >100% achieved)
Percentage of health facilities receiving RI basket funds on a monthly basis	94% (target: 80%, >100% achieved)	100% (target: 80%, >100% achieved)
Percentage of RI fixed sessions conducted as planned	96% (target: 75%, >100% achieved)	98% (target: 65%, >100% achieved)
Percentage of RI outreach sessions conducted as planned	93% (target: 75%, >100% achieved)	98% (target: 55%, >100% achieved)
Percentage of health facilities offering RI services	94% (target: 88%, >100% achieved)	72% (target: 92%, 78% achieved) ³
Percentage of health facilities receiving at least one supportive supervision visit for RI within a quarter	82% (target: 63%, >100% achieved)	97% (target: 72%, >100% achieved)
Percentage of health facilities with no stock out of vaccines for 30 days	95% (target: 70%, >100% achieved)	88% (target: 70%, >100% achieved)
Percentage of satellite cold store health facilities with functional CCE	89% (target: 70%, >100% achieved)	84% (target: 60%, >100% achieved)
Number of children referred from community to health facility for immunization services	22,348 (target: 110,000, >100% achieved) ⁴	17,511 (target: 80,000, 22% achieved) ⁴

[1] All listed targets are set by the State RI MOU partnership and apply to a single calendar year; in this case, January– December 2018.

MCSP's PY4 achievements are for the period of October 2017 – September 2018, so they do not entirely line up.

[2] National Basic Guide for RI Service Providers, National RI Strategic Plan, National Immunization Policy, National RI Supportive Supervision Standard Operating Procedures, Optimized Integrated Routine Immunization Supportive Supervision Strategy and SOP, National Measles Elimination Plan

[3] The 92% MOU target for Sokoto was not achieved because the state decided mid-PY4 to prioritize increasing the frequency of RI services and improving the quality of RI sessions at existing health facilities instead of expanding to new facilities. Furthermore, the state's plan for expansion is dependent on health worker recruitment, which has been challenged by the poor economy and low fund allocations by the states. Plans are underway to recruit more health workers in 2019.

[4] These referral targets were calculated on the assumption that each trained traditional barber would conduct at least 10 referrals per month. During implementation, it was observed that referral tracking was low among almost 40% of trained barbers. This was likely due to demotivation as a result of seeing other volunteers receiving money for the same task (traditional barbers were not incentivized by MCSP and delays in start-up of implementation in Sokoto state.