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TARGET STATES HIGH IMPACT PROJECT

MID-TERM EVALUATION

FINAL REPORT

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TARGETED STATES HIGH IMPACT PROJECT (TSHIP): PART ONE

MID-TERM EVALUATION

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LIST OF ACRONYMS

ACT	Artemisinin-Based Combination Therapy
AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
BASSHDP	Bauchi State Strategic Health Development Plan
BCC	Behavior Change Communication
BEOC	Basic Emergency Obstetric Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CA	Cooperative Agreement
CAC	Community Action Cycle
CBHVs	Community-Based Health Volunteers
CDRF	Community Drug Revolving Fund
CDI	Community Directed Intervention
CEOC	Comprehensive Emergency Obstetric Care
CHO	Community Health Officer
CHEW	Community Health Extension Worker
C/O	Community Outreach
COP	Chief of Party
CSO	Civil Society Organization
CPR	Contraceptive Prevalence Rate
CYP	Couples Years Protection
DCOP	Deputy Chief of Party
DMA	Drug Management Agency
DSNO	Disease Surveillance and Notification Officer
EBF	Exclusive Breast Feeding
EmONC	Emergency Obstetric and Newborn Care
EOC	Emergency Obstetric Care
ETS	Emergency Transport Services

EUV	End-User Verification
FANC	Focused Antenatal Care
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FP	Family Planning
GHI	Global Health Initiative
HBB	Helping Babies Breath
HDCC	Health Data Consultative Committee
HREC	Health Research Ethics Committees
HF	Health Facility
HIS	Health Information System
HMIS	Health Management Information System
HRH	Human Resource for Health
HSS	Health System Strengthening
ICCM	Integrated Community Case Management
IEC	Information, Education & Communication
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment
ISS	Integrated Supportive Supervision
KMC	Kangaroo Mother Care
LEAD	Leadership, Empowerment, Advocacy & Development (USAID)
LGA	Local Government Area
LiST	Lives Saved Tool
LLINs	Long Lasting Insecticidal Nets
LOP	Life of Project
LQAS	Lot Quality Assurance Sampling
MAPS	Malaria Action Program for States
MDG	Millennium Development Goals
MDR	Maternal Death Review
MIP	Malaria in Pregnancy

MNCH	Maternal, Newborn and Child Health
MTE	Mid-Term Evaluation
NDHS	Nigeria Demographic and Health Survey
NEI	USAID Northern Nigeria Education Initiative
NHMIS	National Health Management Information System
NMCP	National Malaria Control Program
NMEMSII	Nigeria Monitoring and Evaluation Services II
NPHCDA	National Primary Health Care Development Agency
OJT	On-the-Job Training
OR	Operations Research
ORS	Oral Rehydration Salts
OPV	Oral Polio Vaccine
PHC	Primary Health Centers
PMP	Performance Monitoring Plan
PMVs	Patent Medicine Vendors
PPH	Postpartum Hemorrhage
PPPs	Public-Private Partnerships
RH	Reproductive Health
RI	Routine Immunization
SBA	Skilled Birth Attendant
SBMR	Standard-Based Management and Recognition
SFH	Society for Family Health
SHREC	State Health Research Ethics Committee
SOP	Standard Operating Procedures
SLT	Senior Leadership Team
SMOH	State Ministry of Health
SMLGA	State Ministry for Local Government Affairs
SMWACD	State Ministry of Women Affairs & Child Development
SMT	State Management Team
SP	Sulphadoxine/ Pyremethamine

SPHCDA	State Primary Health Care Development Agency
SPSESAP	State Pre-Service Education Strategic Action Plans
SPSP	Strengthening Pharmaceutical Systems Program
SSHDP	State Strategic Health Development Plan
SSMC	State Social Mobilization Committee
TA	Technical Assistance
TBA	Traditional Birth Attendant
TSHIP	Targeted States High Impact Project
VOA	Voice of America
VDC	Village Development Committee
VPD	Vaccine Preventable Diseases
WDC	Ward Development Committee
Zn	Zinc

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EXECUTIVE SUMMARY

In 2009, the Targeted States High Impact Project (TSHIP), USAID/Nigeria's flagship project, started improving the quality and delivery of a number of integrated high impact Maternal, Newborn and Child Health (MNCH), Family Planning (FP), and Reproductive Health (RH) interventions in two States, Bauchi and Sokoto in Nigeria. The TSHIP, along with other USG projects, is part of USAID/Nigeria's "Focus State Strategy" designed to achieve impact at the State level. The TSHIP design was based of the achievements of prior USG projects, and on a number of assumptions, to achieve the following four strategic sub-objectives as measured by 25 indicators:

1. Strengthen State and local capacity to deliver and promote high-impact interventions;
2. Strengthen service delivery at Primary Health Centers (PHC) and referral levels;
3. Strengthen the roles of households and communities; and
4. Improve policies, programming and resource allocation.

TSHIP is being implemented by the JSI Institute as the prime organization along with a number of partners. The present draft Mid-Term Evaluation (MTE) report describes the methodology to assess how well the TSHIP has strengthened State and local governments, service delivery and referrals and the role of households (HH). The findings were used by the MTE team to also validate the design assumptions as presented in the project's results framework, and make recommendations to maximize the impact of the TSHIP. This is the final report that was submitted after review of a draft report by USAID/Nigeria.

METHODOLOGY OVERVIEW

The MTE Team, consisting of six experienced international and national health professionals, developed a work plan based on the evaluation questions in the scope of work, and submitted it to USAID/Nigeria on September 21, 2012. The field work of the TSHIP MTE took place from September 17th, when the Team Leader (TL) arrived in country, until October 20th when the TL departed. The MTE Team reviewed documents; interviewed the TSHIP Team by email and in person; interviewed the various beneficiaries of the project; conducted 18 focus groups with users, non-users and adolescent women; and conducted a quantitative survey in 18 PHCs and 5 secondary facilities to measure progress and identify challenges and opportunities for the project to address in the next two years. Effectiveness, sustainability and ownership of the high impact, low cost interventions were the three main guiding parameters of this MTE. The MTE Team looked for evidence that the project activities are being translated and "mirrored" by the States' programs and included in the States' health systems' planning, budgeting and delivery functions. In sum, the MTE Team measured to what extent the TSHIP has progressed in the continuum of project, program and system.

SUMMARY OF FINDINGS AND CONCLUSIONS

1. The USAID /Nigeria 2010-2013 Strategy has two main results for the Investing in People program:
    a. **Number of GON sites providing comprehensive integrated services**
    b. **% of total funding for the response from Nigerian Sources**

    The TSHIP is a Cooperative Agreement that mainly contributes to result a. and through system strengthening, it also contributes to result b. by improving the effective use of funding. However, the TSHIP is not required to report on the progressively increasing number of facilities that provide comprehensive integrated services.

2. The TSHIP has **effectively introduced a number of high impact MNCH/FP/RH interventions**, trained large numbers of health providers in both States and advocated for a number of system strengthening activities.

3. The TSHIP has also **achieved high levels of visibility and good will among all beneficiaries**, raised the level of awareness about quality of care, coverage and community engagement, and created and strengthened an effective community platform, the Ward Development Committees (WDC), to expand the community-based delivery of the target interventions. The high degree of initiative, personal and financial commitment of the WDCs is commendable, and one that must be preserved. As we will describe later, the WDCs are essential to sustaining the demand and supply of MNCH/FP interventions, and the investments made by the USG in renovations and equipment. However, the States have not been perceived to be at the forefront of these activities.

4. The **project progress indicators** show that in spite of these achievements, the project has not progressed as planned due to various factors, mainly :
    a. The fact that a number of critical design assumptions were not fulfilled, regarding availability of sufficient health staff and essential medicines,
    b. The implementation approach does not seem to have followed the sub-objectives pursuant to the original grant application that JSI submitted,
    c. The project has been focused on a broad breadth of activities, that diluted its impact at facility level,
    d. The TSHIP Team has had high turnover, and had a "process" focus instead of a "results" focus, and
    e. There has been a lack of effective progress monitoring to inform project management decisions in a timely manner.

5. The **State-wide focus and the five TSHIP strategies** used to guide project implementation so far have helped the project face the challenges of improving health services at the same scale as the focus States. **At the facility level**, the TSHIP has introduced the SBM-R quality improvement methodology, ORT corners, provided equipment and renovated facilities. However, the assumption that staff and essential medicines would be there to deliver the interventions were not fulfilled. The project has not been able to effectively address, along with other USG projects, the lack of essential medicines that hamper implementation of MNCH interventions. **At the**

community level, the TSHIP has developed and applied innovative solutions such as the creation of the Community Based Health Volunteers Program (CBHV) and the community midwife training program to address the lack of human resources that have reached emergency status at this time; and the introduction of the use chlohexidine and misoprotol to improve home deliveries. **The link between facility and community has not been established** for proper support and monitoring, or to sustain community-based volunteers. There is no one at each facility assigned the responsibility of "TBA or CBHV coordinator" to oversee the work at the facility and provide in-service training.

6. The TSHIP's five overarching strategies do not seem to have followed the approach described in the grant application and the TSHIP Team has not yet taken "**the next step"** to ensure the stakeholders use interventions and incorporate them in their routines. For example; training on various interventions has been conducted, but the **Standards-Based Management and Recognition (SBMR), the approach to Improve Quality and Performance** is just starting to be used in facilities. The manuals have been developed for PHC and secondary health facilities, training has started and manuals are about be distributed. Distribution is just awaiting signature by PHCDA, Executive Director. The steps to implement SBMR that will build on the investment on training and lead to the delivery of quality integrated health care interventions are not clear in the annual work plan for project year 4 (PY4).

7. **Project activities seem to have had much breadth, but not enough depth to effect and sustain change, as observed in visited facilities**. Health care quality and Statewide coverage of the integrated package of interventions requires consistent and progressive implementation, Local Government Area (LGA) by LGA. For instance, the TSHIP has not developed a systematic approach of ranking LGA performance and identifying weak and strong LGAs. Such a system would help the State (and the TSHIP) to rank the performance of beneficiary LGAs, and to proactively target weak links and build on the strengths of the "positive deviants." The TSHIP has implemented activities, but has not facilitated "next step" implementation and problem-solving with all stakeholders. For example, the TSHIP provided training, but organizational changes have not followed to ensure that the staffs change how they work, and apply what they have learned. Therefore, training has not clearly led to improved staff performance. Another example is that the TSHIP provided equipment, but this equipment is not part of the facility inventory. There is no system for the inventory to be checked by a third party such as the LGA or WDC, who should also have a copy of the inventory. The TSHIP mobilized WDCs, but the WDCs do not consistently work to achieve a target that will contribute to the TSHIP's results, such as identifying pregnant women that need to go for their ANC visit. The TSHIP renovated labor rooms, but they are underutilized. The lack of toilets, privacy and respectful treatment by staff were reported as problems, but neither the health staff nor WDCs have been mobilized to address these issues. In addition, **routine immunization system (RIS)** strengthening has not built on prior achievements and, although undermined due to frequent polio eradication campaigns, the RIS does not seem to be integrated with other interventions and has not been strengthened by the TSHIP.

8. **Integrating MNCH/FP Health Services was the main goal of the TSHIP, but it is not evident**. Integration is addressed in policies and manuals, but was not observed in the service delivery in the facilities that seem to still provide services as usual. We noticed that the reintroduced ORT corners are not being used much, at least at the time of our visit, and family planning is not integrated in child health services. Probably this is because facility organization and patient flow have not yet been integrated. Facilities provide immunization usually once a week and ANC services on other days of the week. Given the proportion of population funds the TSHIP receives, we had expected FP integration to be working more prominently. In sum, the model facilities visited do not have an integrated model of patient-provider interaction that focuses on serving the patient's needs and safety. Maternities lack appropriate toilets, do not have space for privacy to provide breastfeeding nutrition education and FP advice or for mother's and baby's belongings.

9. **The critical assumption that the essential medicines and supplies would be there for the target interventions to be implemented was not valid.** Lack of medicines and vaccines still remain a challenge for the States and, consequently, to the TSHIP. Without priorities and concerted effective action to address the essential medicines supply chain, the impact of the TSHIP will be limited and unsustainable.

10. **The TSHIP's achievements are appreciated by State, LGA and WDC authorities, but are not owned by them**. The TSHIP is not perceived to be working with the State on their behalf. It is as if the State is helping the TSHIP achieve its deliverables when it should be the other way around. The project's approach has been that most activities are implemented by project staff, and not by existing organizations or institutions **with TSHIP assistance**. The State does not seem to be at the forefront, and the TSHIP's activities are not seen as contributing to the State's work plan. For instance, project activities are not part of the State-costed work plan and, therefore, the State has no way of coordinating and integrating the TSHIP's activities with its own.

11. **Harmonizing Methods for Community Engagement and Mobilization.** The TSHIP has successfully sensitized and awakened the interest of communities in both States to take a stake in their health mainly through the reactivation of Ward Development Committees (WDCs) using the Community Action Cycle (CAC) methodology. However, there is a need to systematically empower Community-Based Health Volunteers (CBHVs), WDCs and 100 women's groups at the LGA level, as well as female Civil Society Organizations (CSOs), with targeted training, selected commodities and micro-grants based on needs. Linking these community structures to health facilities and relevant government institutions, will truly enable them to become a "seamless bridge" in the continuum between the community and the health system, and strengthen the health system in the process.

12. **The Grants component has been delayed and is two years behind.** The burn rate of the pipeline for sub-grantees to the project is low; and only about half a million has been spent out of the $7.45 million the TSHIP should have spent by the time of the MTE. The total for the LOP is $10.45 million. The grants program is

not simple and streamlined, and it is not focused on contributing to the achievement of the project's deliverables.

In conclusion, we believe that quality improvements are urgent in all of the facilities visited. For Signage, patient flow and hygiene must be improved immediately. The MTE Team identified the following quality improvement priorities to be the focus of supportive supervision and organizational change: overall facility and staff hygiene; patient flow and consistent integrated service provision of Antenatal Care (ANC); child growth monitoring; Oral Rehydration Salts (ORS), Malaria diagnosis and treatment; RI and FP counseling services integrated in all the above Primary Health Centers (PHC). It will take longer than the Life-of-Project (LOP) to sustainably implement Standard-Based Management and Recognition (SBMR) and ensure that a significant number of facilities deliver quality integrated care. We believe this may be achieved in most of the PHC facilities with **a change in the way the project works to accompany PHC staff in a phased, prioritized and focused implementation,** if the life of the current Cooperative Agreement is extended for two more years.

SUMMARY OF RECOMMENDATIONS AND FUTURE DIRECTIONS

Based on the evidence generated from the evaluation, the MTE Team made the following main recommendations to improve the effectiveness of the TSHIP and realign it with its sub-objectives for maximum impact:

a. For the TSHIP Team to include in PY4:

I. **The "Results Framework" and M&E Framework for the TSHIP must be revised so the PY4 work plan** includes **activities by sub-objective and specific results (outcomes) linked to each activity** in order to achieve the expected impact: reduction on maternal and infant and child morbidity and mortality, that is, Millennium Development Goals four and five (MDG4 and 5), and significantly contribute to "Saving a Million Lives." If not corrected in PY4, as with prior USG investments, the TSHIP will have limited lasting impact and many lives will be lost. The PY4 work plan must focus on the results of the 4 sub-objectives and on implementing activities that directly and measurably contribute to achieving those results, namely:

1. Strengthen State and at least a significant number of LGAs so that they actually deliver and promote the project's high impact interventions at a minimum standard of management performance that must be defined in PY4. Through the TSHIP's assistance, the State Primary Health Care Development Agency (SPHCDA), the Ministry of Local Government (MOLG) and the LGAs must be able to perform a minimum number of activities to effectively manage their programs. These activities must be included in the PY4 work plan. In addition, the TSHIP must focus on how to help the Executive Directors of the SPHCDA to succeed in achieving and accounting for a minimum of State goals, as stated in the State Health Development Plans that the TSHIP helped develop. The TSHIP's PY4 work plan should answer the following questions:

i. **What will a stronger State be able to do in 2013 as the result of TSHIP's assistance?**
ii. **What will a stronger LGA be able to do in 2013 as the result of TSHIP's assistance?**

2. Strengthen service delivery at the PHCs and Referral Facilities (RF) that deliver quality high impact health interventions and monitor, oversee and train community-based volunteers and traditional birth attendants (TBA)s at minimum of performance level must be included in PY4 work plan. The TSHIP should list all PHC and RF and rank them according to their current level of performance, and assist an appropriate number of them every year to ensure they deliver quality integrated health care. The TSHIP should assist the SPHCDA to monitor the number of facilities that meet performance standards and be able to answer the following questions:
   i. **What will a well-performing Health Facility (HF) do in 2013 as the result of TSHIP's assistance?**
   ii. **What will a well-performing Referral Facility do in 2013 as the result of TSHIP?**
3. Strengthen the roles of households and communities that organize and monitor the demand for these high impact interventions, community-based volunteers and TBAs. The PY4 should answer the following questions:
   i. **What will a household be able to do in 2013 because of the roles that the Community-Based Health Volunteers (CBHV) and TBAs play in the communities supported by the TSHIP?**
   ii. **As measured by the LQAS survey, how many households will be able to report or demonstrate a strengthened role and demand high impact interventions?**
   iii. **What will a functioning WDC do in 2013 as the result of the TSHIP to increase coverage and access to the integrated high impact interventions?**

4. Improve policies, programming and resource allocation to directly strengthen and institutionalize the high impact interventions. The PY4 should answer the following question: **What essential policies and changes in programming and in resource allocation are necessary to ensure a significant number of LGAs in both States deliver quality integrated high impact interventions?**

II. The TSHIP must work with the States to plan and **implement activities jointly** and include those activities in the State's costed work plan, thus setting an example for donor accountability and promoting ownership.

III. The TSHIP must **sustain the investments** made in renovations and equipment in PY1-3, set **minimum PHC and referral performance standards,** and empower LGA and WDC to monitor and work with PHC staff to meet those standards. For example, if 100 women are pregnant in the community, the standard is that 100 must receive ANC, have a safe delivery plan, and the 100 babies must be fully immunized by their 1st birthday. If fewer than 100 are reached, stakeholders must discuss each situation, find the reasons and find solutions so that it does not happen again.

IV. **Facility performance** must be measured and improved. The TSHIP must work with stakeholders to create a **facility schedule chart** to deliver integrated high impact interventions at a quality performance level. The weekly schedule must also account for all staff/hours in the work day, and include the available staff by name. The TSHIP must empower LGA and WDC to monitor and ensure staff follow the schedule. The TSHIP must work with stakeholders to immediately implement correct **patient flow, facility signage, and hygiene standards** (facilities must look and smell like facilities) in every facility to deliver quality integrated care.

V. **The TSHIP must improve data quality** and, in addition to the existing indicators, use the following additional outcome cumulative State, LGA and Facility Level Targets Indicators based on catchment populations to measure progress and manage project activities and staff performance:

  a. # of facilities that deliver child health interventions at an acceptable quality level (start with renovated ones) to the catchment population
  b. # of facilities that provide malaria diagnosis and treatment according to standards
  c. # of facilities that provide delivery and newborn care according to standards
  d. # of facilities that report minimum accurate information and use selected indicators
  e. # of facilities with functioning pharmacy with minimum stock and updated inventory of minimum essential medicines and supplies.

Assuming the TSHIP has 4 years to go, we recommend that the TSHIP rank facilities by performance and on average target at least 25% of them per year for assistance so they achieve the required level of performance to deliver quality high impact interventions.

b. <u>In terms of additional operational studies , surveys, assessments to inform the TSHIP:</u>

I. **Operational research** must be conducted to measure the effectiveness of a new maternal health policy, the new maternal record, and overall maternal health interventions, that is, the TSHIP must measure the effectiveness of the implementation of the Emergency Medical Obstetric Care (EMOC) State referral network; provision of misoprostol and Mg Sulphate; and the effectiveness of the CBHV and the community midwives programs.

II. Given the average age of marriage and at first pregnancy, it is essential that the **Kangaroo Mother Care** (KMC) program be scaled up and evaluated to measure the effectiveness of its implementation at the State level.

c. <u>For USAID to consider:</u>

I. The MET recommends that USAID extend the TSHIP Cooperative Agreement for at least two years to complete implementation of the above recommendations; realign the TSHIP with the Global Health Initiative (GHI) strategy; and sustain the transfer of management of the target interventions to State authorities and managers in order to maximize the benefit of the relationships and networks the TSHIP has created.

II. The MTE Team also recommends that USAID/Nigeria ask the TSHIP, DELIVER project and LEAD project to revise their work plans to include measurable results from working with the States, the SPHHDA and the LGAs regarding governance and HR management, National Health Management Information System (NHMIS), and Essential Medicines Supply. This will empower State staff with a prioritized funded annual plan every year to sustain basic PHC interventions in each State and the incentive to implement the plan.

III. To ensure the maximum impact of the Focus State Strategy, the MTE Team recommends that USAID/Nigeria and NMEMS II Team have monthly discussions on progress with the TSHIP M&E staff, and quarterly coordination meetings with Senior TSHIP staff to review the previous quarter's progress, measure the project's achievements and coordinate, collaborate and set a timetable for the next quarter activities to maximize impact and not overburden the LGA authorities and community structures.

MTE REPORT

INTRODUCTION

In 2009, the Targeted States High Impact Project (TSHIP), USAID/Nigeria's flagship project, started improving the quality and delivery of a number of **integrated high impact** MNCH/FP/RH interventions in two States, Bauchi and Sokoto in Nigeria with the aim of achieving four strategic sub-objectives:

1. Strengthen State and local capacity to deliver and promote high-impact interventions;
2. Strengthen service delivery at PHC and referral levels;
3. Strengthen the roles of households and communities; and
4. Improve policies, programming and resource allocation.

The TSHIP was also designed to build on the successes and lessons learned of previous USAID investments and projects such as BASICS, Immunization BASICS, ACCESS and COMPASS; and to coordinate the TSHIP's activities with other USAID-funded projects and development partners such as NEI, LEAD, WB, UNICEF, UNDP, DfID, etc. TSHIP is being implemented by the JSI Institute as the prime organization along with a number of partners.

BOX 1. MTE OBJECTIVES

1. Determine how effective the TSHIP has been so far, and whether any adjustments or realignments need to be made based on the evidence of this evaluation.
2. Determine how well the TSHIP has implemented the approaches, strategies, objectives, sub-objectives and fundamental premises included in the USAID Award.
3. Determine whether those approaches are still valid and should continue as the basis for the TSHIP during the remaining length of the project, or should they be changed in any way.
4. Determine the accessibility, availability, quality and level of clients' satisfaction of services being provided.

The purpose of the Mid-Term Evaluation (MTE) is to determine the **overall effectiveness of the project**, assess the validity of the project design in terms of its overall approaches, objectives and strategies, measure progress to date, and assess how well health services are delivered in terms of accessibility, availability, quality, and client satisfaction. The MTE was designed to achieve four main objectives (see box 1). The results and recommendations of the MTE will help USAID, project managers and stakeholders to learn from the lessons learned "so as to improve effectiveness and realign" the TSHIP as necessary.

BACKGROUND[1]

The TSHIP is USAID/Nigeria's flagship project and is part of the Focus State Strategy. Therefore, the project is expected to share and coordinate activities for maximum impact

[1] For this evaluation report, the authors decided to focus on the background of the TSHIP, how the project works and on the findings, and have not included the country background and health situation which are well described elsewhere. Please refer to the list of documents consulted in the annex.

and synergy. This MTE took place as the project is about to start its 4th year and had already submitted its PY4 work plan, which was being reviewed at the time of the evaluation.

The TSHIP is also to be aligned with USAID's Global Health Initiative (GHI), which has three main goals for increasing access to quality health information, counseling, and services and will enable Nigerians to participate more effectively in health decision-making. The TSHIP is also expected to contribute to the expected results of the GHI:

1. Reduced maternal, neonatal, and child mortality and morbidity
2. Decreased unintended pregnancies
3. Reduced incidence of communicable diseases (HIV, TB, and malaria)

The 2012-2016 Global Health Strategic Framework of USAID promotes the achievement of improved health outcomes. Therefore, the progress to date of the TSHIP towards achieving outcomes was the focus of the MTE.

The foundation of USAID/Nigeria's program and the State Focus Strategy rightly focuses on improving governance, because without it, there will be no sustainable results in health or education (USAID/Nigeria Strategy, 2010-2013). Therefore, projects are expected to work synergistically to strengthen citizen's ability to demand services, and by building the capacity of the government to supply those services, ensure they actually do it. The Mission's strategy says that programs must consider the following issues: youth, conflict, gender, anticorruption and local institutional capacity. For maximum effectiveness, USAID/Nigeria has developed a Focus State Strategy in two Northern States, Bauchi and Sokoto, where governance, health and education projects converge. The ultimate results are:

1. **Number of GON sites providing comprehensive integrated services**
2. **% of total funding for the response from Nigerian Sources**

USAID/Nigeria is part of the "**Country Partnership Strategy**" (CPS) II, along with DfID and The World Bank, accounting for 80% of Nigeria's development assistance, and these donors meet once a month to coordinate activities and share information. Therefore, coordination with these partners is essential to increase TSHIP's effectiveness and avoid duplication. It is essential the TSHIP provide accurate information to USAID/Nigeria for this purpose.

The TSHIP follows other USAID investments in health projects (BASICS, Immunization BASICS, ACCESS, and COMPASS) that were not implemented State-wide, but had important achievements on which the TSHIP was supposed to build to improve the supply and demand for a number of high impact interventions. The TSHIP was to also ensure that interventions are managed effectively by the State and local authorities through appropriate policies, programming and resource allocation. The MTE Team expected the TSHIP would have sustained and scaled up these prior USG achievements.

The TSHIP interventions are also intended to contribute to the "**Saving a Million Lives**" program of the Federal Ministry of Health, implemented State-wide and be measured by the planned 2013 Demographic Health Survey (DHS).

To meet all these requirements, the TSHIP proposal identified five strategies designed to achieve the four sub-objectives mentioned above:

1. Applying Standards-Based Management to Improve Quality and Performance;
2. Forging Partnerships in all aspects of the TSHIP;
3. Targeting the "Weakest Links" and Building on Existing Strengths;
4. Integrating MNCH/FP Health Services; and
5. Harmonizing Methods for Community Engagement and Mobilization.

In addition, the project activities are organized in six areas of activities: health service management; organizational development; human resource training; health facility improvement and equipment; commodity security; and pre-service education.

Understanding of the Life of a Project. In a five-year project, years 1 to 3 are usually years of intense intervention testing, training and implementation to ensure maximum coverage, while year 4 is usually dedicated to sustaining the achievements of the previous years by institutionalizing and systematizing the interventions of the previous years. The goal of PY4 is usually to sustain the capacity built in previous years so, eventually, activities become part of the country's programs and can continue being implemented by project counterparts without assistance. In PY3-4, the project staff work to assist counterparts to include the new interventions in their daily routines, work plans and budgets. For example, in PY1 to 3, it is expected that project staff train trainers and supervisors of health providers to implement new state of the art health delivery interventions, create or revise policies and operations manuals to ensure the services are delivered according to quality standards, and to identify and sort out problems, bottlenecks and gaps that prevent their efficient implementation. In PY3-4, it is usually the time when project staff work with counterparts to assume more responsible roles and effectively perform as managers, trainers, supervisors and problem solvers. It is at this time the project staff stop being "doers", and become mentors and consultants.

In projects like the TSHIP, where most staff are Nigerian, the project staff are expected easily to become effective role models who can assist counterparts to take over their responsibilities and perform at a higher level of quality and productivity so the interventions become a real part of the State Ministry of Health (SMOH) programs and are managed effectively. Finally, year 5 is the year of effective transfer the responsibility for implementation to the counterparts, during which time the project staff play the role of consultant and sounding board by accompanying counterparts to monitor their effectiveness and efficiency, and assist them in problem solving. The MTE Team approached the MTE with this 5-year progress framework and designed a survey of facilities expecting to assess the degree of access, quality and satisfaction regarding a number of integrated interventions being delivered at the PHCs. The MTE Team planned to measure the effectiveness of the TSHIP Team to implement project activities; if the target interventions have strengthened the State Ministry of Health (SMOH) programs; and the degree to which the targeted interventions are becoming part of the State health system. It is expected that the recommendations of the MTE will be added to the PY4 and PY5 work plans and will be assessed in the final evaluation.

In sum, the TSHIP was designed to achieve four sub-objectives through five strategies, and a number of project support and cross-cutting activities. At the time of the MTE, the TSHIP had completed 3 years of implementation, the State Ministries of Health had undergone a number of leadership changes (6 commissioners of health in Bauchi and 3 in Sokoto), and there had been a high turnover of project staff, including the COP. A new COP has recently taken over (April 2012) and reported that in PY4, the TSHIP expects to achieve greater depth by focusing activities on the following nine areas:

1. Safe home delivery by prevention of post-partum hemorrhage (misoprostol use in the community) and safe delivery at facilities
2. Prevention of newborn infection: use of chlorhexidine in the community
3. Increase access to FP services
4. Increase access and use of ORT and Zinc, mosquito nets, support for routine immunization
5. Enhance the environment: HIS, referral, and service management
6. Commodity security and supply chain management
7. Quality improvement of pre-service training
8. Financing of health services and polices
9. Community participation and engagement

The MTE Team approached the evaluation with this background information to assess how well the TSHIP had progressed in both States, and to what extent the project was sharing lessons between both sites.

MTE METHODOLOGY

The methodology was developed by the MTE Team in response to the Scope of Work (SOW) developed by USAID/Nigeria, and in consultation with the prior and current COPs and included the comments received during a briefing with USAID/Nigeria.

The methodology developed assessed the degree to which the TSHIP has strengthened State and local government capacity, facility health delivery, community involvement and support for the selected interventions, as well as the number and effect of improved policies, programs and resource allocation.

The main evaluation dimensions are: Project Progress and Effectiveness; Ownership as a prerequisite of sustainability; Validity of Project Design; and Quality of Health Services. Below is a summary of the methods used by MTE objective. Please see Annex 7 for a detailed description of the methodology and the tools used.

Methods by MTE Objectives

1. To determine how effective the TSHIP has been so far, and whether any adjustments or realignments need to be made based on the evidence of this evaluation, the MTE Team studied the evidence as measured by the TSHIP performance indicators. The MTE Team interviewed the TSHIP Team by email and in person, the State and LGA authorities to get their views on whether adjustments and realignments were necessary. Project progress was measured through progress indicators to measure existing cov-

erage of the high impact interventions, capacity in 9 facilities was observed in each State, and ownership and sustainability as reported by counterparts.

2. To determine how well the TSHIP has implemented the approaches, strategies, objectives, sub-objectives and fundamental premises included in the USAID Cooperative Agreement, the MTE Team interviewed the TSHIP Team by email and in person, interviewed health providers and a number of stakeholders in three LGAs in each State, as well as members of 18 WDCs. The list of people contacted is in Annex 3. Effectiveness was defined as the degree to which the project has been able to implement the planned activities, and if these activities have achieved the desired degree of results and impact on the health facilities and the communities where TSHIP works. The PY3 work plan was used to measure the number of activities completed.

3. To determine whether the TSHIP approaches are still valid and should continue as the basis for the TSHIP during the remaining length of the project, or if the approaches should be changed in any way, the MTE Team reviewed the GHI, the GH strategic framework and interviewed counterparts and other development partners to assess alignment of project activities with State goals, health development and costed work plans. The MTE Team also interviewed the COP of the LEAD Project (Democracy and Governance) and NEI (Education). Validity of the Project Design was measured by analyzing the assumptions on what the TSHIP results framework was based, and a review of the project application.

4. To determine the accessibility, availability, quality and level of clients' satisfaction of the services being provided, the MTE Team conducted exit interviews, focus groups and visited 18 facilities, 9 in each State. LGA and WDC members were interviewed about implementation progress and their satisfaction. Quality of Health Services: Indicators of quality were measured through the facility survey.

TSHIP RESULTS FRAMEWORK

SO 13: Increased use of social sector services

PROJECT OBJECTIVE: Increased Use of High Impact Interventions in Bauchi & Sokoto
Overall Indicators:
1. Number of children under 12 months who receive DPT3 through USG supported programs **(IIP1.6.11)**
2. Number of deliveries with a skilled birth attendant in USG assisted facilities **(IIP1.6.4)**
3. Couple years of protection (CYP) in USG-supported programs **(IIP 1.7.1)**
4. Modern contraceptive rate

Sub-objective 1: State and local government capacity to deliver and promote use of high impact MCH/FP/RH interventions strengthened

Indicators:

5. Number of people trained in FP/RH with USG funds (male and female) **(IIP 1.7.2)**
6. Number of people trained in malaria prevention or treatment (male and female) **(IIP 1.3.3)**
7. Number of people trained in maternal/newborn health through USG assisted programs (male and female) **(IIP 1.6.3)**
8. Number of people trained in child health and nutrition (male and female) **(IIP 1.6.5)**
9. Percentage of HMIS indicators reported on in a timely manor
10. Number of health facilities receiving at least one supportive supervision visit during the quarter with observation of clinical skills included

Sub-objective 2: Delivery and promotion of high impact FP/RH/MCH interventions at PHCs strengthened and essential referral levels established

Indicators:

11. Number of counseling visits for FP/RH as a result of USG assistance (male and female) **(IIP 1.7.3)**
12. Number of USG assisted service delivery points providing FP or counseling services **(IIP 1.7.7)**
13. Number of ANC visits by skilled providers from USG assisted facilities **(IIP 1.6.2)**
14. Number of pregnant women who attend at least one antenatal care (ANC1) visit
15. Number of women receiving active management of third stage of labor through USG supported programs **(IIP 1.6.6)**
16. Number of newborns receiving essential newborn care through USG supported programs **(IIP 1. 6.8)**
17. Number of children under 5 years of age who received vitamin A through USG supported programs **(IIP 1.6.12)**
18. Number of cases of childhood diarrhea treated in USAID programs **(IIP 1.6.14)**
19. Rate of non-polio AFP cases
20. Number of wild polio virus cases in USG assisted states **(IIP 1.6.B)**
21. Number of women who receive IPT in prenatal care
22. Number of cases of malaria in children treated with ACT
23. Number of ITNs distributed or sold with USG funds **(IIP 1.3.2)**

Sub-objective 3: Strengthened roles of households and communities in promotion, practice, and delivery of high impact MCH/FP/RH interventions

Indicators:

24. Proportion of Ward Development Committees (WDCs) that are active during the reporting quarter
25. Percentage of people that report attending health services due to exposure to TSHIP community awareness and education activities

Sub-objective 4: Policies, programming, and resource allocation at state and federal levels improved

Indicators:

26. Number of policies that are developed or adapted to support improved RH/FP/MCH services.
27. Number of local organizations provided with technical assistance on institutional capacity building to leverage additional resources for RH/FP/MCH information and services

Critical Assumptions

- Socio-political context in Nigeria remains reasonably stable.
- Staffing levels (State, LGA, HF) are adequate.
- There are sufficient funding levels for high quality health service delivery.
- Supplies of commodities are available.
- HMIS is functioning and is a reliable source of data for TSHIP.
- Community structures are existing or able to be put in place.

FINDINGS AND CONCLUSIONS

The findings are presented by evaluation questions as stated in the MTE scope of work:

EVALUATION QUESTION 1: TO WHAT EXTENT IS TSHIP ON TRACK TO ACHIEVE PLANNED GOALS AND OBJECTIVES?

The USAID /Nigeria 2010-2013 Strategy has two main results for the Investing in People program:

a. **Number of GON sites providing comprehensive integrated services**
b. **% of total funding for the response from Nigerian Sources**

The TSHIP is a Cooperative Agreement and the Mission's flagship project that mainly contributes to result **a.** and through system strengthening. It contributes to result **b.** through improvement in the effective use of funding. However, the TSHIP does not report to USAID according to these indicators.

The TSHIP was designed to implement a number of integrated MNCH/RH/FP interventions through five strategies at the State level. The Focus State Strategy is an appropriate approach to address system-wide gaps and real life challenges that usually are not addressed in small scale demonstration projects. However, the TSHIP does not have a State-expansion strategy, and it is not on track. The main reason is that a number of critical assumptions as listed in the project's results were invalid, and a review of the work plans seem to indicate that the TSHIP Team's work focused on processes that did not clearly lead to results. The email survey of the TSHIP staff showed that most of the TSHIP staff felt that the main legacies of TSHIP will not be the facility strengthening, but the renovated facilities (see photo 1) themselves, and the Community Mobilization of the WDC. Facility renovation is necessary, but the renovated facilities are not sufficient to deliver high impact interventions. However, integrated facility performance was not an outcome pursued by the TSHIP. Therefore,the MTE team concluded that the renovated facilities must have been the focus of the project's interventions.

Photo 1. Renovated Facility in Sokoto.

The fact that the TSHIP staff did not identify the quality delivery of integrated high impact interventions as the main legacy made the MTE Team look at the activities for which they reported to be mainly responsible. The MTE Team noticed that that staff reported to be engaged in a number of "process" activities that do not seem to be on **the direct critical path** to the main goal of the project. Also, the project annual work plans includes wording such as "Promote standards",

"Facilitate", "Support", or "Build capacity", as opposed to more actionable wording such as "Increase by 20% the number of facilities that provide integrated ANC/FP services according to quality standards in the two LGAs with the lowest ANC coverage."

The lack of clarity about the path to improving maternal health was also observed in the **PY4 work plan**. The work plan has three focus areas in maternal health: Prevent PPH in Home Deliveries, Control Eclampsia, and Reduce Incidence of Malaria in Pregnancy. Nothing is said about increasing the number of mothers that receive integrated ANC, or improving the quality of supervised deliveries. Please note that in previous years, the TSHIP invested in renovations, equipment and training, but now does not sustain that investment to ensure those investments actually deliver quality ANC, delivery and postnatal care. The TSHIP must maintain focus on sustaining quality services and achieving planned results.

This "**process**" orientation, as opposed to a results orientation, was also observed in the wording of the activities of PY4, "Facilitate 100 women group to conduct advocacy, resource mobilization for improved maternal and child health interventions" (p. 66). The result that the TSHIP proposes to achieve is to have trained these groups in **advocacy**, but the PY4 does not explain exactly what the TSHIP will do after the women have been trained. It does not explain how the TSHIP will assist them in their first advocacy or how to measure if they are effective, or if the groups actually apply and advocate for supervised deliveries. This is what the MTE Team calls "**next level**" thinking that would be expected to be in the work plan of a project in its fourth year. This activity could be "reworded" as follows: "Train and follow up on 20 women groups (100 members) in 5 LGAs to advocate for antenatal care, and supervised delivery in renovated labor rooms for every woman in their communities, and for funding for construction of female toilets in 10 facilities."

The "process orientation" of the TSHIP Team's activities without anticipating the result to be achieved seems to stem from the staff's job descriptions. This was confirmed in their self-reported contribution of most staff in the email survey. Consequently, the staff's performance is not linked to the project's goals and objectives. To get back on track and stay on track, the focus and mindset of the TSHIP Team must shift. For example, the TSHIP Team must not conduct training without ensuring the training will be applied.

The MTE Team believes that it is the sum of personal effectiveness that leads to a project's effectiveness. For example, service improvement staff do not seem to account for their own effectiveness in improving quality and service coverage in X number of facilities in accordance with the project's sub-objectives. The critical path to achieve TSHIP's results is not operationally defined and, therefore, work plans include a large number of unfocused activities described to "support" the LGAs and facilities. However, it is not clear what type of support was provided. **In PY4, in addition to sustaining results of prior years so they can be effectively handed over to the State, the work plan must stick to the original project sub-objectives , and be specific as to what results or outcomes each activity will achieve**.

In sum, the TSHIP is not on track and facilities are not yet delivering integrated quality services. Table 1.0 in Annex 1 presents the summary of the project's progress by progress indicator. Table 2.0 in Annex 1 presents the capacity of observed facilities. **We will comment on the project's PMP in that section.**

In addition to the limited results of the activities being implemented, the TSHIP was based on a number of critical assumptions that were not valid. Each critical assumption (in italics) is discussed below along with the TSHIP's response to meet the deliverable "in spite of" the challenge:

a) *Socio-political context of Nigeria remains reasonably stable***.** This has mostly only applied to Sokoto, but not Bauchi, where social unrest has interrupted services. Even in Sokoto where there was no social conflict, floods have interrupted services and damaged health facilities. In a PHC facility being upgraded to a district hospital (33 beds), rains destroyed the women's toilets. In any case, when one area of the State was affected, the Team worked on another.

b) *Staffing levels (State, LGA, HF) are adequate.* Staffing levels are markedly inadequate and, in fact, the MTE Team believes there is an emergency situation due to the lack of obstetric competent staff in both States, where the number of trained midwives is about 17% of the required manpower. For example, Sokoto State has 590 midwives and requires 3,537. However, the State has only two nursing schools, which are allowed to have intakes of 50 students per year by the Nursing and Midwifery Council of Nigeria[2].The TSHIP has been instrumental in improving the quality of pre-service education and in advocating for an increase in intake. Although, not sufficient to meet the need, it is expected that the schools will be allowed to have intakes of 100 next year. In addition to the lack of numbers of staff according to international standards, productivity of observed health providers is low because the facilities are open mostly in the morning.

Given the limitations mentioned above, the actual implementation of project activities had a number of delays in the introduction and scaling up of the target interventions. The insufficient number of health manpower, along with reduced productivity of the existing workforce, requires interventions that take longer than the life of the current project (LOP). Low productivity requires a complete change in work routines, behaviors and standard operating procedures. This lack of human resources requires the rapid creation and production of new cadres of health professionals. As in the 1960' in the US when there was a severe shortage of doctors, the Nurse Practitioner and the Physician assistant cadres were created. Bauchi and Sokoto States will require immediate training of alternative professionals that can do C-sections, manage pregnancy complications and common maternal and child health conditions, in addition to the community midwives. Developing alternative manpower solutions may be beyond the mandate of the project. But it is a severe limitation, given the MNCH/FP/RH services that must be provided.

*c) There are sufficient levels of funding for high quality health service delivery***.** The TSHIP has been instrumental in helping to increase State health budget allocations and promoting local funding, such the purchase of misoprostol for community use through the WDCs. To the best of the MTE Team's knowledge, no assessment was done about the level of funding at the LGA level for PHC services, and the TSHIP has not worked with the Joint Allocation Committee (JAC) to streamline health expendi-

[2] Letter to the Honorable Commissioner of Health of Sokoto State advocating for the community midwives training program, June 12, 2011.

tures. The cost of delivering the target interventions has not been estimated and, although the States have a health development plan and costed work plans, the added cost to sustain the TSHIP interventions has not been budgeted in the States' 2013 budget. The TSHIP was not directly involved in the preparation of budgets. But the project contributed indirectly by supporting the costed work plans, which form the basis of the State budget. The costed work plans were being developed at the time of the MTE, and the TSHIP's activities are not included in the State's work plans.

d) *Supplies and commodities are available***.** Commodities were available at the time of the MTE, but there were severe stockouts of essential medicines and for some vaccines, particularly the BCG vaccine, at the time of the MTE survey. Shortages of essential medicine, vaccines and supplies have crippled the delivery of quality health care and prevented health providers from applying TSHIP's training.

e) *HMIS is functioning and a source of data for the TSHIP, however, the data quality must be improved***.** The HMIS has improved under the TSHIP, but the system still needs strengthening at the facility level, where registers are not complete, data are not summarized or used to compare trends and select priorities. The TSHIP has invested resources to modernize, computerize and strengthen the HMIS, and the emphasis seems to be on the flow of data into the system. In addition to registers, accurate and simple patient records are the basis of an information system and essential to provide quality and safe care to patients. The records were mostly in disarray and lacked standardization. Simplification is essential to reduce the work load of information collection. In fact, most facilities can be managed with 10 to 15 indicators. Particularly, we noticed that the immunization registry at the facility level is not nominal, which makes it impossible to track which child has missed a dose. Nominal data is not necessary at the program level, but essential at the delivery level. The TSHIP must consider the information need at each level. Data are reportedly not used for planning services at the LGA level.

f) *Community structures are existing or able to be put in place***.** *The* TSHIP has spent significant time organizing and reactivating WDCs, and has successfully involved them in organizing the demand for services and providing emergency transportation services in selected communities.

At a minimum, the SOW of the MTE required that the following factors be considered in the detailed analysis:

a. **The TSHIP management structure, including organizational structure, staffing and skills mix.**
b. **Strategies and approaches, including technical interventions. This analysis should not only consider the appropriateness and effectiveness of a given strategy, approach and intervention, but equally assess the level of effort against the planned results/outcomes.**
c. **Partnerships, coordination and collaboration within the TSHIP and with USG (e.g. LEAD, NEI, WOFAN), government, civil society and private sector partners.**
d. **Performance monitoring and evaluation, including results framework, quality and relevance of indicators (impact/outcome/process) and operational research.**
e. **The impact of the conflict environment on project performance.**

Each of these questions is answered in the following sections.

a. The TSHIP management structure and staffing

i. *The MTE Team observed that the staffing, skills and professional mix of the TSHIP Team respond to the needs of implementing the target interventions.* The email survey demonstrated that the staff are very experienced and qualified for their positions. However, as mentioned above, the staff do not seem to be focused on activities that directly deliver results, but on intermediary processes that are not taken to the next level. **The "next step" approach must be enforced in PY4 and reflected in the work plan.** Management does not seem to guide TSHIP staff members to what results must be achieved. For example, staff conducts supportive supervision, but the improvements that supervision is to achieve are not followed through. The TSHIP has provided equipment, but the staff did not ensure the equipment is inventoried or used correctly in the facilities. Also, the staff seems to have very vertical lines for reporting to the respective consortium members and they do not work as a team, but compete for resources such as vehicles. Some staff also reported a lack of collaboration between consortium members, which the MTE Team believes must be significant for the staff members to share it with the MTE Team. In addition, high staff turnover has affected a number of activities. The TSHIP lacks a staff retention program. A number of staff reported the need to have access to more training opportunities to be able to stay up to date in their respective areas of expertise. When this was brought up, the new COP said that he had just started a staff development fund to provide the staff with training opportunities. The organizational structure of the TSHIP staff seems to be bureaucratic, and the project's management does not seem to allow for TSHIP staff to proactively anticipate and solve problems that prevent achieving targets. Each staff member works in his/her own area of expertise. We the MTE Team did not see evidence of continuous collaboration between the staff for the Bauchi and Sokoto activities, which seem to working as separate projects.

ii. *Given that the TSHIP is a consortium of several organizations, job descriptions were assessed to ensure they are aligned with the TSHIP's sub-objectives and deliverables.* The job descriptions of the TSHIP staff are not consistent, and do not state the results each person is expected to achieve or contribute to. The MTE Teams considers that some of the job descriptions are more vacancy postings than job descriptions, describing only processes and outputs and not the expected results. They were not adapted to the unique characteristics of each position in alignment with the project's deliverables. Job descriptions have not been updated to reflect changes in the role of each staff member since the start of the project, and are not used by the staff to plan annual, monthly and weekly activities. Individual results were measured through annual performance evaluations. The MTE Team did not evaluate these documents, but it is the Team's opinion that annual performance reviews do not replace job descriptions. Job descriptions are not static documents. They must be update annually, if changes arise, and include the results, not just the processes, for which each person is responsible. Job descriptions for the TSHIP are different, depending on which consortium partner has

hired the staff. This makes management by results difficult. Given the large number of staff, it is essential that JSI implement a clear, consistent format for job descriptions that are linked to the project's results. This will help to have a management strategy that really reflects the "one project" spirit described in the project's grant application.

b. Strategies and approaches, including technical interventions.

This analysis should not only consider the appropriateness and effectiveness of a given strategy, approach, or intervention, but also equally assess the level of effort against the planned results/outcomes. Pursuant to the SOW, the MTE Team addressed two TSHIP components in regard to the TSHIP's strategies and approaches:

1. **Integration of Services**
2. **Health Systems Strengthening**
3. **Integration Findings**

The TSHIP's main goal is to deliver an **integrated** number of high impact MNCH/FP/RH interventions. The emphasis is on integration in the delivery of services. Below we present the findings related to each intervention and the degree of integration observed during field visits.

a. Maternal and Newborn Care

Photo 2. Simulation classroom in nursing school (Sokoto). This is the "gold standard" in patient care.

The TSHIP has provided equipment and helped nursing schools have simulation classrooms like the one in Photo 2. Notice the clean linen on the beds, the correct separation between the bed, the baby bed, and the space for patient's belongings. The only thing missing here is a mosquito net over every bed. This is the picture that must be shown to LGA staff so they have a vision of what "quality healthcare" looks like and what they must strive for.

Increasing the number of supervised deliveries in facilities is essential to providing quality maternal and newborn care. This cannot be achieved if facilities are not managed properly and minimum quality standards of hygiene are not consistently met. Women will not want to deliver in a dirty ward, and they should not. Photo 3 shows such a delivery room. Notice that water and soap are correctly available for hand washing, and the instructions for the Active Management of Third Stage of Labor (AMSTL) are on the wall. However, notice that the bed used for delivery lacks clean linen, is against the wall impeding traffic and that the wall has not been scrubbed in a long time. This room is not suitable for deliveries.

Photo 3. Lack of hygiene in delivery rooms.

The TSHIP is not responsible for cleaning facilities, but they must inspire and support the staff to implement Standard Operating Procedures (SOPs) so rooms are scrubbed daily and mopped between deliveries. Infection prevention must be routine in the facilities. Without that, women are not going to deliver in these facilities. It is important to ensure that women have positive experiences in the ANC visits so she will feel safe and well taken care of, and trust the staff during delivery.

Increasing the number of ANC visits is essential! This cannot be done if a HF offers services only two mornings out of 5! Photo 9 (see child health section below) shows the schedule of most facilities. Schedules must be focused on patients' needs. The supply of services is not enough to meet the demand. This is compounded by the unfriendly attitude and manners of some staff as shown by our focus group discussions, and makes it hard for women to want to receive ANC, or any service for that matter.

Photo 4. Ward in facility in Sokoto. Notice the lack of linen, mattresses and screens on windows, and overall cleanliness.

The SOPs in the simulation room are in contrast with the observed patient care in some facilities. The MET Team recognizes that the TSHIP rightly does not have to provide for linen and mattresses. However, it shows the attitude of the health staff, and that are not taking action to improve quality of care. The health staff in every facility must be a "problem solver". The staff working in the facility in photo three could show this photo and request the LGA or local WDC to allocate funds and purchase linen or mosquito nets. Based on the interviews conducted by the MTE Team, the LGA and WDCs are very supportive and would

surely say yes to such requests. They cannot act if they are not informed and asked. Assuming the LGA approves a request, the health staff must then ensure that one staff is responsible for ensuring the linen is inventoried, changed every day and washed. These are SOPs that must be implemented and made routine. Things always break down and linen and mattresses must be replaced. What must happen is a change in attitude so when something needs fixing, it is someone's responsibility to fix it. Why are people motivated to find solutions and just "get it done" in other countries? Because they know that someone regularly checks to ensure that standards are met. The TSHIP must make the WDC and the LGA focus on checking that standards are met in every facility. Using photos is an easy way to set standards and help enforce them. (The MTE Team *knows this photo is not from a maternal or labor ward, but out of respect to the mothers that just delivered we did not take photos. However, the wards the Team visited were not different.)*

Photos 5 and 6 show the state of restrooms in some facilities visited. A toilet is not a luxury. It is essential in a facility that delivers babies and has outpatient and inpatients.

Photo 5. This photo shows that patients must walk out in the night to these restrooms, which in fact were locked and not used at the time of our visit. Inpatients in this 33 bed PHC do not have a restroom. Neither do the outpatients. Pregnant women attending ANC must have access to clean toilets. Pregnant women often must urinate more often and, with the long wait in most facilities, they are forced to go to the bush. This is not acceptable. The WDCs that have been mobilized must be given goals for ensuring quality restrooms and facilities must have SOPs so they are maintained clean. Restrooms in other places are maintained clean because there is a chart in them. Someone is responsible for cleaning the restrooms, and someone is responsible for checking them several times a day to ensure they are clean.

Photo 6. Inside of toilet in district hospital

These photos are not intended to humiliate anyone. They are intended to make visible the invisible and inspire action. It is common human nature that when things break down, little by little they get worse. But we do not realize it because we get used to it, and they be-

come *invisible* until someone points it out. There is an experiment that throws a frog in hot water; and it jumps out. But when the temperature of the water is increased little by little, the frog can very well boil in it if not removed. It is a matter of contrast that makes people react and take action. The TSHIP must make the contrast visible. The purpose of the MTE is to point out those things that must be fixed to ensure the TSHIP achieves its goal of increasing the quality and delivery of high impact interventions. The TSHIP staff has been busy and, as it happens when in the middle of all the work, we all lose sight of the forest for the trees. Therefore, the TSHIP must also visit facilities and provide an outside perspective that points out problems, gets all stakeholders to "see and feel that the water is getting hot", and take action. The TSHIP staff may use PHOTOVOICE, or give cameras to the HF staff and ask them to take photos, then discuss what they saw and what to do about it. A HF cannot work without restrooms, and that is why they must have SOPs. So when something breaks down, someone must fix it right away, and someone must check to see that it did get done!

Below are a number of the other observations that point out "next steps" to sustain project activities.

1. To reduce Institutional Emergency Obstetric Care delays (3rd level delay), the TSHIP provided **Emergency Trolleys** to health facilities in Bauchi and in Sokoto. Few trolleys were observed in the visits and most lacked equipment and medicines. The TSHIP also assisted the Midwife Service Scheme Primary Health Centers with **Neonatal Resuscitation Kits**, and the nursing schools with computers and training materials. Equipment was also provided for other MNCH/FP/RH interventions, but none was entered in the facility or school inventory, and no one was assigned responsibility for it. All public sector and private sector facilities in every country in the world have (or must have) inventories of all the equipment and the inventory is checked regularly. The TSHIP must ensure that all of the equipment the project provided is part of an inventory that lists the equipment and where it is supposed to be. A copy of that inventory must be given to the LGA, which must have the inventories of all facilities, and another given to the WDC so the WDC can help check that the inventoried equipment is there. In the case of the schools, a school authority must check the inventory regularly to ensure that each shelf and cabinet has the exact equipment it should have. If something breaks down, it must be fixed or replaced. If something is missing, someone must be responsible for it. Many time small pieces of equipment are misplaced. For example, someone may take a pair of scissors from an emergency trolley and does not replace it. That is why **daily** checks of the trolleys and resuscitation kits must be implemented to ensure they are ready for emergencies.
2. Improvement in the quality of care were reported through **capacity building** on MNCH/FP/RH interventions for staff from health facilities in Bauchi and in Sokoto, but the field visits did not show that staff are applying what they learned. The adaptation or application of the training is left to the staff who are not supported in the follow up or supportive supervisions. The MTE Team does not know how supportive or effective the TSHIP's supportive supervision is. However, based on what we saw, we believe the health staff in the HF needs someone to help them **take action**. Sometimes one has to roll up sleeves and help staff set up a day of "deep cleaning" to get started, or to accompany the staff as they apply the AMTSL to ensure they do it correctly and provide positive reinforcement. For effective implementation, "always catch them doing something right" is the saying, so they keep doing it. The HF staff must feel proud of

their work and competence so they keep doing it even when no one is watching, that is called being a professional. OTJ training is essential to sustain use and skills.

3. Also related to training in maternal and newborn care and in other topics too, the States lack a human resource (HR) database of who was trained and where, and cannot plan training to ensure all staff are covered without such a database.
4. The TSHIP has introduced the use of Misoprostol for the prevention and management of PPH. This activity has started with the support of a few WDCs that have committed to purchase the medication. We assume this is in rural areas without access to facilities. A system to regularly procure, distribute, use and monitor the medicine in the community has not been designed yet. This activity is very prominent in PY4 work plan, and the MTE Team is concerned that it may not lead to sustainable results, and may in fact detract from sustaining facility-based services in renovated facilities. The TSHIP must ensure that facility based deliveries, the indicator for which they are responsible, receives adequate attention and is monitored regularly.
5. The use of Magnesium Sulphate for prevention and management of Eclampsia was introduced, but stockouts were observed in most facilities. It is vital for the HF staff to work with LGAs and ensure that no HF lacks this life saving medicine. The MTE Team understands that there are stockouts of medicines and sometimes the HF may not have the 40 or so products they need, according the Essential Medicine List, but at least the 5 lifesaving medicines must be there and maintained. Someone has to help the LGAs prioritize and do what matters most. That someone has to be the TSHIP.
6. The TSHIP has promoted use of SP for prevention and management of Malaria in pregnancy. However, monitoring data are unreliable to exactly measure the actual use of Intermittent Preventive Treatment (IPT). We suggest that the HF staff be motivated to **look at their records every day** and **summarize** the data to answer the following **problem-solving** questions:
    a. How many women received ANC today?
    b. How many did get SP?
    c. Is it 100%? If yes, good, celebrate. If not, what can we do to make sure all women do get IPT?
7. The TSHIP has tested the use of 4% Chlohexidine for umbilical cord care for prevention of Neonatal Sepsis. The number of neonatal sepsis cases in the States is not known, so it will be hard for the TSHIP to evaluate this intervention. We suggest that the TSHIP set up a study to monitor the effectiveness of the program in facilities.
8. The TSHIP has promoted the "Helping Baby Breathe Initiative" for the management of Asphyxia. This is a very important practice as asphyxia is the most common cause of death. Monitoring data on the consistent use of this practice in facilities and, therefore, the effectiveness of the implementation of this program is not available. For management purposes, the TSHIP has to measure that what they promote is actually applied, and if it produces the expected result. **The indicators show a gap between the number of women that delivered with a Skilled Birth Attendant (SBA) and the number of babies that got the newborn care package**

Photo 7. Underused Facility

9. During the visit to the health facilities, the MTE Team observed that the hygiene of facilities and the layout of the ANC clinics are not conducive to provide quality of care. In some facilities, walls and floors are in need of scrubbing and we did not observe hand washing between patients. The staff do not have consultation areas and work in groups. Health staff seem to work for 3 to 4 hours a day in the ANC and it is not clear what they do the rest of the day. Neither visited facility had a working toilet for the ANC clinic or in labor rooms.
10. Productivity is very uneven. Some facilities are overcrowded and some underused **(Photo 7).** Windows and doors do not have screens and beds lack mosquito nets. Beds do have linen, and are too close or against the wall impeding traffic. There is no space for the mother's and baby's personal belongings. Air conditioning (AC) equipment is not used due to lack of electricity, and are not used even when there is electricity. (The MTE Team observed a mattress over an unused compressor, see Photo 8). Creating rooms with good cross –ventilation, ceiling or vertical fans would be more appropriate, but where AC equipment has been provided, generators and provisions for petrol must also be included. All labor rooms visited lacked appropriate lamps and deliveries at night were reported to be done with a torch, no solar powered lamps were observed.

Photo 8. Unused AC

11. Post-partum visits are not proactively encouraged or recorded consistently, and no systematic home follow up was reported either. The CBHV is supposed to help with follow ups. The MTE Team would like to see a systematic solution, a SOP to ensure PNC, follow up of the newborn and integrated FP counseling provided.
12. The introduction of Kangaroo Mother Care (KMC) for the Management of Low Birth Weight Babies is very important, given the early age of marriage in both States and that prematurity is common in teen mothers. However, monitoring data on the actual number of mothers that practice the KMC, the effectiveness and the wellbeing of "premies" and, therefore, of the implementation of this program was not available.
13. **Referral System.** All the secondary health facilities visited in the two States during the MTE had the minimum components required of a secondary essential referral center in terms of the availability of blood transfusion services, C-section services and ability to provide anesthesia for a C-section. However, none of them was performing their sec-

ondary essential referral services function optimally. This was a result of several factors such as staff shortages; low staff productivity; inconsistent presence of available staff; lack of essential obstetric drugs/equipment; broken down hospital transportation/ambulance; lack of a functional linkage or referral system with PHC or tertiary health facilities; no health facility maternal death audit; no registration or tracking of referrals; and unsystematic upgrading of PHC facilities to secondary health facilities. One of the PHC visited was in the process of upgrading to a general hospital, i.e., RHC Gwadabawa, Sokoto State and could not be assessed because it did not have the components of an essential secondary referral center, despite its high patient load. This facility also lacked restrooms. Not all the secondary HFs we went to during the MTE had been supported by the TSHIP in terms of training, provision of equipment/drugs, blackboard for summary maternity statistics etc. for Comprehensive Emergency Obstetric Care (CEOC). However, facilities that have been supported by the TSHIP were not using the items optimally, e.g., none of the facilities visited had a properly placed or updated completely filled summary blackboard with the summary maternity statistics of the maternity unit. Most of the labor and delivery registers provided by the TSHIP were tattered, and the donated emergency trolleys seen during visits were empty.

It is easy to be overwhelmed by all the problems and fall into "action paralysis." As can be seen, these facilities have many "reasons" for not performing. However, we prefer to call them "excuses." The TSHIP must take a "NO EXCUSES" attitude. The antidote to action paralysis is to ask: What CAN you do? Yes, we agree that there are many things these facilities cannot do **"yet",** but **there are many things they CAN do**. The HF staff can have a "clean day party" and clean the surroundings of the facility and throw away trash - remember the old mattress on the compressor? They can also do outreach and visit mothers that missed their ANC appointment; check mothers for all home deliveries to see if they are OK; do more health talks about FP; use the ORT corner; or promote exclusive breastfeeding. The goal is to help the HF staff focus on what they CAN do and get used to taking action! They can ask the WDC for support to fix a broken-down ambulance. Of course, someone has to be responsible for the vehicle after it is fixed. The TSHIP can use the same approach they use for their own vehicles. Regarding vehicles, the State staff reported not being able to make supervision visits due to the lack of vehicles. The TSHIP might consider joint management and planning of the use of its vehicles. After all, the project's vehicles will likely be turned over to the State, so the State might as well start now to learn how to manage a vehicle pool.

The main conclusion is that the primary achievements of the project are related to inputs, and not outcomes. It seems the TSHIP stops after conducting training, the indicator in the Results Framework, and does not take the "next step" to ensure the training is applied, or to see whether or not it achieves the expected results. For example, the TSHIP has to help the State Maternal Health program manager, who is ultimately in charge of the KMC intervention that TSHIP introduced, to ask himself/herself: Do premature babies actually gain weight and survive? Managers must not assume the effectiveness of these programs without evidence.

***b.* RH/FP.**

TSHIP has had major accomplishments in this area. However, we noticed integration is not full yet. FP is not integrated with routine immunizations or child health services. Although, it was reported to be integrated with ANC. Below are some of the achievements recorded:

1. Increased FP counseling and services sites from 284 to 404
2. Increased number of FP counseling visits from 13,725 in 2010 to 55,299 in 2012
3. Increased Couple Year of Protection (CYP) from 2,504 to 10,732
4. The TSHIP reported to have strengthened the Post-Partum Family Planning Initiative, but the MTE Team did not have evidence that this is working after the training the TSHIP provided.
5. Long-acting Family Planning Services have been introduced: IUCD insertion and implants were also reported as an achievement. However, monitoring data on the effectiveness of the implementation of this program, or monitoring of complications of IUD insertion were not available.
6. Promoted the use of Community Health Extension Workers (CHEWs) for the provision of injectable contraceptives as part of an operational research. It is not clear what the next steps are for this intervention. No monitoring of the effectiveness of this strategy is being done.
7. Facilities visited had contraceptives and provided services. This is an important achievement of the TSHIP and DELIVER. However, the capacity of the local staff to manage the logistics in a professional way, after the projects' completion, is not there yet. As mentioned above, the MTE Team believes that a project is not about training, because both projects have provided lots of training, but of attitude. Changing mindsets and attitudes must be the main goal of the TSHIP (and maybe DELIVER too) to **ensure staff follow SOPs** and are accountable for contraceptives. Accountability is not inborn. It is learned because someone else models and enforces it. The TSHIP must empower the LGA staff to monitor stocks and ensure supplies are available according to inventory. Integration of contraceptives, and also HIV medicines and supplies, in the facility pharmacy will be discussed later in the report.
8. Privacy is a concern because of the current mode of "group" consultation. This is discussed in more detail in the Child Health Section, but applies to maternal health, FP and all outpatient services.

c. Adolescent RH.

The TSHIP does not have an Adolescence Reproductive Health (ARH) program at this time. The focus groups with adolescent girls showed that they are satisfied with the services and the improvements so far. But, at the same time, they are aware of the lack of medicines; the lack of staff; the lack of electricity; and lack of hygiene and toilets. (Please see the focus group discussion report below for more detail.) If an extension is granted, the MTE Team encourages the TSHIP to assist States to design an ARH program, involve the USAID Northern Nigeria Education Initiative (NEI) and all the other "focus states" stakeholders.

d. Male Involvement.

This was initially championed through training given to selected WDC members in a TSHIP initiative called "Male As Partners" (MAP) initiative. The training has not yet been consistently provided to all WDC members, and there is limited follow up and support of those already trained. The WDCs have been greatly involved in raising awareness in their communities, e.g., at local festivals, town hall meetings, house to house visits, etc., regarding the importance of ANC attendance and hospital delivery for pregnant women; arranging Emergency Transport Schemes (ETS) to convey children and pregnant women with complications to health facilities; providing free drugs and toiletries to women that attend ANC or deliver in the health facilities; setting up community sponsored Drug Revolving Funds (DRFs), and overseeing their utilization in order to ensure adequate supply of essential drugs; repairing, renovating or even building new units for their health facility; as well as ensuring that health workers posted to the health facility in their locality come to work regularly and work diligently. On the other hand, the enabling environment that will allow men to be actively involved in supporting their pregnant wives in attending ANC or hospital delivery is not in place, because of reasons such as unavailability of policies that allow husbands to attend ANC or deliveries; lack of space or trained personnel to handle pregnant couples; attitude of health workers; etc. This may become increasingly important even in the northern part of Nigeria because a significant number of the ANC clients that were interviewed said that their husbands brought them for ANC and were waiting outside to take them back home. **In sum, the MTE Team believes there will be more male participation, if "room" is made for men in the mode of health service delivery and separate bathrooms are made available in the health facilities.**

e. Gender and female participation.

Gender has not been systematically addressed by the TSHIP at the community level, e.g.,100 women groups and the women's wing of WDC, have not been specifically targeted for grant support. At the State level in Bauchi, FOMWAN and RAHAMA were given grants mainly to reactivate WDCs and conduct training. While the TSHIP pre-service component addresses gender, the TSHIP needs to push for expansion of intake, as well as establish a female quota on a needs basis, for different LGAs in the State tertiary health training institutions. The community midwife scheme will be a powerful incentive and can help bridge the HRH gap, as well as provide role models that can positively further the sub-objectives, especially sub-objective 2. Still there is need for more female nurses, nurse aides and doctors in both States.

The urgent need of appropriate restrooms for facilities has not been raised with LGAs and WDCs. This is a gender, public health and hygiene issue. We saw men going into the bush to urinate, but women cannot do that for cultural and physical reasons. Female anatomy does not work that way. Culturally women cover themselves head to toe; it is unacceptable from a cultural and hygiene point of view to expect them to "go" behind the facility. LGAs and WDCs must be made aware and helped to take action. Microgrants can be given by TSHIP to co-finance and help them address the problem, that is, that every day large numbers of pregnant women flock to these facilities. The facilities do not give ANC appointments, and the MTE Team suggested they at least give group appointments and invite mothers to come from 9 to 10, 10 to 11 and 11 to 12, etc. That would avoid all women coming at the same time and having to wait for many hours until seen. It is not gender sensitive or acceptable to have pregnant women who must urinate frequently or who have just delivered a baby to go to the bush areas nearby.

f. Integration of SRH and HIV/AIDS. It was not evident in the organization of services or observed in the field, because the patient flow has not been designed to allow patients to receive integrated services. Testing was observed to be at another place in the facility and signage may contribute to stigma. Lack of privacy also prevented the discussion of HIV testing or birth spacing and family planning methods.

g. Child Health and IMCI. Putting aside Photo 9. Health Facility Schedule besides the unsightly aspect of the chart, Photo 9 shows how a HF schedules services and the impact this has on child health. First, a formal bulletin board to post announcements must be placed in every facility. Second the schedule of services must meet the needs of the population. Routine Immunization (RI) services are provided on Wednesdays from 9 to 1 only! This is not enough to cover the hundreds of thousands of children that are not immunized in both States. TSHIP must work with the HF staff to revise the schedule for maximum productivity. (One wonders what they do on Mondays and Fridays and in the afternoons.) Third, FP should be added to the services for effective integration.

Photo 10. Outpatient Consultation, Bauchi

Photo 10 shows a waiting area separate from the consultation area. This is a good model to be practiced in all facilities. However, notice the use of the TSHIP posters. Posters are not wall decorations. They are tools that must be used. The Vitamin A poster must be placed in an area where nutrition and health talks can be given and consultation areas where staff can advise mothers how to wean and feed their young children. The ORT poster must be in the ORT corner. The diarrhea treatment chart must be in the consultation area where the health provider can refer to it for proper treatment. The FP poster (photo 12) must be in every consultation area to remind the health provider to counsel every patient.

Photo 11. Chaos in the Outpatient Care.

In contrast with the consultation room seen in Photo 10, in Photo 11 you can see the chaos in some other facilities caused by the provision of child heath "group" consultation. This is not acceptable particularly in a renovated facility with consultation rooms. Notice the empty boxes on the floor. This outpatient consultation is in the HF on the cover of this report where there are enough consultation rooms. Also, notice that you cannot tell who the health providers are. Male providers are not using uniforms and still are providing vaccines. (Notice the vaccine carrier on the desk). The MTE Team did not observe the staff washing their hands after handling a child. The good thing is that they use the safe boxes to dispose the sharps, but the safe disposal of the boxes is another problem. All child health services must be integrated along with FP and HIV counseling. It is a fact that the job of a health provider is to solve problems. When one is solved, more are created. Staff must perceive themselves as "competent problem solvers" and ensure they meet the quality standards.

Photo 12. Wrong use of Posters and Lack of Signage

Photo 12 is another view of the same consultation area. Notice the wrong use of posters and that facility data and patient information posters are mixed up. There must be a bulletin board for facility statistics for staff to track and discuss in a separate area. If statistics are to be shared with the community, they must be done in a clear way and put in the proper place.

Also notice that there is no signage in most of the facilities visited as to where mothers must go for intake or registration, and then where to go to wait or for consultation. The window to what could be the registration or record room is blocked with boxes and empty shelves. Signage in a facility is essential, and must follow the correct patient flow. There must be areas for the public, and restricted areas that must be kept clean where staff can give medication or testing. We understand there is no gold standard to compare with. So, the facilities' staff does not know what quality care looks like, but it is up to the TSHIP staff to show them. The TSHIP staff must set up facilities correctly and take photos to show the facilities' staff how things must be kept. Finally, the CHEW in this photo is using a bench to sit down and record information, ignoring the large group of patients waiting. The work load of record keeping must be reduced.

Photo 13. Patient Provider Interactions

In Photo 13, notice again that only female staff are wearing uniforms, five (5) staff are sitting while the mother carrying the child is standing. Also notice that the scale is for newborns and small babies, and is not appropriate or safe to weigh this child. He is too big. In other facilities, staff were using adult scales and measure the mother's weight with and without the child. This is not acceptable. Spring scales to weigh older children are cheap and essential. Growth monitoring is essential given the high prevalence of malnutrition in both States.

Here is the SOP for child health care: Each staff must have one individual consultation room, for which they are responsible and prepared according to standards, for seeing one patient at a time. Every provider must invite the mother to sit down and explain what services her child will receive that day and why, and provide nutrition and FP counseling.

Below are a number of the other observations that point out "next steps" to sustain Child Health project activities.

The TSHIP must be alert, and keep the focus on how services must work to deliver quality services. Otherwise they risk becoming part of the problem, and not part of the solution.

1. The TSHIP has reported that 60 health facilities have been designated as "IMCI Centers" for integrated management of childhood illness utilizing: antibiotics for sepsis,

pneumonia, antimalarials, antibiotics for dysentery; Zinc and Vitamin A supplementation. However, we observed services being delivered separately. The TSHIP staff must follow up to ensure the mode of delivery does not undermine the training provided, and staff are actually implementing IMCI. In addition, stockouts of all these medicines were observed during our visit to the States. We will discuss essential medicines later, but here we want to stress that States must be counseled during the annual budget cycle to ensure that vital medicines are prioritized. Then, when funding is allocated, if funding for only 10 medicines is available, ensure that those 10 are distributed, stored, inventoried and used correctly according to standards.

2. The use of LiST (Lives Saved Tool) to improved Vitamin A coverage from the 2008 DHS coverage of 5% to 91% in Sokoto and 82% in Bauchi. We do not know if LiST will be used by the States for other services, and would like to ensure it is used for all MNCH/FP services.
3. The TSHIP has supported the establishment of 180 ORT Centers for Oral Rehydration Therapy for diarrhea and teaching mothers about preventive measures and home management of diarrhea. The ORT corners must be sustained and incorporated into the routine of the facility and have staff assigned. The MTE Team saw ORT corners, but they were not staffed or being used. So we suggest that staff be appointed to work in the ORT corner, and the ORT function be included in the HF schedule chart, including giving a talk every day to mothers about boiling drinking water and ORS, as well as giving the same talk to children in schools. Water is still a scarce resource in the north. It just takes a quick look at all the people carrying yellow containers to fetch water to see that the containers, and maybe even the source, may not be clean. John Snow proved that the source of water can be a health hazard! The ORT poster must also be placed in the corner and used in supervisions to make sure the HF staff have incorporated it in their routine.
4. The TSHIP has increased Routine Immunization Sessions from monthly to weekly at 60 sites. This is an improvement in the right direction, but the TSHIP must not stop there. Coverage rates cannot be achieved providing vaccines once a week. "Every opportunity" must be brought back from IMMUNIZATION Basics. The TSHIP's PY4 work plan says it will "*support the States to invest in interventions that will increase RI coverage among infants and pregnant mothers"* (p10). It is critical to determine what interventions those will be, and what will be achieved with that support. Will the interventions include ensuring hand washing before vaccination, providing vaccine carriers, generators, solar refrigerators, vaccine temperature monitors, improved record keeping and quantification to procure enough supply of vaccines? Will the number of facilities providing vaccines 3 times and 5 times a week increase? If yes, by how many? The TSHIP must start from the result to be achieved and plan the activities to get there. It is essential for RI and all Child Health services that the TSHIP staff work with the HF Officer in Charge and health providers to troubleshoot the problem of increasing coverage find and implement solutions. More training is not the solution. At this time, and based on our observations, it is the MTE Team's opinion that it is not due to lack of knowledge that staff perform poorly, it is that they lack motivation to figure out how to implement what they know, and they have not engaged by the LGA and the community to address the challenges they face to immunize all children.
5. The TSHIP has increased budgetary allocations on EPI from 10 million naira in 2011 to 40 million naira in 2012. However, the TSHIP was not involved in the 2013 budget preparations that were taking place at the time of this evaluation. When asked, we were

told that the TSHIP had given some figures. The TSHIP must assist the States to anticipate what resources will be available in 2013 and 2014 and ensure the system is in place for future budget cycles.

6. Improved DPT3 coverage in Bauchi increased from 2% in 2008 to 26% in June 2012, while in Sokoto it increased from 1% in 2008 to 24% in June 2012. This is a marked improvement, but it also means that hundreds of thousands of children have not yet been immunized AND that there is not enough herd immunity to prevent epidemics. The risk of epidemic and death is high in both States. It is unfortunate that the result from BASICS and IMMUNIZATION Basics were not sustained. Sustainability must be built into projects, it does not occur by default! It is the result of putting SOPs in place and making the SOPs routine, by putting several controls and checks in place. Stakeholders, like the PHCDA, the LGA, the WDCs, the 100 Women's groups, the HF itself and the TSHIP, must be watching vaccine coverage and all child health coverage indicators.
7. There is need to empower the WDC to strengthen Routine Immunization Coverage through a nominal record system. This cannot be overemphasized! If 100 children are born in the ward, the WDC and the facility must keep a nominal record to ensure every child is reached and that :
    1. **Every child is immunized**
    2. **Every child's weight is right for the age**
    3. **Every child sleeps under a LLIN**
    4. **Every household has a packet of ORS to be used when necessary**
8. Nutrition monitoring is essential in both States where there is a high proportion of stunted and malnourished children. The TSHIP has supported the strengthening of child welfare clinics by providing weighing scales to 230 health facilities for growth monitoring. However, the project provided scales for newborn babies, but not for older infants and toddlers that require the hanging spring scale. At this time, the health workers weight the children with the mother on a standing scale and do not use the MUAC consistently.

In sum, health providers do not apply the integrated package of child health interventions and IMCI <u>consistently</u>, and patient flow does not facilitate its use. Consistency is essential to deliver quality care.

g. Malaria.

The Malaria situation in Bauchi and Sokoto States continues to be endemic and is still the first among 10 notification disease accounting for 75% of out-patient consultation and at least 11% maternal deaths. All age groups are affected, the worst are children under five years of age and pregnant women. Malaria is more severe in children, if treatment is neglected. However, facilities do not keep consistent records of cases and statistics are not used. **There is a need for reliable information for the effective management of the State malaria program**, maybe through the use of sentinel sites until the information system improves.

Long Lasting Insecticidal Nets (LLINS): The general objective of preventive efforts using LLINS is to rapidly reduce transmission of malaria to the lowest possible level in reducing the vector – human contact. The TSHIP supplied almost 3 million nets in PY1, but it is not clear if TSHIP and staff followed up to measure if they are being used[3]. During our visits, we observed no net on patients' beds in the facilities, which sets a bad example, and no nets were provided to confirmed cases. Neither of the facilities visited was distributing LLINs to pregnant women. The TSHIP must assist the State to establish distribution of nets at every facility. All confirmed cases must get one, along with inpatients. The target was at least 80% of households with two or more LLINS by 2010 and sustained at this level until 2013. Are we there yet? The channel and mechanism for LLINS distribution in the States so far has been systematically based on house-house distribution. The distribution was jointly undertaken with other activities with Immunization plus Days and MNCH Week. **However, it is not acceptable that facilities do not have LLINS for their patients and malaria cases are sent back home without an LLIN.**

Indoor Residual Spray (IRS): The target is to introduce and scale up IRS to 80% households coverage in selected areas. IRS was not introduced in the States, but plans are under way for its implementation in the 2012 operational plan. The TSHIP is not supporting this activity so far, but must consider assisting the malaria program manager with the planning and coordination of this big undertaking.

Malaria control is an enormous and cost intensive program that cannot yet be undertaken by the either State Government alone. Also, RollBack Malaria and the Global Fund are supporting the program. Our understanding is that under sub-objectives 1 through 4, the TSHIP is to provide support to the malaria program and help the States utilize the assistance. However, it is not clear how to make the malaria program more effective. State policy of free MCH allows for free treatment for all malaria patients and IPT for pregnant women, limited by the availability of SP at public and private service delivery points for IPT. There is LGA Malaria Focal Persons, but it is not clear how the TSHIP supports them. In sum, from the programmatic point of view, we are not sure about the impact the TSHIP is making in relation to malaria.

Now, from the clinical point of view of how cases are managed, the impact is limited. In Bauchi and Sokoto States, the TSHIP is to achieve a number of indicators: number of staff trained in IPT, ACT and lab testing. Diagnosis is essential, and **Rapid Diagnostic Tests (RDTs) are being introduced by the TSHIP.** Up until now the RDTs are introduced in the States only at the capacity building levels. Malaria diagnosis using RDT equipment in the State is **not available**, only microscopic diagnosis exists in the General Hospitals. Microscopic data are not available from the General Hospitals. The State needs to strengthen the management of existing labs, improve the quality of services, supply of reagent, production of SOPs, in addition to training and retraining staff. Plans are under way in 2012 plan for improved RTDs distribution and implementation. The fact that so many people are being treated without confirmed diagnosis is a serious concern. Drug resistance may be generated

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[3] At the mission debriefing, Mr. John Quinley informed the MTE Team that two HH studies had been conducted but the reports are not available yet. In any case, we believe that health providers must ask every mother whether the child sleeps under a net as part of an integrated child health delivery SOP .

fast. **We wish to stress that treatment of malaria without diagnosis is not acceptable. However, that is what is happening in both States and the risk of drug resistance is looming.**

We know that in PY4, the TSHIP will train large numbers of health providers. We recommend that this training not be provided in hotels, but in the States' training institutions by TSHIP staff and staff from those institutions, so the training will be institutionalized there. This will also strengthen the capacity of the State to train its work force. This will not be a onetime training and will have be part of regular in-service training that the States must continue providing on a regular basis. It is essential that the training institutions that train the States' professionals also have access to state of the art information and training materials.

In short, everything the TSHIP does must directly strengthen the State, the LGA, the PHC facilities and referral system, or the community-based services, and the result must be measurable. This means that the TSHIP must be able to anticipate what it will leave at the end of the project and answer these questions:

1. **What will a stronger State do in 2015 as the result of the TSHIP that it was not able to do before?**
2. **What will a stronger LGA do in 2015 as the result of the TSHIP that it was not able to do before?**
3. **What will a stronger HF do in 2015 as the result of the TSHIP that it was not able to do before?**
4. **What will a stronger Referral Facility do in 2015 as the result of the TSHIP that it was not able to do before?**
5. **What will a stronger WDC do in 2015 as the result of the TSHIP that it was not able to do before?**

Of course, these questions do not apply to malaria only and must be answered for the integrated MCNCH/FP package and each of high impact interventions, whose quality and delivery the SHIP must improve.

h. Nutrition.

We addressed this as part of the child health section, since nutrition should be integrated in the service delivery package. As mentioned above, we did not observe the staff systematically using the MUAC to assess nutritional status. All facilities visited lacked spring scales to weigh children, and now staff use adult scales and weigh the mother with and without the baby. This is not an effective way of monitoring children's growth. In fact, we observed many children (at least in Sokoto) that looked malnourished to the naked eye. We asked if the facilities had plumpy nut and they said they do have it in stock, can ask for more, if needed, since the LGA that had a lot in store. We suggested they give talks about nutrition, and give out the nut to children whose weight was not according to age.

i. Routine Immunization and Polio Eradication.

We discussed this topic also in an integrated manner above. Here we will just emphasize that the MTE Team had expected that after the BASICS and Immunization BASICS projects, that cold chain and availability of vaccine coverage would be better, at least in some "early

adopter LGAs". Unfortunately, all facilities visited lacked cold chain equipment; ice packs were not available; refrigerators were not maintained; and temperature records were not consistently displayed or maintained. **Vaccines are not readily available and this poses a challenge for RI. Vaccines are provided once or twice a week due reportedly to the lack of transportation** to move the vaccines to and from the HFs on a regular and sustainable basis; limited or no material and human resources allocation for outreach services by PHC and general hospitals; lack of a nominal mechanism for tracking all immunization drop outs; not tracking of newborns for vital registration as is proposed for the CBHV scheme; and gaps in the cold chain system. Other explanations are the lack of systems for preventive maintenance; no inventory systems; broken down equipment; inadequate staffing and supervision; poor technical capacity due to poor productivity; under staffing and frequent transfers; lack of integrated OTJ training for operational staff at LGA level;, overwhelming visibility of IPDs campaigns, which are house to house in contrast to RI which is usually facility based; little or no systematic engagement of the WDC/100 women group in the RI system.

All these explanations are understandable. However, in the end they are excuses that stop people from looking for solutions and taking action. The question the TSHIP needs to ask itself is: What can the State, LGA and PHC HF do to make RI work? The ultimate goal is to make it work in spite of the reasons why RI does not work. There are lessons learned from previous projects, so there is no need to reinvent the wheel. The TSHIP knows it is about to just getting it done! Becoming an effective problem solver is what managing a facility is about. There are and there will always be problems. In fact, it is well known that as a facility improves, new problems arise. Health providers must not give up, but figure out a way to overcome the challenges.

Given this progress, the MTE Team questions to what extent the project interventions are aligned and contribute to "Saving 1 Million lives Initiative" and Nigeria's MDG program. There is a need for the LGA to plan and set targets by community and facility for children to be immunized and tracked by name. Nominal records are essential to ensure coverage at acceptable levels. To save a million lives means that each LGA must save a number of lives. How will the TSHIP help them to do that?

2. Health Systems Strengthening Findings

This is the second component that the MTE SOW asked the MTE Team to assess. In the scope of work for the MTE, the MTE Team is asked to measure the TSHIP's progress and achievements in the following areas:

1. ***Improving State Government systems, processes and outcomes ensuring access to quality integrated PHC services, both clinic and community-based, for women and children. Special attention will be given to PHC plan implementation, increases in budget contributions by the Government at each level of the system and to the effective flow of funds for PHC services at each level;***

   The TSHIP has started to improve some systems, particularly health information ,and has increased funding to some programs such as immunization. But systems strengthening must have a strong focus on improving the performance of the PHC facilities. It is essential over the next two years to bring a significant number of fa-

cilities up to par so they can benefit from other improvements. For example, improvements in essential medicine supply will not be effective if the PHC do not have a functioning pharmacy with basic inventory and dispensing practices. The HMIS will not be effective if the facility cannot collect basic information, monitor accuracy and completeness of its records. Increasing human resources will not improve service delivery if there are no systems to ensure staff are productive, demonstrate competence and actually wash their hands between patients so they are not vectors of infection. The TSHIP has mobilized the WDCs and now the demand for services can increase. The PHC must be able to meet an increased demand, at least in some 'early adopters' LGAs at the start.

2. ***Increasing the effectiveness of PHC clinics, dispensaries and general hospitals as secondary level referral sites; community-based services; and the linkages between clinic and community-based services.*** Increasing the effectiveness of a critical mass of PHC and referral facilities must be the main goal of PY4 for TSHIP. The project has spent the first three years building various aspects, now it is time to sustain and support effective problem solving. Linkages between clinic and community-based services do not exist. Linkages are going to be critical with the introduction of the CBHV and misoprostol. There has to be someone in each PHC that is in charge of overseeing the work of the CBHV, provides refresher training and gathers reports of births or deaths in the community. Someone must coordinate the distribution of misoprostol and keep track of the medication to ensure that every mother that receives ANC, and has chosen to deliver at home, has the pills. These linkages must be established, tested and supported by the State MNCH and RH/FP managers with the TSHIP assistance. If CBHV are not approved, the linkages with WDC become even more important.

3. ***Increasing the effectiveness of PHC staff, including midwives recruited through the Government's Midwives Services Scheme and other midwife training programs; Community Health Extension Workers (CHEWs); and community-based health workers of all types.***
Human resource effectiveness must be a priority. This has not been a goal of the TSHIP up until now. The MTE Team believes that the low level of implementation of training must make the TSHIP question their approach to training, and that training alone is not enough. The TSHIP must take the "next step" and ensure staff are motivated to apply what they learned. Here are a number of questions for the TSHIP to consider:
    - Is training all about presenting information?
    - Is there hands-on practice, troubleshooting, problem-solving and role playing?
    - Do they work in model facilities where they are actually applying the integrated package?
    - Does every participant have a number of steps to start using the training?
    - Has the facility signage and patient flow been changed to ensure the trainee can provide effective quality service?

4. ***Improving the supply chain to facilitate access to commodities at the PHC level, and***
5. ***Strengthening the monitoring, evaluation and use of data and findings for evidence-based decision-making by key State government staff and service providers***.

Supply chain and logistics and the M&E system, along with Grants are assessed below:

- **Essential Medicines, Commodities and Supplies**. *The MTE TEAM evaluated four aspects:*
    1. The TSHIP achievements
    2. Coordination with DELIVER
    3. Capacity of the State: DMA in Bauchi. What to do in Sokoto?
    4. Functioning of facility pharmacies, part of SBMR and revolving drug funds.

The TSHIP's achievements. It is apparent that effort has gone into increasing the availability of commodities within the State. For example, with family planning commodities, through the technical assistance provided by the TSHIP, Sokoto State is now constantly provided with family planning commodities for 533 health facilities, most of which are provided to the patients at no cost. Prior to the TSHIP's and DELIVERs involvement, it was estimated that about 64 health facilities in the State received an erratic supply of family planning commodities. In Bauchi State, the TSHIP and DELIVER were able to assist in the procurement and delivery of 25 solar refrigerators to 25 health facilities, and to facilitate the procurement of equipment for the university teaching hospital in Bauchi. The TSHIP is also making an effort to partner with local pharmaceutical suppliers and manufacturers to ensure the availability of chlorhexidine 4% solution. The TSHIP also facilitated the renovation of the Sokoto State central medical store. Overall there is more awareness by policy makers and the existence of an enabling environment to ensure commodity security. This was made possible through continuous advocacy by the TSHIP to stakeholders. Capacities have also been built in commodity logistics management at the State, LGA and health facility levels. The MTE Team observed that there were logistics system strategies in place that focused on the specific areas within which the TSHIP works.

<u>**Vaccines**</u>**:** Working together with the National Primary Healthcare Development Agency, UNICEF and WHO, the TSHIP is involved with the State task force that ensures that at all levels, the vaccine stock does not fall below the minimum stock level. They do this by taking stock weekly at the State level to ensure that vaccines are replenished. The minimum stock requirements differ at different levels, i.e., at the State, LGA and Health Facility level. **In spite of these measures, there were vaccine shortages last year that prevented the vaccination of over 200,000 children who did not get their DPT 3. The MTE Team did not assess all the vaccines, but if this is an indicator of all vaccines, the States are at risk of epidemics of measles and rubella and other vaccine preventable diseases. Again, the achievements of IMMUNIZATIONBasics,**

also implemented by JSI, must be recovered and sustained. In addition, the TSHIP might also gain by sharing its experience with the "Partnership for Reviving Routine Immunization in Northern Nigeria; Maternal Newborn and Child Health Initiative" Project. (http://prrinn-mnch.org/index.html)

Family Planning: The TSHIP works together with stakeholders to ensure family planning commodities are available. The Contraceptive Management Logistics System, which was developed by the DELIVER Project, was bought into by the State. The system is in place to help ensure that the family planning commodities do not fall below the minimum stock level. At the LGA level, commodities are supplied every quarter, and bi-monthly at the health facility level. (Note: For health facilities the maximum stock level is a 4-month supply and the minimum stock level is a 2-month supply.) If a facility experiences high consumption, they are able to get their stock replenished from the LGA so as not to fall below the minimum. Stakeholders include State Primary Healthcare Development Agency, Federal Ministry of Health and UNFPA. **This is a very effective system that needs to be institutionalized and used for all supplies. All facilities visited had contraceptives. The only problem was that commodities and essential medicines, lab reagents, Global Fund provided ACT, HIV/AIDS testing and medicine, each was managed separately by different people in different parts of the facility. Each facility must have a functioning pharmacy that manages all supplies in the PHC. The pharmacy has an inventory and a stock card for each product and a lock so no unauthorized staff can enter. Stock cards and inventory must be supervised by the OIC weekly and by a logistics supervisor monthly!**

Having a functioning pharmacy is not a luxury, but essential for a PHC to function and provide integrated quality care. Also, a PHC pharmacy is the basis of an effective State logistics system. If supplies are not managed well at the facilities, all is wasted, the equipment, the health provider's diagnosis and work, etc. is rendered useless because the medicines do not reach the patient.

Photo 14. Lack of medicines in renovated facility with new labor room

This is the pharmacy in the facility where the labor room had been renovated (See Photo 7). There is no lignocaine for an episiotomy; there is no vitamin K for the newborn, not even misoprostol for the mother.

Even the emergency trolley is empty and unused. All of the TSHIP's investment will be lost if a functioning pharmacy is not created.

The next photos show what not to do when a facility does have medicines. This is important because patients must not be harmed, and if not stored and dispensed properly, patients may be hurt.

Photos 15 and 16. What not to do when there are medicines

In Photo 15, notice that the medicines are in disarray. The air conditioning does not work and it was hotter in the pharmacy than outside due to the lack of proper ventilation. Medicines must be stored at the right temperature and arranged in alphabetical order and by date of expiry. A stock card with the current quantities in hand must be placed next to each medicine.

In Photo 16, notice that the pharmacy assistant student, who was packing the medicine, was using the same pill counter and the same spoon to pack different medicines without cleaning the counter. The dust left by the previous medicines would contaminate the next medicine. Good dispensing practices are essential to ensure patient safety.

Medicines: The availability of SP for IPT seems not to have had stock outs and was available in 7/9 of the facilities visited in Bauchi and in 3/9 in Sokoto. ACT availability was exactly the opposite. Please annex for the availability of other essential medicines.

Quantification and Procurement. The public health facilities in Sokoto State is largely dependent on supply by the Global Fund. The supply and information chain for Artemisinin-Based Combination Therapy (ACT) from procurement to delivery and utilization is very long and, unfortunately, the State does not allocate much for the provision of antimalarial commodities. The strategy used for malaria commodities involves the **Malaria Commodities Logistics System.** The TSHIP has plans to increase access to ACT through Advocacy to the State MOH, SPHCDA and MOLG to allocate fund for ACT, and facilitating the purchase of ACT by the State agencies (MOH, MOLG, HSMB, SPHCDA, MDG/NHIS) from the Society for Family Health (SFH) and other first line buyers through AMF mechanism at a subsidized price; roll out Malaria Logistics Management in the State and monitor stock on a monthly basis at the facility level; and support scale up of private sector supply of Global Fund/AMFm supported ACT through SFH. The TSHIP also plans to facilitate introduction of Injectable Artesunate for severe and complicated cases of malaria in referral hospitals. **Procurement is usually based on historical purchases and the quantities may not**

have any relation to actual needs. The advantage of having a functioning pharmacy with inventory and stock cards is that each facility is then able to start to quantify their own needs based on consumption and HF statistics, and to determine more accurately what they will need and inform procurement decisions, as opposed to just getting whatever the government sends them. That is the vision we wish for the facilities in Bauchi and Sokoto.

Capacity of the State: DMA in Bauchi.
Photo 17. Vaccine refrigerator in rural facility in Peru.

As it relates to the systems that States have in place for the different classifications of commodities, the TSHIP has conducted capacity building training for officers (at all levels) on the contraceptive logistics management system, but not for essential medicines or facility pharmacy management. They also provide cold chain management training for all cold chain officers, which is followed up with refresher training so that everyone is up to date and current with the technology and best practices available. However, we did not find evidence of this training in the cold change practices in facilities visited. **The photo on the left is of a refrigerator in a rural facility in Peru. Notice that although it is a regular refrigerator, the temperature chart is on the door as well as what is stored on each level and instructions as what to do when power is cut. We would like to see every refrigerator like this in Sokoto and Bauchi by the end of TSHIP. It is time!**

<u>Bauchi State Drug Management Agency</u> was an important achievement of the TSHIP. The Agency, whose objectives are to ensure the regular supply of quality drugs, at affordable cost, to secondary and primary healthcare facilities, is also responsible for improving healthcare service delivery systems of Bauchi State, as well as maintain sustainable **drugs revolving funds scheme** and enhance production activities of the drug-manufacturing unit. The Agency is under the supervision of the State ministry of health and functions specifically to administer the operation of the drug revolving fund and the drug manufacturing unit; authorize, manufacture, procure, deliver, sell and manage drugs in the State and LGAs; collaborate under the national health insurance scheme of the State to supply drugs and medical consumables and participating health institutions; to effectively manage procurement, supply and distribution of drugs and medical consumables of the State under the Free Maternal and Child Health Program; and to support warehousing and distribution of donated drugs and medical equipment from international development partners, civil society organization and philanthropists.

Box 1. PY 4 Work plan, page 6

- Support the States to strengthen institutional frameworks for coordinating and managing health commodity logistics to track commodity availability and utilization;
- Support the States to develop and implement a framework for logistics coordination and integration;
- Support the States to train service providers on commodity logistics management (malaria, FP, vaccines, and other essential commodities); and
- Support the States in the systematic distribution of LLINs, malaria, FP and other essential commodities to the LGAs, HFs, and community levels (WDCs, CBHVs and household).

System integration: For PY4 efforts are being made to harmonize and centralize the logistic system. It is not clear what the TSHIP will achieve because, again, the language is vague and not quantifiable (See Box 1). It is not clear what the TSHIP will achieve in Sokoto. Will there be another DMA?

There is a need to have a common logistics system for ALL commodities, and not have separate systems for each commodity classification. This will allow for better planning and budgeting for the procurement and delivery of ALL medical commodities needed by the State. This approach is the most appropriate and will improve the utilization of human resources. The TSHIP also plans to support the State to institutionalize a health commodities logistics system that will track the available commodities and their utilization**.**

- **M&E, PMP and the HMIS.**

The M&E framework in the TSHIP needs to be revised so that the project has **clear outcome indicators** that relate to the sub-objectives. We understand that some indicators must be collected to meet USAID/Washington requirements, however, for project management reasons; another set of indicators must be used. Then the project will be able to work from those outcomes and design "critical paths" to achieve them, that is, the minimum number of effective activities to achieve the outcome. At this time, the TSHIP has the following outcomes:

1. Number of deliveries by a skilled birth attendant
2. Number of women that received AMSTL
3. Number of newborns that received the newborn care package
4. Number of children that received DPT3
5. Number of children with diarrhoea treated with ORT
6. Number of malaria cases in children treated with ACT
7. Number of children that received Vitamin A
8. CYP

Most of the other indicators are input indicators that do not necessarily lead to improved quality and delivery of high impact interventions, or to strengthening the State, the PHC and referral facilities or management of health problems in the household or the communities. In addition, the source of the information for measuring these indicators is registers and medical records used in the facilities. The photos below show that data are recorded, but not summarized daily and used. Medical records are in disarray, on the floor and cannot be used as a source of medical information.

Photos 18, 19 and 20. Various facility records

- **Grants Program findings:** *Rapid disbursements, effective awards and monitoring*

The total grant pool is US$10.45million over the life of the TSHIP, with approximately US$4.45 million to be disbursed in PY2 and US$3.0 million in PY3 and PY4 respectively. At the time of the MTE, $552,745 has been disbursed. Small effective micro-grant programs can be used through the platform of WDCs to establish village health committees, community local drama clubs, and other novel means to promote child vaccination and family planning. The rural poor, especially women and girls in Sokoto and Bauchi States in general, are not reached by information via the popular media. Innovative approaches to generating public awareness is a critical task that the TSHIP must undertake if sub-objectives 2a and 2b are to be realised. The village health committees, the local drama groups, with very little grants, can set up a community mobilization structure through the procurement of local talking drums, use of local costumes, use of stories and progressive norms to drive the need for immunization, sanitation and family planning to the consciousness of the people. To get a sizeable audience, they can select a very important day in the community calendar for health education mobilization and sanitation. The main objective of the mobilization will be to talk to people in a friendly and subtle way on the basis of quotes from the Holy Quran that states clearly that Allah (God) has provided medicine for the mitigation of all illnesses confronting mankind.

The MTE Team notes the following achievements and has made some "next step" comments:

1. The TSHIP has reported capacity improvement of the current pool of Master Trainers (MT), and also the expansion on Standard-Based Management and Recognition (SBMR) to cope with regular follow-ups and supportive supervisions of trainees in their respective health facilities. This is to translate knowledge acquired into practice at the workplace. It is not clear how the Master Trainers will work and translate their knowledge without clear phased and prioritized performance goals. It is essential that performance targets be set for every facility, and then the MT can get to work with the staff to achieve those targets. With the exception of Integrated Community Case Management (IMCI), training is not integrated. So it is hard to believe that integration is practiced and how SBMR will help achieve it.
2. The TSHIP is reported to have developed SOPs and job aids, but they do not seem to be used. Posters are used as decorations and placement is not appropriate to the use.
3. The TSHIP has supported the establishment of the **State Central Health Information Database,** which is located at the SMOH headquarters, and to have achieved buy-ins from all of the SMOH Agencies and Development Partners already working in Bauchi

State. This is a good start, but we would have liked for the State be at the forefront of this coordinating effort. It is not good for the sustainability of the TSHIP's interventions to be seen as taking the leadership role, because the credit will then be attributed to the project. Also, information collection at the facility level where most data are generated is still cumbersome and data are not checked for accuracy or completeness.

4. The TSHIP has promoted the use of DHIS2.This is a new version of the District Health Information System. Sustaining this achievement is one of the main challenge in PY4. The MTE Team would like to propose that simplifying the data collection system and sustaining it at facility level should be one of the goals of PY4 work plan.
5. The TSHIP has reported to use the State Strategic Health Plan (SSHP) to provide better coordination with SMOH and its parastatals, but it is not clear how the Plan is used and how the SMOH has been strengthened to coordinate all inputs, including those for the TSHIP. The Plan does not have the names of the parties who are will participate in the implementation of the Plan, or who is accountable for what and when. There are no regular coordination meetings. There is a need for an activity calendar for the State to ensure these activities are scheduled. The Team would have liked to see what activities of the SSHP the TSHIP will support in PY4.
6. The TSHIP has developed and maintained a training database for tracking the various capacity building activities that have a high impact on the delivery and promotion of MNCH/FP/RH interventions. This is TSHIP-driven and is not yet available at the State and LGAs levels, and must be transferred as soon as possible to the States. By transfer, The Team means not just giving a copy of the database, but ensuring that it is maintained, and working with the State to make sure it is part of the training planning and participant selection.

Systems Strengthening Findings at the Facility level

Based on interviews conducted with both healthcare providers and patients at the facility level, the MTE Team found the following:

1. Mostly CHEWs, female and male and Nurse/Midwifes, attend to women clients and that does not seem to be a problem.
2. Over 70% of the health providers have worked at the facility for 1-10 years, which implies there is a fairly long retention rate of staff in the visited facilities.
3. Almost half of the service providers are aware of the TSHIP services in MNCH and FP.
4. The high percentage for members of staff are organized in the different departments and implies that there might be no case(s) of overlap in duties among staff which promotes efficiency.
5. The high percentage of facility staff with "No job description" implies that most service providers are not aware officially of what duties they are expected to perform. They mostly based knowledge of their official duties on the category of their professional training.
6. Almost all the service providers reported receiving supervisory visits at least in the past 2 1/2 months. Although, this does not indicate the quality of the visits, but the fact that they have been supervised recently is a good star.
7. The high percentage of service providers that claimed to have been trained implies that capacity to perform their duties has been significantly enhanced. This may somewhat attest to the TSHIP's concerted effort towards capacity

building for service providers. Performance on the other hand, will take more effort to improve in PY4 and 5.

8. The high percentage of service providers that attested to have noticed a significant change in their unit implies improvement has occurred in their facility, mostly due to TSHIP and other projects. The role of the State may be perceived as weaker when compared to projects. The fairly high percentage of service providers attributed change to the work of other donors and projects.
9. The high percentage of service providers do not notice the discrimination between the provision of service(s) to males and females indicated no serious gender imbalance issue.
10. The high percentage of relationship with community members shows the strong impact the community component of the TSHIP has had.

Table 2 summarizes the findings in 18 facilities visited. In sum, facility performance is uneven and does not meet quality standards in most facilities.

Evaluation Question 1c: Partnerships, Coordination and Collaboration

This part of the evaluation assessed partnership and collaboration within the TSHIP and with other USG programs, e.g., LEAD, NEI, WOFAN, government, civil society and private sector partners.

The TSHIP has made headway in engaging the State MDAs, collaborating with USG funded projects, international partners and local NGOs/CSOs, but at different intensities across the different categories of partners. The TSHIP understandably has a relatively strong working relationship with the MDAs at the State and LGA levels, and has reportedly been able to maintain a good balancing act against the backdrop of rivalries between State owned institutions. The TSHIP has worked with the partners to develop policies, guidelines, protocols, improve quality of services, renovate facilities, etc. We believe the TSHIP should continue this work, but as a partner to the SPHCDA and the MOLG to assist with the implement their programs and, therefore, help them succeed in advancing public health program in the States.

Some of the reported challenges that effective collaboration between the TSHIP and MDAs include:

1. Lack of a formal or documented arrangement like an MOU or LOA that clearly identifies the roles and responsibilities of the TSHIP and partners in most instances.
2. Perception by MDAs of long bureaucratic delays within the TSHIP before responding to requests or proposals, as well as poor follow up on agreed issues.
3. Lack of openness in sharing the TSHIP work plans with relevant MDAs or partners.
4. Lack of a formal coordination mechanism for collaboration between the TSHIP and stakeholders, e.g., a focal person or desk officer from the TSHIP for a particular issue. Collaborations are currently managed mostly through adhoc meetings or personal arrangements, particularly at the technical staff level.
5. Lack of "clarity or confusion" on the part of the TSHIP about the mandate of some MDAs in the States.

In general, we observed the lack of ownership of the project's goals and strategies by the State. The new Executive Director of the SPHCDA has been on the job for 3 months and would like to coordinate his activities with the TSHIP. We believe that the TSHIP should look for ways to contribute and strengthen the systems in the Agency to ensure it can coordinate all activities.

The photos on the next page show various examples in which the lack of ownership is manifested. The first photo shows various books that rightly have the logos of the State. The MTE Team observed these documents at a PHC, and it was evident they had not been used. Next is a number benches donated by various project, but this time the logo of the State and/or an inventory number marking the ownership of the benches is missing. The third photo shows the plaque the TSHIP has added to some facilities, but the State logo is missing. This undermines the perception people have of the State.

Photos 21, 22 and 23. Examples of State Ownership

In PY4, the TSHIP plans to "Systematically document and disseminate project experiences and lessons for public consumption and in professional journals and social media, as accountability and stewardship of the TSHIP to Nigeria and the public health community" (page 1). The MTE Team recommends that the TSHIP do this on behalf of the State, so that the TSHIP website becomes the SPHCDA's website with collaboration of the TSHIP and USAID funding; that lessons learned are the lessons of the SPHCDA's in collaboration with the TSHIP. The TSHIP must strive to put the State and its agencies in the forefront, not only because it will help accomplish the first sub-objective, but also because it will increase the ownership of the achievements and successes and their commitment to keep moving forward.

It was reported that the collaboration between the TSHIP and MDG program was based on the agreement that the MDG program build health facilities, supply drugs, dig borehole and install other water equipment and provide sanitary facilities in health facilities; while the TSHIP would renovate dilapidated health facilities, supply medical equipment, trained health workers on variety of high impact health interventions, conduct supportive supervisory visits, train WDCs to provide support to health facilities and links to the community for health care management services.

With technical support from UNICEF, the TSHIP trained health workers on nutrition, management of diarrhea, childhood illnesses and Routine Immunization. Follow up to ensure staff applies training is essential for all partners, and the TSHIP can set a new standard for effectiveness in global health.

In addition, the TSHIP reported that its newsletters are shared with UNICEF and WOFAN. WOFAN and the TSHIP collaborated on issues: WOFAN repaired borehole and other water equipment, while the TSHIP provided all the services highlighted under MDG partnership. Collaboration between the TSHIP and MDG/WOFAN were confirmed by physical observations at the health facilities visited, and the MTE Team also observed fact that most of them have either broke down or lack proper maintenance. It is strongly recommended that the TSHIP draw-up a follow-up and maintenance action plan with the respective collaborating organization for implementation. We believe that these partnerships have been successful because the goal was clear and the result tangible. Those are elements of effective aid.

Leadership, Empowerment, Advocacy & Development (LEAD) NIGERIA is a USAID project on governance and community leadership interventions, and also part of the Focus State Strategy. The most important achievement is the collaboration to create the WDC's action approach that helped mobilize hundreds of WDCs. LEAD and the TSHIP had partnership arrangements and have implemented a number of activities together:

- Collaboration on budgeting/service delivery capacity in 8 LGAs of Bauchi State and 12 LGAs of Sokoto State. – (SO1)
- Strengthening the capacities at LGA level – (SO1)
- Alignment of strategies and common project sites with TSHIP, i.e., Ministry of LGA and the Community – (SO1 & 3)
- Partnership mechanism through USAID IPs' quarterly meetings
- Engagement with the TSHIP on open budget public hearings
- Budget transparency
- Invited the TSHIP on capacity building on 'oversight of the State house of assembly
- Supported the LGAs to provide a budget line for the IMCI component of Child Health; conducted gap analysis on gender issues
- Supported the HSMB and SPHCDA in the area of Health Care Waste Management

The need for joint health governance outcomes is evident to ensure the above activities contribute to a defined strategy that delivers tangible results. They reportedly conduct staff weekly meetings at the management level and monthly meetings at the programming level, and the process has been in existence since the early phase of the TSHIP, but now these meetings are very irregular due poor attendance, especially from the field staff.

NEI and the TSHIP have collaborated on RH interventions for girls for a school health program under Ministry of Education; promotion of hand washing in schools under Nutrition Education; assisted CSOs with capacity building by providing access to TSHIP grants. NEI works with communities through the creation of "community coalitions", which are similar to the WDCs. Given that USAID has a Focus State Strategy, a common community governance approach should benefit service delivery in health and in education.

Finally, it the TSHIP has reportedly collaborated with MARKET 11 Project by training of Community Liaison Officers on Family Planning Services; with Rahama Women Development Society, which was awarded grants provided by TSHIP; with CEDA-SIET in a project supporting research on MNCH Services; SFH to support FP Commodity Security; and supply of ACTs/SP to priority health centers.

The LGA system is designed to support the PHC system, but had no funding flow from the statutory federal allocation for the past two years. One of the Directors of the PHC Departments of the LGAs had this to say, "The LGA System has been crippled by the total lack of funding from the State/LGA joint account." Bauchi State government had created the State Primary Health Care Development Agency to address the fragmentation of the PHC system. The Agency is still a young structure that needs support to succeed. The TSHIP has to strengthen the SPHCDA to be able to address the PHC system fragmentation through the PHCUOR concept being proposed by the NPHCDA. In MTE Team interacted with the TSHIP Advisors, and they had this to say, "It is better to focus on low hanging fruits for better results". The Team agreed that accompanying the growth and development of the Agency is the low hanging fruit! The question that remains is what tangible results the TSHIP will achieve in this area, because the language in the PY4 work plan is vague and unquantifiable. Notice the use of the word "support".

Box. PY4 Work Plan page 6

- Support SMOH, State Primary Health Care Development Agency (SPHCDA), and LGAs in Sokoto and Bauchi States to develop costed 2013 work plans derived from SSHDPs;
- Support the States and LGAs to improve the competencies of health care managers to coordinate MNCH /FP services;
- Support the States and LGAs to strengthen their health information systems and their use for decision making;
- Support the States and LGAs to strengthen operational support and management systems for commodity tracking, staff performance evaluation, and standard adherence at State and LGAs levels;

Need for stronger internal coordination within the TSHIP. One of the LGA PHC Directors acknowledged that, "the TSHIP Zonal offices are doing their best and we have very good cooperation and collaboration between the LGA Team and TSHIP". To keep the high level of coordination for better performance and program outcomes, the staff asked for the re-activation of the staff weekly meetings with most field staff in attendance. This meeting should be regular and compulsory.

Cost Share: JSI Institute has systems and operations manuals in place to meet the cost sharing requirements to support the TSHIP operations. Available evidence shows that the program manager recognizes this need and is working in this direction. This MTE Team did not evaluate the cost-sharing activities or their outcome.

c. Performance monitoring and evaluation

The MTE assessment included analyzing the results and M&E framework, quality and relevance of indicators (impact/outcome/process) and operational research.

The TSHIP has a strong M&E Team comprising the Director, an M&E Specialist and NHMIS Specialist who are based in Bauchi office and who oversee the activities of M&E in both States (Bauchi and Sokoto). The Team also has an Assistant M&E Officer based in the Sokoto office and reports to the M&E Specialist. The junior personnel that are responsible for data collection and entry are also available in both States. The assessment of the effectiveness of the M&E was carried out through key Informants Interviews (KII) with the pro-

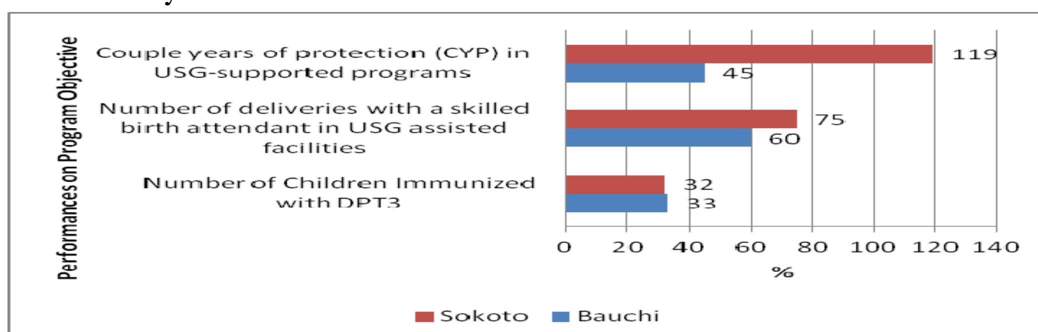
ject's M&E Team, evaluation of the performances of the project on the indicators through the Performance Management Plan (PMP) and observations of the data system at the State Ministry of Health (SMOH), LGA offices and at the PHCs. The M&E Team's main accomplishments are:

- Establishment of the multi-sartorial Health Data Consultative Committee (HDCC). The HDCC carries out policy and advocacy on strengthening the M&E systems of the State Ministry of Health (SMOH) and its implementing agencies.
- Formation of State monitoring and evaluation Technical Working Groups (TWG) to strengthen the State M&E system.
- Supported the production and dissemination of HMIS materials, including 8,500 copies of booklets of the forms, and provided technical assistance and training for 109 health personnel (male and female) from the SMOH and LGAs on the harmonized HMIS tools. Consequently, the HMIS tools were available in every PHC visited in the two States (Bauchi and Sokoto).
- Facilitated Monthly State data review meetings. As part of the TSHIP M&E effort in strengthening information system and flow, the TSHIP staff has continued to participate in State monthly RI/IDSR and malaria data review meetings and provided technical support to the LGA M&E, LGA Immunization Officers (LIO) and Disease Surveillance and Notification Officers (DSNO) on data compilation, validation and analysis.
- Established very vibrant and organized community level organizations - Ward Development Committees (WDC) and Village Development Committees (VDC) that have facilitated advocacy and mobilization of the communities on health related issues. The Committees have contributed to the development of PHCs in their communities and have been very helpful in ownership and community entry.
- **Unfortunately, the DQA report showed that only 1 out of 10 of TSHIP's indicators is valid.**

Performances on Indicators

The performance of the TSHIP on reaching the set targets for the third year show that the project achieved at least 40% on 15 indicators (Table 1: Appendix) out of 27 indicators. There exist inconsistencies in the trend of performance over the period of the three years, probably due to the non-standard method of setting the targets. Figure 1, shows the performances of the TSHIP on the program objective: Increased use of high impact interventions in Bauchi and Sokoto. The project performed better in Sokoto than Bauchi. In order to streamline the management of activities, the indicators most appropriate for the project, and a set of additional indicators are recommended for the project in the next two years.

Figure 1. Performance of TSHIP on selected program indicators in the project States in the third year



*The OR component of the TSHIP has the mandate of s*upporting and building the capacity of State Health Research Ethics Committees (HRECs) in assessing and monitoring all health research protocols in the State.

The OR component was designed to provide TSHIP with evidence of the effectiveness of project interventions, activities or implementation processes.
Findings in this area include:

- Lack of transportation for State HREC to conduct monitoring of approved OR studies in the State
- Lack of trained personnel in the States with technical capacity to review and monitor research proposals
- High attrition rate among members of HREC previously trained by the TSHIP on OR
- Both State Health Research Ethics Committees (HRECS) are still not registered with the National Health Research Ethics Committee (NHREC) and cannot legally give ethical approval for any research proposal in the State
- "Poor appreciation of the utility of OR in providing evidence for health policy even by technical people" in the State and the TSHIP
- Prevailing poor research culture in both States

e. The impact of the conflict environment on project performance.

Prior to travelling to Bauchi for the field data collection exercise, the bombing at a church in Bauchi town disrupted the original plan for the trip, and prevented the Team Leader from traveling with the Team, thereby altering significantly the field Team's structure. Interaction with TSHIP Bauchi project staff attested to the fact that the TSHIP management took seriously the security concern in the State. Security measures were taken right from the gate where visitors (including the MTE Team) were screened with metal detectors and bags thoroughly searched. All vehicles, except for staff and project vehicles, are mandatorily parked outside. Staff are given security tips about movement within town and at what appropriate times. However, no incidence of project activity disruption was reported, although a specific inquiry to this effect was not made.

Security issues were more prominent in Bauchi State than in Sokoto State. An incidence of bombing was reported only once in Sokoto state. The MTE Team learned that the TSHIP has produced a security manual (not sighted yet) to guide staff on security issues in the State. Beyond bombings, incidents of armed robbery in Isa LGA were reported by the TSHIP zonal staff, which led to suspension of project activities in this LGA for some time in the 2nd quarter of 2012. Although project activities have resumed, the LGA is still under a security watch with necessary precautions being taken when going for assignment in this LGA.

Evaluation Question 2: How has the TSHIP and its partners defined sustainability and how has the project progressed in this area? In particular, how is the project building capacity and how has this been translated into improvements in program management and in service provision? What indicators will be used to measure sustainability of their support to Sokoto and Bauchi States?

THE TSHIP's Understanding of Sustainability is extracted from the grant application:

> The TSHIP rightly requires active **State ownership** of best practices, approaches and investments; given this focus, the States will be in the forefront of the TSHIP partnership. **Each State will lead coordination efforts with projects, donors, NGOs and private sector actors using the TSHIP coaching as needed**. To improve efficiency and sustainability, the State must **mobilize currently under-utilized private sector actors and NGOs. Partnerships with LGAs will enable the critical work of improving use of high impact health interventions to move forward.** While LGAs have considerable responsibility, they often lack the capacity to plan, manage and support the implementation of health services. As detailed on page 12, by identifying **early adopter LGAs, the TSHIP will create motivation for true partnership by recognizing achievements of a small, but critical mass of LGAs in year 1."** (**A**pplication page 12)

We notice that this definition has not been implemented yet. The TSHIP staff must decide what definition they will use, and stick to it. Given that it is PY4 already, the implications are that this definition will determine the approach to the other activities. The evidence of the TSHIP's progress, particularly in training to date, suggests that the TSHIP is on the road to building sustainability, if it focuses its activities progress towards that goal, avoids vagueness in the work plan and aligns other activities toward empowering the State to be in the forefront, and the facilities and the communities to take action. We address the evidence in favor of the TSHIP sustainability by the TSHIP's sub-objectives below:

1. ***Sub-Objective 1.Strengthen State and local government capacity to deliver and promote use of high impact FP/RH/MCH interventions***. *Below is a list of selected activities carried out to strengthen State and local government capacity.*
   - Capacity of States and LGAs to deliver and promote high impact MNCH interventions
   - Creation of a pool of Master Trainers with a series of subsequent step down capacity building training with the LGAs providing the venues
   - TSHIP supported the development of 2012 operational plans with the State & LGAs
   - Joint plans with the States' and LGAs' human resource capacity building projections

- Institutionalization of Integrated Supportive Supervision with stakeholders at State and LGAs Teams leading
- Strengthening the Health Information System (HIS) in both States through
    - Assessment of HIS in both States by engagement of a Consultant - (SO1)
    - Training conducted on DHIS, Data Quality etc. – (SO1)
    - Migration of HIS in Sokoto from database to web base – (SO1)
        a. Implementation of strategies that makes maternal death noticeable in the State led to securing of funds (₦18.9 million) from Sokoto State Commissioner for Health to purchase misoprostol to provide post-partum care (treat cases of bleeding after delivery) and make childbirth in community a lot safer – (SO1, 2 & 3)
        b. Conduct supportive supervisory visits in collaboration with LGA to PHCs – (SO1 & 2)
        c. Collaborating with LEADS on budgeting/service delivery capacity in 8 LGAs of Bauchi State and 12 LGAs of Sokoto State. – (SO1)
        d. Conducted training workshop for staff at the ministry and LGA (Coordinator PHC – Min. for LGA, "I attended their training on – Essential Drug List for the State.")
        e. Rolled out essential drug list in the State
        f. Conducted integrated supportive supervision to health facilities with staff of SMoH.
        g. Advocacy lead to Sokoto State government recruiting 1,200 health workers
        h. A zonal manager indicated that LGA in his zone has bought the idea of using Community-based Health Volunteer (CHV) for community outreach events and interventions.

These activities are all valid attempts at building capacity, but our TSHIP staff failed to see the direct connection between these efforts and with the project outcomes and ultimate impact. The "so what?" question must be answered by the TSHIP staff when planning activities.

2. ***Sub-Objective 2. Strengthen the delivery and promotion of high impact MNCH/FP/RH and selected disease prevention/treatment at PHC facilities and essential referral levels***

- Delivery of integrated MNCH - Family Planning and RH interventions:
    a. Supported streamlining of Commodity Logistics Management System (CLMS) with the objective to identify requirements, forecasting and the placement of orders for Family Planning Commodities
    b. The approval of N40 million for the Drug Management Agency, the – sole re-supply system for quality and affordable drugs, consumables, commodities and other supplies to the health facility
    c. HF Renovations – This is one of the main TSHIP legacies to be left behind at the end of the project. The renovation had good quality work and demonstrated practical efficient use of resources referred to as "value for money In-

itiative". This will serve as model to be replicated by the State and local governments. Further renovations will require redefining the approach to address the service delivery requirement to promote high-impact MNCH/FP/RH interventions. There will be the need to define minimum building standards on infrastructure rehabilitation of health facilities that are culturally acceptable at different levels of care.

3. ***Sub-Objective 3. Strengthen the role of households and communities in promotion, practice and delivery of high impact FP/RH/MCH and selected disease prevention and treatment interventions***

   The high level of good will and commitment to support health that the TSHIP has created in hundreds of WDCs is remarkable. These community structures, some stronger than others, are the key to sustain the impact of the target interventions.
4. ***Sub-Objective 4. Improved policies, programming and resource allocation.***

- The following are specific activities the TSHIP and its partners carried out toward improving policies and programming:
  - **a.** Support to the 2 State governments in the development of State Strategic Health Development Plan - SSHDP (2010-2015). – (SO4)
  - **b.** Advocacy resulted in Bauchi State Health budget being increased from 15% to 17%. - (SO4)
  - **c.** Have participated actively in donor coordination meetings.
  - **d.** Held review meetings in partnership with DELIVER on logistic chain management of health commodities in Bauchi State. – (SO4)
  - **e.** Collaborative development of State and LGA work plans with other partners in the State. – (SO4)
  - **f.** Had collaborative discussions with LEAD on governance issues and community based interventions. – (SO4).
  - **g.** Harmonization of the health system working with the State MoH which resulted in the development of the SSHDP (2010-2015). – (SO4)
  - **h.** Use of data/information for decision making through strengthened HMIS. – (SO4)
  - **i.** Conduct of OR on ORT corners. – (SO2 & 4)
  - **j.** Use of media in HSS. – (SO1 - 4)
  - **k.** Advocacy to government (SPHCDA) to fund PHC directly and LGA for dispensaries.

The TSHIP supported the drafting of a bill for the development of the Bauchi State Drug Management Agency that is now in the process of composing the Bauchi State Essential Drug List. This Agency will help the State ensure better service provision through the availability of medical commodities. It is also a step in the right direction for sustainability because the agency allows the State ministry of health to be in the forefront and take ownership of the supply and logistics of the State's medical commodities.

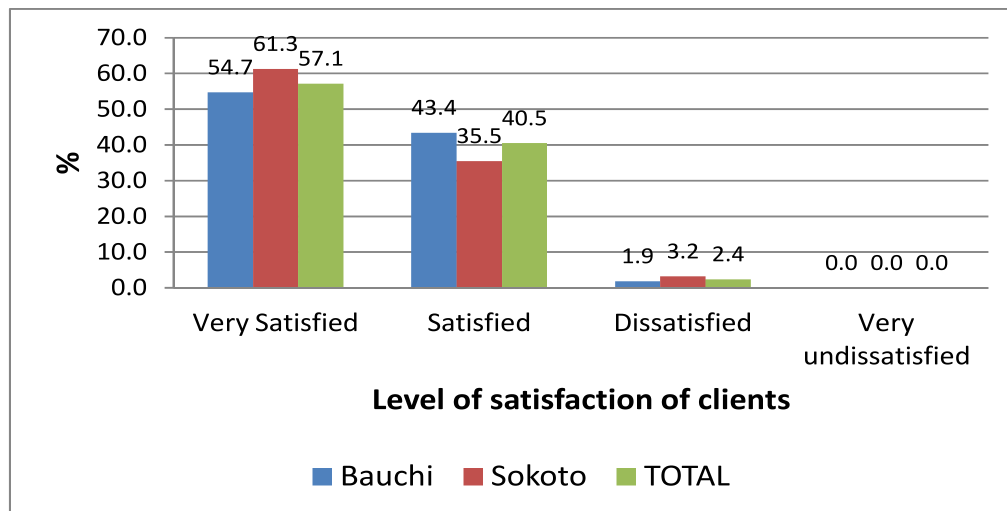
Evaluation Question 3: To what extent are clients satisfied with services provided through facility and community services? Do services provided to pregnant women and children in the primary health care centers and hospitals meet their needs and expectations in a timely manner and at expected quality?

All those interviewed expressed gratitude and appreciation for what the TSHIP has done or given them. Staff appreciated the training and equipment, the WDC appreciated the support and users were grateful for facility renovations and improvements in the quality of care. The WDCs interviewed expressed interest in knowing more about health issues beyond Polio, so they can help their communities better. Below are some of the comments of the Focus Group Discussions (FGD) participants and results of the exit interviews. The MTE Team noticed that users and non-users in general had a good understanding of the health issues and benefits of getting timely health care:

- "They are always very caring and attend to me on time, they go round to visit us on our sick bed and often explain things to us, before doing it. They make sure the environment is clean and always quarrel with people who throws dirt's and dirty water around."- User
- "If the mother or child is sick as they visit hospital when the doctor prescribe drug it work effective, and in the case of pregnant woman it ease delivery because of the anti-natal care, there is a great difference between hospital users and non-users" – Non-user

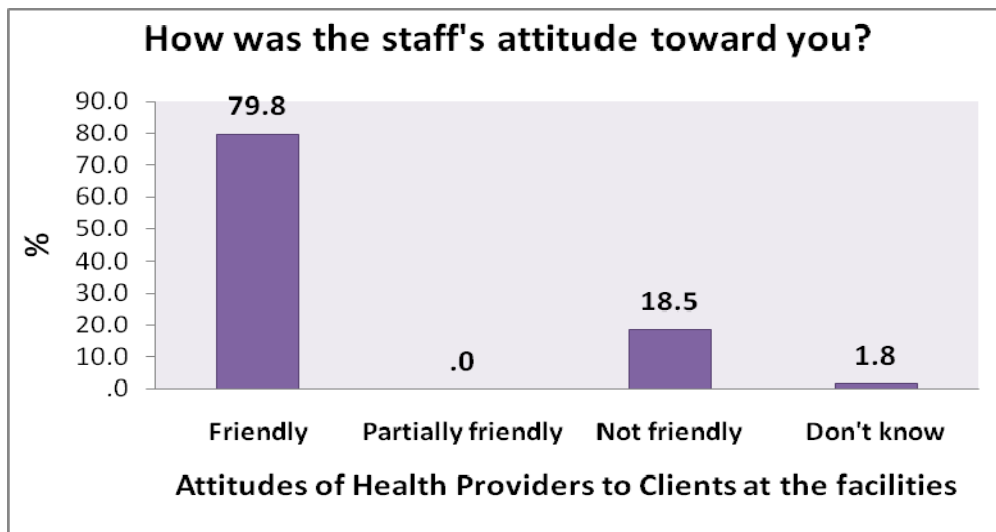
The exit survey among the clients showed that almost 98% (57.1% very satisfied and 40.5% satisfied) of the people that attended the facilities were satisfied or very satisfied with the service received (Figure 1). The level of satisfaction varied slightly in the two States (Bauchi and Sokoto).

Figure 1. Exit interview: satisfaction with services received.



However, it seems to come down to the perception of the community has of the facility, the staff and the care they can get there. Figure 2 below shows the impact a friendly attitude has.

Figure 2. Health Provider's Attitudes



The Focus Group Discussions (FGD) shed more light on the community perceptions of the facility and the staff:

"I don't visit hospital because the health personnel are not friendly due to the fact that some are not sympathetic in attitudes." Non-user Sokoto

"There is need for power supply because some drugs needs to be refrigerated." Teenage girl Sokoto

"There is need for toilets and beds for the patients in the labor room. Here is need for beds for admission and clean environment because the hospital is smelling and dirty." User, Sokoto

"I prefer to give birth in my room than being insulted and treated without pity and respect." Non-user, Bauchi

In sum, the communities are more discriminant than probably providers think, and they can tell when quality care is provided. There is no excuse for bad manners or mistreating patients. The focus of any quality improvement is to **serve the patient**. The HF must develop a culture of service and standards of good behavior must be set, modeled and enforced. For example, standards might include: Did the health provider do the following:

- smile at patient/mother
- invite the patient to sit down
- ask for the patient's name
- refer to the patient by name
- ask "How can I help you today?
- ask for permission to examine
- explain possible diagnosis and need for lab tests
- ask if the patient has any questions
- answer questions and confirmed the patient's understanding

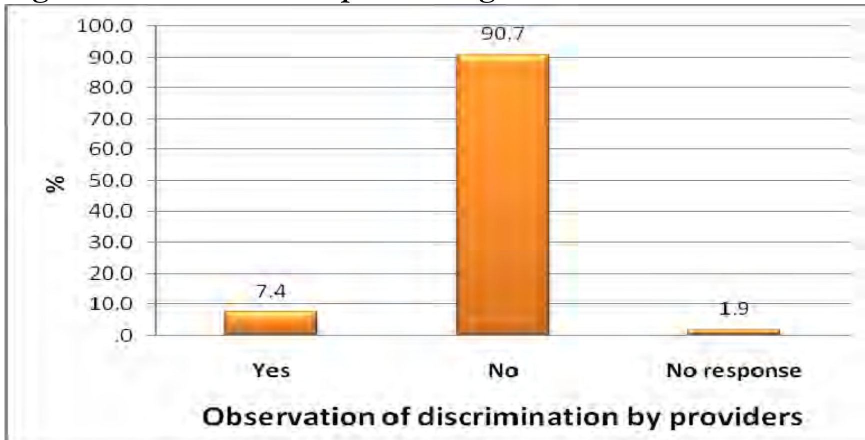
- make sure the patient knows when to return
- end the encounter with a smile

Raising satisfaction must be a goal of every health facility. The TSHIP may have already done so but, if not, please ensure "satisfaction" is measured in the LQAs' surveys.

Evaluation Question 4: To what extent are the project interventions and activities gender sensitive and transformative?

The TSHIP has implemented a number of interventions that are gender sensitive and that could be transformative, such as gender programming, male involvement in Family Planning – Expanded Men as Partners Initiative and the continuous advocacy under the Pre-Service Education Program to increase female enrollment into health training institutions. The fact that only 7.4% of the patients reported feeling they were discriminated against because of gender is a significant achievement that must be sustained (See Figure 3). The TSHIP must continue reinforcing and scaling up these efforts and ensure they are institutionalized and sustained by WDCs and LGAs and the States. Advocacy for gender appropriate restrooms in facilities, particularly in proximity of labor room, is essential and must be undertaken immediately. No woman will feel comfortable and well taken care of in a dirty labor room without a restroom.

Figure 3. Distribution of perceived gender-oriented discrimination in exit interviews.



ISSUES AND CHALLENGES

TSHIP CHALLENGES

Throughout the findings section, we have raised a number of issues and challenges with the intention of helping the TSHIP focus its work and address priorities. In this section, we will summarize and prioritize them to make it easier for the TSHIP to address them.

- Consortium relations. We know the new COP is trying to address consortium relations. These relationships must be openly discussed so reconciliation and proactive collaboration can be ensured. The creation of teams that focus on addressing LGA and HF performance issues, as opposed to having a focus on implementing respective areas of responsibility, should help overcome the perceived issue.
- State staff turnover and changes in political authorities. During the LOP, the Bauchi State has had 6 commissioners of health, and Sokoto State has had three, along with changes in the SPHCDA, whose executive directors have been 6 months on the job in Bauchi, and 3 months in Sokoto. Instead of just accepting this as a fact, the TSHIP must implement a way to mitigate this. An "orientation and briefing packet" (maybe a short video could be included) must be created to rapidly help new officials get oriented to their jobs; to be briefed on what PHC outcomes the State is striving to achieve; to understand the SSHP and the various public programs being implemented and the roles of various stakeholders in them. Nigeria is a very large country with complex health issues to be addressed. It is not realistic anymore to expect political candidates and new political officials to get up to speed on their own with all that is going on in their States. The SPHCDA must have a tool to ensure that happens regularly.
- Severe lack of health manpower and low productivity. The lack is critical. There are just not enough people to take care of the population. And they ones that are there are not performing optimally.
- The TSHIP staff turnover has also delayed activities. The new staff development and salary policy will help with staff retention. We believe that a staff retention and satisfaction program would help too. An anonymous satisfaction survey might also help. The staff must have a way of voicing their concerns without risk of confrontation.
- No clear outcome of project activities. The TSHIP must make an effort to avoid jargon, but use action words when planning and implementing activities. It will not be easy at first, but it will pay off. The use of words such as build capacity, support and provide technical assistance must be challenged by Team members to be changed for outcome words such as "HF staff wash their hands", HF now counsel on FP at every consultation, WDCs mobilized 24% of unvaccinated children this month, occupancy rate of renovated maternities has increased by 10% this month."
- Suspension of activities. There is lack of security in some geographic areas in Bauchi, and there is a need to have a plan to manage it (floods, social unrest,

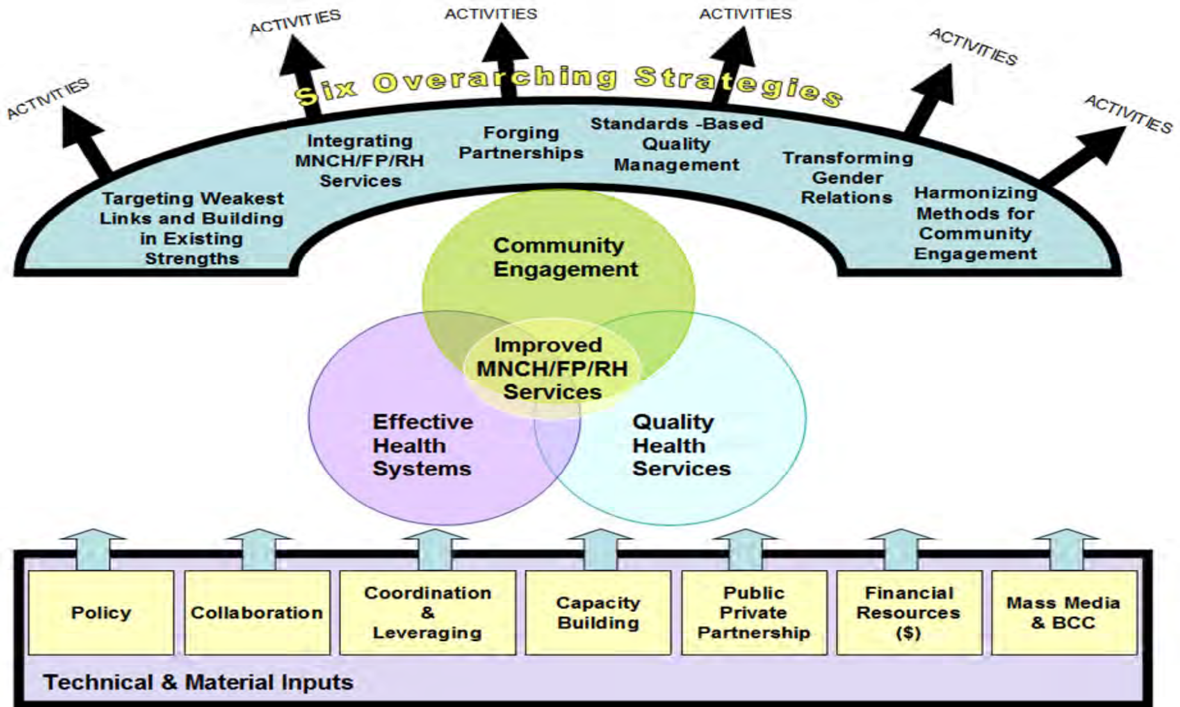
etc.) The TSHIP must have alternative LGAs where they can work when social unrest or floods impede travel to certain areas of the State. Use of mobile phones must be made routine to follow up on progress on performance commitments with the officer in charge in the facilities. For instance, where a trusting relationship has been built, instead of going to the areas, a phone call might be just as effective to help solve a problem, get an update on quality improvement activity or gather information.

- Lack of reliable denominator for HF planning and measuring coverage. Information, not too little and certainly not too much, is essential to manage a health facility. The MTE Team noticed that some facilities have a map of their catchment area and a number for target populations, such as the number of infants. This is an excellent practice that must be made routine. Engaging WDCs, TBAs and CBHV to keep track of the "catchment population" is essential for the HF to plan and measure their coverage rates. Every HF must know the number of pregnant mothers to provide ANC, the number of newborns to be immunized, the number of women in reproductive age that are using FP and whose spouse is involved, etc. For every high impact intervention, there must be a coverage target in every HF, Ward and LGA. This target is based on coverage populations that are collected locally. Census data are not useful for this purpose because people move!
- Ensuring that facilities are adequately equipped with the tools they need to provide quality service for their patients, i.e., working refrigerators with thermometers for vaccines, and mosquito netting for in-patient wards. Being a problem solver is what being a health provider is. Neither the State nor the TSHIP is going to provide the equipment or the nets, or the solution to the many problems HF have. It has to be the staff in these HF that work with local LGA and WDCs to find solutions to their problems.
- Facility inventories are missing in every facility and are probably not customary in the public sector in Nigeria, but they are essential to sustain the correct use and availability of equipment provided to HF and nursing schools. In any case, scissors and small equipment do get broken and must be replaced. A plan to replace small equipment, at least at about 10% per year, must be included in each LGA costed plan.
- Facility pharmacies need to be a part of SBMR. There was many health facilities that did not have a minimum stock level of essential medicines and commodities required. Having a functioning pharmacy to manage all the supplies is essential. Each pharmacy must have an inventory, keep a stock card for each product and have a lock so only authorized staff can enter.
- Facilities lack work schedules that maximizes the time of existing staff to provide care in the facility and outreach. With the increasing number of CBHV, it will be essential that the HF staff to oversee their work, keep track of the numbers of pregnant mothers they identify and provide OJT and problem-solving support.
- TSHIP and DELIVER need to implement together a number of activities to strengthen the State's supply of vaccines, selected essential medicines and medical commodities, and allow the State ministry, as well as the LGAs, to move to the forefront and take ownership. For example, the 2013 budget

figure for the procurement of vaccines and essential medicines must be advocated for and used by the SPHCDA. The TSHIP can help the agency with their advocacy and ensure they have the information to improve the supply year by year. The TSHIP must improve how medicines are used in each facility. Each facility must have a pharmacy that keeps track of consumption rates for each product, and can provide information for quantification purposes. We suggest that this start in at least 10% of the project facilities in 2013.

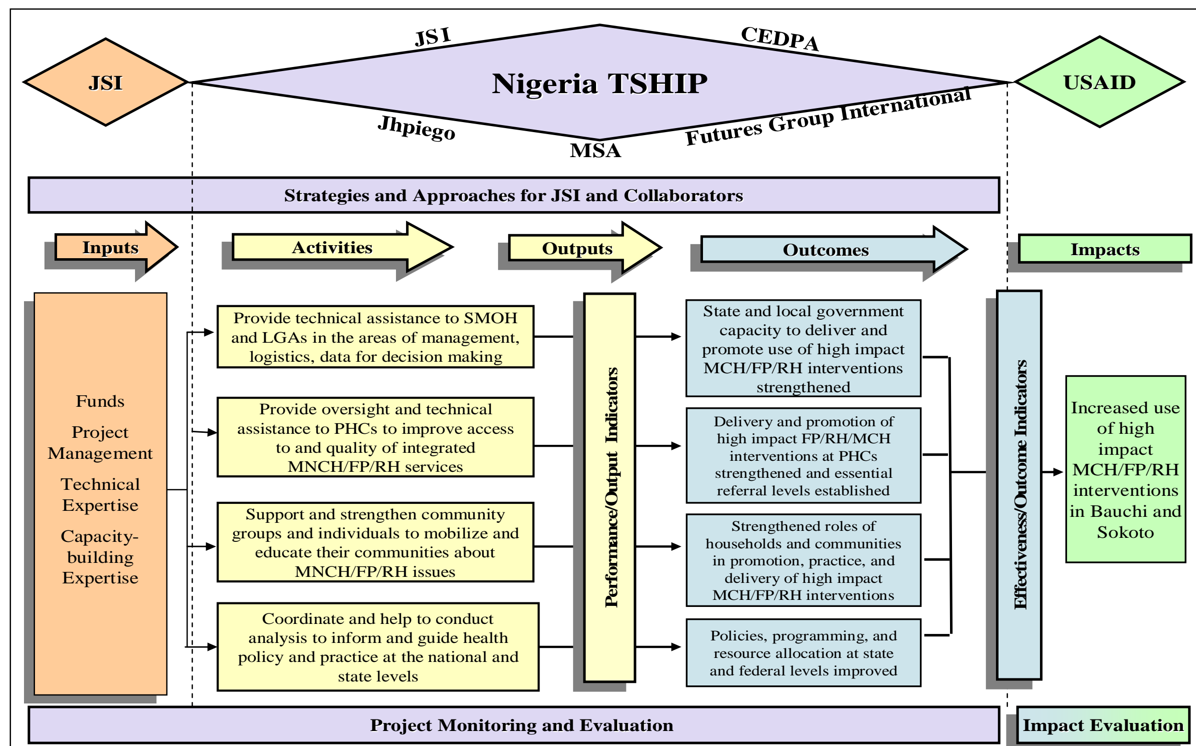
- Coordination of all programs in the State is the main challenge of States. For example, the SPHDA must be able to gather all donors and know what their contribution will be in 2013. It should be easier for the TSHIP than for WHO, because TSHIP's mandate is to strengthen the quality and delivery of high impact interventions that the Agency must manage. This coordination will model transparency and accountability, which are essential to sustain the TSHIPs results.
- The TSHIP has a tri-focus strategy (see chart below). Keeping balance on the each of the foci: community, systems and facilities is the TSHIP's challenge.

Figure 5. TSHIPs tri-focus strategies.



- The results and M&E framework for the TSHIP must be updated and checked to ensure that it is aligned with current needs. The indicators in the RF are the floor, not the ceiling. The TSHIP must differentiate between reporting indicators that are required by USAID, and project management indicators that measure how well the project is on track. Otherwise, it is like driving at night without the lights on. The M&E Framework must include key activities that are aligned with outputs and outcomes. The outcomes listed now are the sub-objectives and the impact is an outcome.

Figure 6. Current M&E Framework (Source: JSI Application)



The text box below is a quote from the JSI application in regards to the improvement of the referral system. The TSHIP is working to create an effective emergency obstetric care referral network. As seen on the map, the green dots are renovated PHC and the red dots are referral facilities. The quality of care and the timely referral of mothers will save lives. It is essential that the TSHIP include this activity in the PY4 work plan and continue strengthening the referral system. The MTE Team suggests that clear outcomes be defined and achieved in PY4.

Box 1. Improvement to the Referral System (source, JSI application)

"Creative approaches to enhanced communication include leveraging support from mobile phone companies (e.g. MTN, Zain, Glo) to donate phones and recharge cards for communication within and between HFs and communities (especially to women without interference by men), and providing small grants for use of appropriate technology.

TSHIP will assist LGAs, LACs and WDCs/VDCs to use appropriate modern technology to coordinate services by building two-way patient referral networks. CHEWs will use text messaging (SMS) and talking books to augment more traditional ways of promoting health and educating the community about services that are available.

Talking books will be used to collect stories, qualitative data, or other information from communities that CHEWs can then share with each other and other communities. "Talking Books" are designed specifically for use in very rural, very resource-limited environments and by low-literate users, and are low-cost enough to go to scale. (Application p 27)"

Photo of map of renovated facilities in Sokoto State.

- Immediate attention to RI to define a coverage target by LGA and facility are essential to achieve impact. Below is a text box, also taken from the JSI application, that shows that it is possible for the LGAs to strengthen the cold chain and the RI program. Sustaining that achievement is the challenge. Institutionalization of accountability networks, i.e.,who is responsible for what, are required, and the creation of job descriptions and work routines are essential for the system to continue without outsider influence. In a nutshell, someone needs to be responsible for making RI work at each level, and it must be someone's job to ensure they do.

Box 2. Routine Immunization system at the time TSHIP started.

"Over the last two years in both Bauchi and Sokoto States, **IMMUNIZATION basics** provided initial limited logistics assistance (maximum of 3-4 months per LGA), while simultaneously advocating for and working with States and LGAs (including LGA Chairmen and their Health Councilors) to develop their own monthly funds to cover all activities relating to immunization and including supervision. During planning sessions involving an integrated PHC supervisory team, both States and LGAs realized that they were not using their scarce resources well—that they were duplicating logistics efforts every month as they delivered supplies to health facilities on one (or more) trip(s), and then conducted supervision visits on another trip. **As of May 2009, both States as well as 14/20 LGAs in Bauchi and 22/23 LGAs in Sokoto were providing their own logistics support to carry out supervision visits.** All of this was accomplished in the context of a highly monetized polio environment. TSHIP will build on these lessons and achievements, and continue to inject into the existing system managerial and technical elements that will further bolster functionality at all levels. (Application p 26)

tion may have blurred a bit. It is essential that the TSHIP apply this understanding to all its activities.

Box 3. TSHIP's understanding of delivering an integrated number of interventions.

Evidence suggests that well designed and executed integrated approaches **increase utilization of all PHC services**. To assess whether integrated approaches are working, TSHIP will gather and track information on two key questions: (**1) Did the client (parent, care giver) receive the service that he/she came to the facility for?** and (**2) What additional services (information, counseling, services) were dispensed at the same visit? Were these complementary to the services the client originally came for?**

Successfully rolling out a strategy of integrated health services necessitates recognition of the **"continuum of care"** as highlighted in the IMNCH strategy. As a core principle in the IMNCHS, **a continuum of care of care approach requires that the provider must look at the needs of the client or family as a package—with health care needs intrinsically linked.** Treating a child's acute fever, for example, is important and life saving, but the care is not complete unless immunization and vitamin A coverage are verified, the parents are counseled on child spacing, etc. This approach **mandates PHC service sites to build the capacity of health workers to provide integrated care as well as provide referrals to maternity centers or other specialized sites and secondary or tertiary hospitals." (Application p 15)**

2. **% of total funding for the response from Nigerian Sources**

And the Global Health Initiative (GHI) strategy for Nigeria has two main short-term outcomes:

1. Increased access to, demand for, and quality of health services
2. Increased stewardship of the health sector

And the following intermediate results:

1. Improved human resources for health
2. Improved delivery of highest impact interventions at the PHC level
3. Strengthen leadership, management, governance and accountability
4. Allocation and production of health human resources

The TSHIP and USAID need to harmonize all this into one PMP and M&E frame work.

- The Risk Management Plan needs to be reworded to ensure effective results. Below is the PY4 risk management table.

Table 2: Program Risks and Mitigation Strategies **Risk**	**Issues (Probability of Occurrence)**	**Mitigation Strategy**	**MTE observation**
Persisting, disruptive insecurity in the supply of Commodities (e.g. Zincfant, Chlorhexidine 4%, vaccines, Misoprostol, etc)	Predictable availability of essential MNCH commodities is far from certain. Key deliverables will not be met if supplies remain persistently deficient. (80%).	Work with Ministry of Local Government in Sokoto and Bauchi Primary Health Care Agency, to promote more efficient, and evidence-based forecasting. Undertake multilevel and high level advocacy throughout States, USAID and FMOH. Promote role of Private Medicine Vendors as key actors in the essential medicines value chain among other PPP approaches.	Set a list of priority medicines that must not run out ever: cotrimoxazole for pneumonia, ACT for malaria, ORS and Zinc for diarrhea, lignocaine for episiotomies, Vitamin K for newborns, vaccines, etc. This list must be part of the State 2013 budget. Improve HF pharmacies to be able to conduct the first quantification estimate based on real consumption information and not historical data in 2013.
Delays, non-acceptance of Community-Based Volunteer(CBHV) Scheme for delivery of essential MNCH to communities	Given that 90% or more of birth deliveries in both States occur at home, a CBHV scheme is indispensable to save lives. Sokoto and Bauchi have accepted CBHV/CDI in principle. Neither State is yet to confirm that they will assume the financial obligations of the program in the short to medium term. (65%).	Work closely with Ministry of Local Government in Sokoto (to secure buy-in) and Bauchi MOH and Primary Health Care Agency (to undo fragmentation, and secure buy-in on a common approach).	Work with States to create a State policy on community health providers and volunteers. There is a need to have a vision of community-based health care, whatit will look like and how it will work Statewide. We suggest the CBHV program be started in 20% of the communities in 2013 and monitored properly. Linkages with HF must be created for OJT, reporting and supervision of volunteers. Liability for volunteer errors must be considered especially in the distribution of miso-

Table 2: Program Risks and Mitigation Strategies **Risk**	**Issues (Probability of Occurrence)**	**Mitigation Strategy**	**MTE observation**
			prostol.
Delays, under-, non-financing of critical MNCH/FP/RH interventions at LGA and State level.	Under-use of evidence for budgeting coupled with delay or non-release of funds for MNCH/FP/RH interventions. At grave risk of not sufficiently allocation for and timely procurement of essential MNCH commodities (80%).	Work with both states (LGA, MOH, MOLG, States' House of Assembly) on the use of Lives Saved tool and other evidence to guide planning. Undertake advocacy on effective budgeting and financing, and actively work to increase use of evidence, use instruments of transparency and participation to align budget and release with key interventions. Explore basket funding to increase allocation efficiency.	LiST is an excellent advocacy tool. It must be used to also account for lives actually saved. LiST can also be used in donor coordination meetings to promote a "functional basket" approach to activities. A budgetary basket may be difficult at this time until more accountability systems are in place.
Pervasively weak, and underutilized coordination mechanisms in health sector	Extent of adverse impact of fragmentation on health system efficacy not-well understood. Information system and procurement systems in Bauchi reveal massive serious fragmentation, which needs to be addressed. Government will to coordinate growing. Donors' will to be coordinated is less evident. As a consequence, accountability systems for results are fragmented (90%).	Weak management capacity at State and LGA level due to lack of availability of standard cadre of managers leading the health team.	Yes, we agree it is weak, that is what the TSHIP must strengthen and improve the capacity of managers starting at the SPHCDA and LGA levels. Online training and OJT are essential so as not to take staff from their jobs for training. Management is learned by doing. Provision of e-books such as the "the 7 habits of highly effective people" must be considered.

Table 2: Program Risks and Mitigation Strategies **Risk**	**Issues (Probability of Occurrence)**	**Mitigation Strategy**	**MTE observation**
Insecurity leading to disruption of technical support to States	Diffuse, sporadic incidents may occur in both States, which restrict movement of personnel of State, LGA and TSHIP staff. In Bauchi, long running conflicts in Tafawa Balewa and Bogoro LGAs are likely to continue to reduce the pace of work there, especially data collection as assurance. Securing STTA to work in both States at times of generalized crises has become more difficult (70% in Bauchi and 40% in Sokoto).	Maintain continuous vigilance to track events. Increase the use of indigenous civil society organization. Continually update USAID of conditions that may compromise TSHIP's ability to offer effective support when they arise.	When these activities affect services, the TSHIP must transfer the focus of its activities to LGAs where the conditions are favorable. Improving the coverage and quality of services such as health and education are peace-building tools.
Deficient availability, and inefficient allocation and production of health human resources	Both States now recognized severity of shortage. Neither States have HR information system to track progress and act proactively. Long term view on tackling critical shortages on track in Bauchi; and Sokoto needs to do more on the cadre of community midwives to increase chances of staff retention (90%).	Work with both States to accumulate and use evidence to analyze and advocate for optimum policy choices.	The THSIP must assist the States to develop a simple policy to get started in 2013 to manage existing staff properly. No new staff will work effectively and efficiently if the current staff are not productive and managed well. Optimum is sometimes the enemy of good enough.

RECOMMENDATIONS AND FUTURE DIRECTIONS

A number of recommendations have been made in the course of presenting the findings to ensure that not only problems were reported, but also possible solutions. It was not the intention of the MTE Team to find fault, but to help the TSHIP Team see all the opportunities to make a bigger impact that the MTE Team saw in the course of this evaluation. We know it is hard to see solutions when one is in the middle of a situation, and an outsider's perspective always helps to see the forest AND the trees. We encourage the TSHIP Team to read the MTE report as a Team several times, and select the photos and the actions they are going to act upon next month as well as next year. After the PY4 work plan, the PMP and performance targets are revised, we suggest that monthly results targets be set by dividing the annual targets by 12. Then, weekly planning and prioritization will be essential to ensure that everyone on the Team is working on those activities that will deliver the results of each sub-objective, and ultimately a significant number of lives will be saved in each State. Focus on results is the main recommendation, not processes.

TO THE TSHIP

Action taken by the Health Staff is what is going to make a difference. The TSHIP must model taking action. Nobody is going to do it, if they do not do it first! A basic rule in management is to "never ask someone to do what you are not prepared to do yourself." We recommend that the TSHIP announce to all stakeholders that it is entering a new phase in its work of strengthening the State, the PHC services and the community. This will be marked by focus on results, quality at all times and coverage.

In the executive summary, we presented five main strategic recommendations for the TSHIP Team:

1. Revise work plan to include outcomes by sub-objectives that builds on sustaining prior years' achievements
2. Implement jointly with State and LGA authorities so they can "mirror" effective management and own interventions
3. Improve HF organization and performance
4. Set performance targets for each Ward and LGA
5. Improve data collection and use

Below we have detailed each main recommendation under each strategy:

1. **Revise Work Plan for PY4, Results and M&E Frameworks.**
    a. Focus on results of each sub-objective. The PY4 must be organized by sub-objective. In short, everything the TSHIP does must directly strengthen the State, the LGA, the PHC facilities and referral system, or the community-based services, and the result must be measurable. This means that the TSHIP must be able to anticipate the following in the PY4:
        1. **What does a stronger State do now as the result of TSHIP that was not able to do before?**
        2. **What does a stronger LGA do now as the result of TSHIP that was not able to do before?**

3. What does a stronger HF do now as the result of TSHIP that was not able to do before?
4. What does a stronger Referral Facility do now as the result of TSHIP that was not able to do before?
5. What does a stronger WDC do now as the result of TSHIP that was not able to do before?

b. Governance is the main foundations for sustaining the improvements. As the lack of sustainability of previous USG investments has shown, without sound governance that institutionalizes new systems, things will revert to the way they were before the project, or worsen! It is essential for the Focus State Strategy and the sustainability of the TSHIP's results that the PY4 include activities with LEAD or NEI projects in work plan to address State, LGA and Ward governance.

c. The MTE Team recommends asking the following questions to ensure each activity in the PY4 work plan is the most effective and efficient way to achieving the 4 sub-objectives.

Check for focus on Results

- **To which results does this activity contribute to and how?**
- **Is the State, LGA, ward, facility, health provider in the forefront?**
- **Did it work? Will it last? How can I ensure it will?**

Check for quality in health care delivery

- **What aspect of quality of care does this activity contribute to?**
- **How will we measure if quality has improved? What else can be done to ensure it does?**
- **Will it last? How can I ensure it will? Check for Coverage**
- **Have we set targets for each LGA, facility and community?**
- **What are they doing to achieve those targets?**
- **How can we help them measure if they achieved the targets?**
- **Will it last? How can I ensure it will? Check for Language**
- **Does the wording convey action? (avoid vague language)**
- **Is the facility getting "it" done, that is solving problems, or are they bogged down by unsolved problems?**

d. Revise the Results Framework to include main activities that need to be repeated in each LGA and M&E Framework to ensure indicators measure achieving and sustaining results. No one can manage something they cannot measure. The current indicators in the framework are the "floor" not the "ceiling." The project must have project management indictors to ensure the activities are achieving the desired results and compare progress in each State.

e. Promote the role of the State: logo on everything and introduce the TSHIP as working on behalf of the respective State as part of the SSHP. Risk management. The TSHIP must reconsider its risk management approach. We have made a number of suggestions for the project to consider. Please refer to the issues section above for specific recommendations to be considered in the PY 4 work plan.

f. Revise Result Framework to change process indicators and include outcomes

g. Work with the NMEMS to improve DQA reports and regular monthly progress monitoring and quarterly project performance reviews
h. Revise staff's job descriptions to add results linked to project results

2. Implement activities jointly with State and LGAs.
    a. Prioritize activities in the State/LGAs health development plans
    b. Rank LGAs and PHCs to identify performance strengths and weaknesses and have the TSHIP staff develop activities to support them to get up to par. Indicators can include RI coverage, ANC and supervised delivery coverage, and medicine shortages. The ranking alone will stimulate healthy competition among LGAs.
    c. Set coverage targets to increase by at least 10% per year
    d. Set LGA and Ward targets to increase Routine Immunization by at least 10% per year and assist measure and report results.
    e. Joint supervision with State using the TSHIP vehicles. The excuse that the State does not have vehicles to supervise is not true. The TSHIP must coordinate activities with State. In fact, the vehicles may be disposed to be used by the State. PY4 is a good time to start learning how to use and maintain a pool of vehicles.
    f. Support the State to secure funding for recurrent expenditures such as essential drugs and vaccines, in-service training, supportive supervision (to pay for petrol and maintenance of vehicles) in 2014
    g. There should be quarterly participatory mapping of resources and target populations within the catchment areas of every secondary HF to ensure planning and service expansion in at least 10% of the facilities per year. In this way, in 10 years or less, all facilities will have been improved to function up to standards. At this time, it is not well known what facilities are open and functioning, staffed, and used fully by their respective communities. Catchment area maps must be developed for each facility so each Village Development Committee (VDC) and WDC knows which facilities must serve their communities. Shortage of personnel – After improving the performance and productivity of current staff, the TSHIP must determine which facilities need what health providers and then develop a simple staffing plan to help the State and the SPHCDA advocate to the Government so that the Government will employ more personnel and training institutions to produce more health providers: nurses, nurse aides, CHOs, CHEWS, lab technicians, medical record technicians, etc., including new cadres of professionals.
    h. Establish a system for States to monitor and rank facility and LGA performance monthly and plan next month's activities
    i. Ensure States coordinate with donors and monitor their performance, e.g., use sentinel sites to measure health status
    j. Promote and measure ownership: Start transferring products, tools and strategies to States, e.g., Website, newsletter, all must be the State's with TSHIP's support

3. Improve HF organization and performance
    a. Cold chain equipment must be included in the facility's inventory and a replacement plan developed for at least 10% of the facilities in each LGA.
    b. Records and information use must be simplified at the facility level. Include record keeping in the facility's schedule so time spent on patient care and recording is monitored. Registers must be checked for completion and accuracy, numbers added up and information recorded daily, weekly and monthly.
    c. Reinforce three basics: hygiene, facility patient flow, and patient-provider consultation process and communication.
    d. Emergency trolley and equipment must be accounted for in the facilities' inventories and nursing and midwifery schools. Copies of inventories must be shared with at least two other stakeholders to ensure transparency and accountability. Inventory of HF equipment and supplies must be done in PY4 and a copy to the WDC and LGA to check twice a year.
    e. A functioning pharmacy must be ensured in at least 10% of State facilities per year. A pharmacy management manual with simple SOPs must be available along with stock cards and inventory forms in each facility. Pill counters and spoons must be available and locks placed on the pharmacy door in each facility.
    f. Labor rooms standards must be observed, solar lamps must be available. No more deliveries by torch.
    g. Set minimum performance standards: Create a chart to account for all hours in the work day, week and staff available, and empower the LGA and WDC to monitor and ensure staff apply it.
    h. Work with States and UNICEF to obtain spring scales to weight children, and use MUAC to monitor growth.
    i. Human resource management: HF production, productivity, distribution, handover and appropriate delegation and supervision must be simplified and enforced with proper job descriptions.
    j. Posters and visual aids, properly placed and used correctly. Bulletin boards must be placed for announcements and areas in each facility must be well defined, including the area for health talks.
    k. Develop model facilities and create a photo bank for supervision and training. Having a gold standard and being able to "see" what a good practice looks like is essential! Otherwise, health providers do not have anything to compare with.
    l. PHC health facilities in the catchment area of a secondary, essential referral center must be formally linked with one another, as well as with the WDC emergency transport scheme for that area. They should have monthly meetings and review facility statistics and use these to take action when necessary. This can be supported by the TSHIP zonal staff and backed up by TSHIP MNH Advisor/State Hospitals Management Board/State Primary Health Care Development Agency
    m. The supply, inventory, maintenance and replenishment system of essential obstetric drugs and equipment to secondary HFs must be strengthened with supportive supervision by technically competent staff on a regular basis. This can be supported by the TSHIP zonal staff and backed up by the TSHIP MNH Advisor/State Hospitals Management Board/State Primary Health

Care Development Agency. The community national health insurance scheme- NHIS/MDGs can be collaboratively explored as a mechanism for supporting drug revolving funds for this system for long term sustainability.

4. Set performance targets for each Ward and LGA
    a. A micro-grants program must be started to rapidly ensure the initiation of activities. Not for recurrent costs, but for starting new activities. For instance, a micro-grant can be given to the WDCs to do the first population coverage count. From then on, the WDC should maintain the population records. When a vital events registry is in place this may not be necessary, but for now, that is the only way to ensure coverage.
    b. Assist WDCs to do local identification of catchment population for facility management to monitor RI, ANC and LLIN use.

5. Improve data collection and use
    a. The maternity registers or admission register should be re-designed to include referral details, or a separate referral register be designed for recording referral cases and their outcomes. This can be supported by the TSHIP zonal staff and backed up by the TSHIP MNH Advisor/State Hospitals Management Board/State Primary Health Care Development Agency.
    b. There should be institutionalization of facility maternal death audits in health facilities that include participation of the WDCs and 100 women group members.. This can be supported by TSHIP zonal staff and backed up by TSHIP MNH Advisor/State Hospitals Management Board/State Primary Health Care Development Agency.
    c. The personnel at all levels (HF, LGA and SMOH) should be accompanied as they use data for decision making, planning and for forecasting. Operational decisions (short term decisions) should be taken at the facility level to help address issues before they get out of hand. Also, at the LGA level the M&E officers should be able to analyze and interpret basic service data collected to assist PHDA in planning budgets to respond to emerging issues at the HF level.
    d. The TSHIP should build on the training the project has carried out over the past two years. Expectations of what a HF must do now must be conveyed clearly and in written form through job descriptions and personal performance plans that are linked to targets. All health providers should be able to complete correctly the HMIS tools. The TSHIP must accompany staff so they use of the data, as well the proper ways of keeping the tools, at the three levels (HF, LGA and SMOH). Also, at the LGA and SMOH, a training system must be institutionalized in the State's training organizations so that the relevant personnel can be trained on a regular basis, since new staff are always coming in.
    e. Flow of data – the design of the project is such that data flow from the community to HF, LGA and to SMOH and the TSHIP offices. However, the process is carried out manually, which makes the process highly inefficient given the size of the States. Computerization of medical records and the information system must be considered at least in sample facilities where in-

formation is being used properly. Otherwise, garbage in and garbage out will impede planning. Secondly, there is no feedback mechanism, and information now flows in one direction. It is time that reports start to flow back to LGAs, wards and facilities to be the basis of discussions, advocacy and planning. The project should also ensure that the SPHCDA managers provide the HF with feedback of the service data collected.

f. Modernization of the health system. In the Sokoto State, laptops are provided at the LGA level. This should be extended to Bauchi State. In both States desktops, along with a clear IT policy and anti-virus programs, should be made available at the HF level, and the M&E personnel at that level should be trained on the use of the computer. HF computers must have internet modems to facilitate flow of service data to the LGA by internet and access to state of the art medical and pharmaceutical information. It is not the TSHIP's job to provide the equipment or technology, but provide a "new vision" of what a health facility and health district must look like in the 21st century.
g. Use cumulative State Level Targets and Outcome Indicators based on catchment population. The current non-cumulative indicators do not allow USAID or the project to see the trend in the improvement in the expansion of the high impact interventions. The following additional project management indicators are proposed:
    i. # of facilities that deliver child health interventions at an acceptable quality level (start with renovated ones) to catchment population
    ii. # of facilities that provide malaria diagnosis and treatment according to standards
    iii. # of facilities that provide delivery and newborn care according to standards
    iv. #of facilities that report minimum accurate information and use selected indicators
    v. # of facilities with a functioning pharmacy with minimum stock and updated inventory

TO MEMS II

1. MEMS II must conduct training and assist projects to improve DQA results
2. MEMS II must conduct quarterly monitoring meetings to review progress, give feedback and help the TSHIP set new targets

TO USAID/NIGERIA

1. **Extension for the TSHIP to expand coverage of target interventions and institutionalize them into State programs**
2. Coordinate with DELIVER to: establish a number of facilities that have a functioning pharmacy with a minimum set of essential medicines and supplies (If it is only 10, help focus on sustaining those 10.)
3. Coordinate with DELIVER and the TSHIP to establish mechanism for LGAs to supervise revolving drug funds

4. Focus on governance and partnership with SMOH and SPHCDA and other UGS partners; particularly LEAD to lead the focus State governance strategy
5. Ensure linkages of CB providers with FB providers for support and monitoring purposes, one person must be responsible
6. NEI to include hand washing and health education in the curriculum
7. Ensure work plans include action language that is linked to delivering results
8. Fast track the micro and small grants program to expand service delivery and coverage by delegating authority to the COP to approve grants for up to $10,000 without Mission approval.
9. The TSHIP is the Mission's flagship project. Therefore, there is a need, with MEMS II assistance, to harmonize GHI, Mission and THIP M&E framework to ensure alignment.
10. To ensure the maximum impact of the Focus State Strategy, the MTE Team recommends that USAID/Nigeria and MEMS II have monthly discussions about progress with the TSHIP's M&E staff, and quarterly coordination meetings with senior TSHIP project staff. The purpose would be for the projects to report on progress made on the project's previous quarter's achievements, and to coordinate, collaborate and develop a timetable for the next quarter's activities in order to maximize impact, and not overburden the LGA authorities and community structures.

ANNEX 1. TABLES

Table 1.0 : The TSHIP Performance on Project Indicators

INDICATOR	YEAR 1			YEAR 2			YEAR 3		
	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED
Program Objective: Increased Use of High Impact Interventions									
1 Number of children Immunized with DPT3	200,000	194,260	97 0	194,260	230,602	76 3	169,000	55,547	32 9
2 Number of deliveries with a skilled birth attendant in USG assisted facilities (IIP1 6 4	6,350	19,905	100 0	19,905	67,427	100 0	78,000	46,664	59 8
3 Couple years of protection (CYP) in USG-supported programs (IIP 1 7 1)	1,800	4,250	100	4,259	14,003	100 0	24,000	10,732	44 7
4 Modern contraceptive rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sub-Objective 1: State and local government capacity to deliver and promote use of high impact MCH/FP/RH interventions strengthened									
5 Number of people trained in FP/RH with USG funds (male and female)	425	530	100	530	1,881	74 5	4,845	624	13 0
6 Number of people trained in malaria prevention or treatment (male and female)	425	663	100	663	1,130	90 4	1,940	570	29 0
6c: Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTS) or microscopy) with USG funds	425	449	100	N/A	701	N/A	N/A	N/A	N/A
7 Number of people trained in maternal/newborn health through USG-assisted programs (male and female)	425	709	100	445	1,098	100 0	2,225	31	4 0
8 Number of people trained in child health and nutrition (male and female)	425	N/A	100	709	N/A	90 0	1,510	93	13 0
9 Percentage of HMIS indicators reported on in a timely manor	N/A	N/A	N/A	N/A	N/A	N/A	N/A	189	N/A
10 Number of health facilities rehabilitated	80	83	100	83	644	100	395	557	100
Sub-Objective 2: Delivery and promotion of high impact FP/RH/MCH interventions at PHCs strengthened and essential referral levels established									

INDICATOR	YEAR 1			YEAR 2			YEAR 3		
	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED
11 Number of counseling visits for FP/RH as a result of USG assistance (male and female)	6,000	22,829	100	22,829	82,561	100 0	54,228	54,228	100
12 Number of USG-assisted service delivery points providing FP or counseling services	250	479	100	479	756	100 0	1,051	1,051	100 0
13 Number of ANC visits by skilled providers from USG-assisted facilities	72,00	148,841	100	148,641	516,109	100 0	275,371	275,371	10059 0
14 Number of pregnant women who attend at least one antenatal care (ANC1) visit	16,000	49,371	100	49,371	198,202	100 0	212,000	120,260	57 0
15 Number of women receiving active management of third stage of labor through USG-supported programs	N/A	4,238	N/A	4,238	19,673	100 0	53,000	17,092	32 0
16 Number of newborns receiving essential newborn care through in USG-supported programs	3,810	8,292	100	8,292	23,014	100 0	17,252	17,252	10033 0
17 Number of children under 5 years-of-age who received vitamin A through USG-supported programs	200,000	1,659,508	100	1,659,508	3,184,617	100 0	1,321,027	1,321,027	100 0
18 Number of cases of childhood diarrhea treated in USAID programs	15,000	49,656	100	49,656	123,462	Actual not available	38,708	32	14 0
19 Rate of non-polio AFP cases	N/A	N/A	N/A	8 5	N/A	N/A	N/A	N/A	N/A
20 Number of wild polio virus cases in USG assisted States	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21 Number of women who receive IPT in prenatal care	14,785	68,487	100	68,529	175,174	100 0	82,733	82,733	10055 0
22 Number of cases of malaria in children treated with ACT	11,672	114,671	100	114,671	130,364	61 5	76,416	76,416	10080 0
23 Number of ITNs distributed or sold with USG funds	3,100,000	2,793,303	90	2,793,303	175	14 0	N/A	N/A	N/A
Sub-Objective 3: Strengthened roles of households and communities in promotion, practice, and delivery of high impact MCH/FP/RH interventions									
24 Proportion of ward development committees (WDCs) that are active during the reporting quarter	N/A	N/A	N/A	567	N/A	55 4	323	197	60 0

INDICATOR	YEAR 1			YEAR 2			YEAR 3		
	TARGET	**ACTUAL**	**% OF TARGET ACHIEVED**	**TARGET**	**ACTUAL**	**% OF TARGET ACHIEVED**	**TARGET**	**ACTUAL**	**% OF TARGET ACHIEVED**
25 Percentage of people who report attending health services due to exposure to community awareness and education activities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sub-Objective 4: Policies, programming, and resource allocation at State and federal levels improved									
26 Number of policies that are developed or adapted to support improved RH/FP/MCH services	7	10	100 0	10	28	100 0	29	29	100 0
27 Number of local organizations provided with technical assistance on institutional capacity-building to leverage additional resources for RH/FP/MCH information and services	10	86	100 0	86	134	100	88	88	100 0

Table 2.0: The TSHIP Performance on Primary Health Care Facility Checklist

Questions	Bauchi		Sokoto	
	Frequency (Yes)	Percentage	Frequency (Yes)	Percentage
1 **Is a staff member always available at night for official call? (n=16)**	7	43 8	5	31 3
2 **Is staff housing provided by the local government authority? (n=18)**	1	5 6	4	22 2
3 **Do you think the renovation of the HF improved the quality of care? (n=18)**	7	38 9	7	38 9
4 **Main source of water for HF (no of facilities?)** a Tank water b Well c River/stream/spring d Piped water e Bore water f Other rainwater collection g Other stored water h Other i No water source **(multiple responses possible)**	 0 2 1 2 2 0 1 0 2	 0 11 1 5 6 11 1 11 1 0 5 6 0 11 1	 2 1 0 1 5 1 0 1 0	 11 1 5 6 0 5 6 27 8 5 6 0 5 6 0
5 **Source of power for the health center? (Number of facilities/)** a National Electricity grid b Generator c Kerosene d No energy source **(multiple responses possible)**	 9 4 0 0	 50 22 2 0 0	 5 3 1 2	 27 8 16 7 5 6 11 1
6 **Is there a place for counseling? (n=18)**	6	33 3	7	38 9
7 **Is the examination area clean? (n=18)**	6	33 3	2	11 1
8 **Is there an adequate source of light in the examination area?**	8	44 4	2	11 1
9 **Where is most equipment stored?** a In a locked cabinet/cupboard b In an unlocked shelf c Other (n=17)	 4 2 2	 22 2 11 1 11 1	 1 2 6	 5 6 11 1 33 3
10 **TYPE OF EQUIPMENT/SUPPLIES** a. Air Ways Infant (number of facitities) b. Airway Resuscitation c. Ambu bag (resuscitation bag) d. Fridge/Freezer Electric Kerosene or Solar e. Gloves Surgeon (Different Size) f. Vaccine carrier g. Mama kits h. LLINs	 numbers3 4 1 2 3 7 5 1	 Not 16 7 22 2 5 6 11 1 16 7 38 9 27 8 5 6	 aligned 0 1 1 3 2 1 4 0	 0 5 6 5 6 16 7 11 1 5 6 22 2 0
11 **Drugs &Vaccines**				
Cotrimaxazole tablets 80mg (n=14)	6	42 9	2	14 3
Coartem (n=15)	3	20	7	46 7
Diazepam injection – for ivi, rectal use (n-14)	4	28 6	1	7 1
Ferrous sulphate/iron (n=14)	8	57 1	5	35 7
Intravenous fluids (n=14)	5	35 7	4	28 6
MgSO4 (n=14)	3	21 4	2	14 3
Oxytocin (Pitocin, syntocinon) (n=12)	7	58 3	1	8 3
Sulphadoxine with pyrimethamine (n=14)	7	50	3	21 4
Vitamin K injection 1 mg in 0 5 or 1 ml (n=13)	4	30 8	1	7 7

Questions	Bauchi		Sokoto	
	Frequency (Yes)	Percentage	Frequency (Yes)	Percentage
BCG (n=13)	5	38 5	3	23 1
DPT (n=14)	3	21 4	5	35 7
Hepatitis B(n=14)	6	42 9	5	35 7
Measles (n=14)	6	42 9	5	35 7
Polio (n=13)	7	53 9	4	30 8
Tetanus toxoid (n=14)	0	0	5	35 7
Yellow Fever Vaccine (n=14)	5	35 7	5	35 7
12 **How often does the facility get fresh supplies of drugs? (n=17)** a Every month b Every week c Every quarter d Cannot remember e Don't know	 2 2 2 2 1	 11 8 11 8 11 8 11 8 5 9	 0 4 1 0 2	 0 23 5 5 9 0 11 8
13 **How often does the facility get fresh supplies of vaccines? (n=14)** a Every month b Every week c Every quarter d Cannot remember e Don't know	 7 1 0 1 0	 50 7 1 0 7 1 0	 2 2 0 0 1	 14 3 14 3 0 0 7 1
14 **Stock outs? (n=17)** a Every month b Every week c Every quarter d Cannot remember e Don't know	 4 1 1 2 1	 23 5 5 9 5 9 11 8 5 9	 1 1 0 4 1	 5 9 5 9 0 23 5 5 9
15 **On hand inventory checked (n=15)**	4	26 7	5	33 3
16 **Patient counseling (n=16)**	9	56 3	6	37 5
17 **Are consumables like disinfectant, cotton wool, gauze, soap and gloves available? (n=17)**	8	47 1	5	29 4
18 **Have you had to interrupt services in the last 6 months? (n=17)**	1	5 9	0	0
19 **Were community outreach activities carried out by the health centre in the past 3 months? (n=18)**	7	38 9	8	44 4
20 **Was a "health talk" (group lecture or discussion with clients) held today? (n=17)**	6	35 3	6	35 3
21 **Records (n=17)** a Medical Records b Immunization record c ANC Register d Delivery Register e Child register	 9 9 9 9 8	 52 9 52 9 52 9 52 9 47 1	 2 0 1 2 4	 11 8 0 5 9 11 8 23 5

Table 3.0: PERFORMANCES OF THE TSHIP BAUCHI ON PROJECT INDICATORS (YEAR1 - YEAR3)

INDICATOR	YEAR 1			YEAR 2			YEAR 3 (Q1-Q3)		
	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED
Program Objective: Increased Use of High Impact Interventions									

INDICATOR	YEAR 1			YEAR 2			YEAR 3 (Q1-Q3)		
	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED
1 Number of children Immunized with DPT3	130,000	88,634	68%	169,000	107,664	64%	169,000	55,547	33%
2 Number of deliveries with a skilled birth attendant in USG assisted facilities (IIP1 6 4	5,000	14,212	284%	31,700	50,941	161%	78,000	46,664	60%
3 Couple years of protection (CYP) in USG-supported programs (IIP 1 7 1)	1,200	2,504	209%	2,700	4,599	170%	24,000	10,732	45%
4 Modern contraceptive rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sub-Objective 1: State and local government capacity to deliver and promote use of high impact MCH/FP/RH interventions strengthened									
5 Number of people trained in FP/RH with USG funds (male and female)	225	311	138%	1,655	625	38%	4,845	624	13%
6 Number of people trained in malaria prevention or treatment (male and female)	225	437	194%	500	645	129%	1,940	576	30%
6b Number of health workers trained in case management with artemisin-based combination therapy (ACTs) with USG funds (IIP3 1 3 1-1)	NA	NA	-	NA	NA	-	NA	570	-
6c Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTS) or microscopy) with USG funds	NA	NA	-	NA	NA	-	NA	31	-
7 Number of people trained in maternal/newborn health through USG-assisted programs (male and female)	225	244	108%	200	269	135%	2,225	93	4%
7b IIP3 1 3 4-1 Number of health workers trained in intermittent preventive treatment in pregnancy (IPTP) with USG funds	NA	NA	-	NA	NA	-	NA	570	-
8 Number of people trained in child health and nutrition (male and female)	225	375	167%	550	710	129%	1,510	189	13%
9 Percentage of HMIS indicators reported on in a timely manor	NA	45% HF 40% LGA	-	60% HF 88% LGA	66% HF 92% LGA	-	80% HF 100% LGA	86% HF 100% LGA	-

INDICATOR	YEAR 1			YEAR 2			YEAR 3 (Q1-Q3)		
	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED
10 Number of HFs receiving at least one supportive supervision visit during the quarter with observation of clinical skills included	60	60	100%	390	439	113%	395	557	141%
10 Number of health facilities rehabilitated	-	-	-	NA	42	100	NA	19	-
Sub-Objective 2: Delivery and promotion of high impact FP/RH/MCH interventions at PHCs strengthened and essential referral levels established									
11 Number of counseling visits for FP/RH as a result of USG assistance (male and female)	3,750	13,725	366%	31,500	39,596	126%	98,120	54,228	55%
12 Number of USG-assisted service delivery points providing FP or counseling services	150	284	189%	304	292	96%	531	409	77%
13 Number of ANC visits by skilled providers from USG-assisted facilities	52,000	105,090	202%	209,200	377,684	181%	469,440	275,371	59%
14 Number of pregnant women who attend at least one antenatal care (ANC1) visit	10,000	34,651	347%	88,400	144,797	164%	212,000	120,260	57%
15 Number of women receiving active management of third stage of labor through USG-supported programs	NA	2,915	N/A	9,510	18,080	190%	53,000	17,092	32%
16 Number of newborns receiving essential newborn care through in USG-supported programs	3,000	6,147	205%	9,510	23,013	242%	53,000	17,252	33%
17 Number of children under 5 years-of-age who received vitamin A through USG-supported programs	80,000	1,085,650	1357%	1,080,000	881,238	82%	881,000	845,634	96%
18 Number of cases of childhood diarrhea treated in USAID programs	7,500	16,279	217%	35,500	53,689	151%	276,480	38,708	14%
19 Rate of non-polio AFP cases	2 4	7 3	-	5 4	11 1	-	5 4	14 1	-
20 Number of wild polio virus cases in USG assisted States	0	0	-	0	0	-	0	2	-
21 Number of women who receive IPT in prenatal care	10,000	63,487	635%	50,000	138,995	278%	150,000	82,733	55%
22 Number of cases of malaria in children treated with ACT	2,000	98,294	4915%	153,000	90,346	59%	95,000	76,416	80%

INDICATOR	YEAR 1			YEAR 2			YEAR 3 (Q1-Q3)		
	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED
23 Number of ITNs distributed or sold with USG funds	1,500,000	1,493,303	100%	0	0	0%	258,000	0	N/A
Sub-Objective 3: Strengthened roles of households and communities in promotion, practice, and delivery of high impact MCH/FP/RH interventions									
24 Proportion of ward development committees (WDCs) that are active during the reporting quarter	9%	9%	-	48%	54%	-	60%	61%	-
25 Percentage of people who report attending health services due to exposure to community awareness and education activities	This indicator is planned to be measured through a LQA survey that is planned for PY4 and the indicator will be tracked accordingly								
Sub-Objective 4: Policies, programming, and resource allocation at State and federal levels improved									
26 Number of policies that are developed or adapted to support improved RH/FP/MCH services	4	5	125%	12	13	108%	17	60	353%
27 Number of local organizations provided with technical assistance on institutional capacity-building to leverage additional resources for RH/FP/MCH information and services	5	79	1580%	100	107	107%	61	88	144%

Table 4.0: Performances of the TSHIP Sokoto on Performance Indicators

INDICATOR	YEAR 1			YEAR 2			YEAR 3		
	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED
Program Objective: Increased Use of High Impact Interventions									
1 Number of children Immunized with DPT3	70,000	105,626	151%	133,152	122,938	92%	150,090	48,617	32%
2 Number of deliveries with a skilled birth attendant in USG assisted facilities (IIP1 6 4	1,350	5,693	422%	11,000	16,486	150%	30,000	22,603	75%
3 Couple years of protection (CYP) in USG-supported programs (IIP 1 7 1)	600	1,755	293%	4,000	9,404	235%	20,000	23,820	119%
4 Modern contraceptive rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sub-Objective 1: State and local government capacity to deliver and promote use of high impact MCH/FP/RH interventions strengthened									
5 Number of people trained in FP/RH with USG funds (male and female)	4,845	624	13%	4,612	711	15%	4,612	711	15%
6 Number of people trained in malaria prevention or treatment (male and female)	1,940	576	30%	1,581	786	50%	1,581	786	50%
6b Number of health workers trained in case management with artemisin-based combination therapy (ACTs) with USG funds (IIP3 1 3 1-1)	NA	570	-	NA	674	-	NA	674	-
6c Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTS) or microscopy) with USG funds	NA	31	-	NA	365	-	NA	365	-
7 Number of people trained in maternal/newborn health through USG-assisted programs (male and female)	2,225	93	4%	2,059	476	23%	2,059	476	23%

INDICATOR	YEAR 1			YEAR 2			YEAR 3		
	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED
7b IIP3 1 3 4-1 Number of health workers trained in intermittent preventive treatment in pregnancy (IPTP) with USG funds	NA	570	-	NA	674	-	NA	674	-
8 Number of people trained in child health and nutrition (male and female)	1,510	189	13%	1,447	329	23%	1,447	329	23%
9 Percentage of HMIS indicators reported on in a timely manor	80% HF 100% LGA	86% HF 100% LGA	-	80% HF 100% LGA	100% HF 100% LGA	-	80% HF 100% LGA	100% HF 100% LGA	-
10 Number of HFs receiving at least one supportive supervision visit during the quarter with observation of clinical skills included	395	557	141%	320	270	84%	320	270	84%
10 Number of health facilities rehabilitated				NA	38	100	NA	10	-
Sub-Objective 2: Delivery and promotion of high impact FP/RH/MCH interventions at PHCs strengthened and essential referral levels established									
11 Number of counseling visits for FP/RH as a result of USG assistance (male and female)	2,250	9,104	405%	19,600	42,965	219%	78,210	72,312	92%
12 Number of USG-assisted service delivery points providing FP or counseling services	100	195	195%	434	464	107%	500	533	107%
13 Number of ANC visits by skilled providers from USG-assisted facilities	20,000	43,551	218%	86,000	138,425	161%	280,000	106,718	38%
14 Number of pregnant women who attend at least one antenatal care (ANC1) visit	6,000	14,720	245%	30,000	53,405	178%	122,000	48,143	39%
15 Number of women receiving active management of third stage of labor through USG-supported programs	NA	1,323	N/A	2,750	6,805	247%	18,000	11,871	66%
16 Number of newborns receiving essential newborn care through in USG-supported programs	810	2,145	265%	2,750	6,805	247%	18,000	11,727	65%
17 Number of children under 5 years-of-age who received vitamin A through USG-supported programs	120,000	573,858	478%	748,981	841,021	112%	650,000	764,676	118%
18 Number of cases of childhood diarrhea treated in USAID	7,500	33,377	445%	22,300	69,773	313%	100,000	44,318	44%

INDICATOR	YEAR 1			YEAR 2			YEAR 3		
	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED	TARGET	ACTUAL	% OF TARGET ACHIEVED
programs									
19 Rate of non-polio AFP cases	12 05	10	-	2	9 3	-	2	11 8	-
20 Number of wild polio virus cases in USG assisted States	0	1	-	0	5	-	0	2	-
21 Number of women who receive IPT in prenatal care	4,785	5,042	105%	20,805	36,179	174%	50,000	18,473	37%
22 Number of cases of malaria in children treated with ACT	9,672	16,377	169%	59,000	40,018	68%	45,000	18,048	40%
23 Number of ITNs distributed or sold with USG funds	1,600,000	1,300,000	81%	1,248	175	14%	202,000	7046	N/A
Sub-Objective 3: Strengthened roles of households and communities in promotion, practice, and delivery of high impact MCH/FP/RH interventions									
24 Proportion of ward development committees (WDCs) that are active during the reporting quarter	9%	16%	-	65%	65%	-	84%	90%	-
25 Percentage of people who report attending health services due to exposure to community awareness and education activities	This indicator is planned to be measured through survey, an LQAS survey is planned for PY4 and the indicator will be track accordingly								
Sub-Objective 4: Policies, programming, and resource allocation at State and federal levels improved									
26 Number of policies that are developed or adapted to support improved RH/FP/MCH services	3	5	167%	5	15	300%	20	65	325%
27 Number of local organizations provided with technical assistance on institutional capacity-building to leverage additional resources for RH/FP/MCH information and services	5	7	140%	30	27	90%	74	121	164%

Summary Table for Secondary Health Facilities Visited During the MTE

	Name of Secondary Health Facilities				
	Maternity Unit, Bauchi State Specialist Hospital	General Hospital, Giade, Bauchi State	General Hospital, Darazo, Bauchi State	Maternity Unit, Sokoto State Specialist Hospital	General Hospital, Bodinga, Sokoto State
Blood transfusion services	Available & functional blood bank	Available & functional blood bank	Available & functional blood bank	Available & functional blood bank	Available & partly functional blood bank
Manpower and type Anesthesia services	4 anesthetic nurses. Can provide GA/spinal block	1 nurse who administers ketamine.	1 nurse who provides GA	1 anesthetic nurse Can provide GA/spinal block	1 nurse who administers ketamine.
Theatre and manpower for C- section	Has a theatre for C-section but it is located at another unit Has 4 medical officers who perform CS	Has a theatre for C-section Has 1 medical officers who perform CS	Has a theatre for C-section Has 1 medical officers who perform CS	Has a theatre for C-section Has 3 medical officers who perform CS	Has a theatre for C-section Has 1 medical officers who perform CS
Maternal deaths recorded in Health facility from Jan – Sept 2012	1 (it is low because the theatre is located elsewhere, they only take deliveries)	4	23	18	4
Stillbirths recorded in HF Jan – Sept 2012	79	19	103	93	31
Formal referral linkage & or records with adjoining PHCs	None	None	None	None	None
Average weekly ANC attendance(estimated by the respondent)	300	20	75	700	100

	Name of Secondary Health Facilities				
	Maternity Unit, Bauchi State Specialist Hospital	General Hospital, Giade, Bauchi State	General Hospital, Darazo, Bauchi State	Maternity Unit, Sokoto State Specialist Hospital	General Hospital, Bodinga, Sokoto State
Average weekly deliveries in HF (estimate by the respondent)	30	5	30	150 (have 2 delivery suites)	3
Health facility maternal audit	None	None	None	None	None

ANNEX 2

RESULTS CHECKLIST

Table 5.0 : Evidence Collected

Sub-Objective	Approach Evaluated	Indicator	Evidence to be Collected	Method of Data Collection	Data Source	Sampling	Analysis
SO 1 ***Strengthen State and local government capacity to deliver and promote use of high-impact FP/RH/MCH interventions***	Partnerships at State level : Capacity of State government	Partnership agreements	State level staff trained	TSHIP reports KII	TSHIP Team, Stakeholders	Purposive	Document review
		Satisfaction of State authorities	Reported satisfaction	KII with examples	Stakeholders (State Govt)	Purposive	KII, Document review
		% budget increase for health and target MCH and FP services	TSHIP interventions part of State Health plan and budget	Document review KIISSHP,W/Plan, Budgets & annual Reports	SMoH, MoLG ^ Other Agencies	Purposive	KII, Document review
	At LGA	No Of LGAs (out of 20 in Bauchi and 23 in Sokoto) that have trained staff to manage interventions	State Records (SSHP, State Training Plan, TSHIP Records)	KII Document review	TSHIP Team, Stakeholders (LGA, PHC Dept , SMoH)	Purposive	KII, Document review
		No of LGA staff trained	TSHIP Record (Attendance, Training curriculum,)	KIITSHIP Reports	All record available	Purposive	KII, Document review
		No of LGA plans and budgets include target interventions		TSHIP report			KII, Document review
		No of visited facilities that deliver target interventions		Survey			KII, Document review
		Satisfied LGA authorities					
SO2 ***Strengthen the delivery and promotion of high impact MNCH/FP/RH and selected disease prevention/treatment interventions at PHC facilities and essential referral levels***	TSHIP implementation of High Impact Interventions	Staff trained/total staff	No Of Staff trained	Document review and KII	TSHIP Reports, State LGA Annual Reports	Purposive	Review ^ Analzsis of KII Questionnaire
		Supervisory Report on SBMR Activities	Staff Performance Appraisal Reports, HF Reports, Patient Chart and Registers	Document Reviews	Supervisor Reports	NA	Documentary review
		Number of HFs with functional ORT corners	Inventory of ORT materials & equipment	Document review & Observation	Treatment Register & Demonstration records, Stock Register	Purposive	Document review and Report of observation
		LLNs available *specified quantity per period	Stock in the facility	Document review	Stock card	Purposive	Record review
		Vaccines available	Stock in the facility	Document review	Vaccine supply, Immunization,registers	Purposive	Record review
		Active Polio program	Date of last campaign	Document review	Registers	Purposive	Record review
		Family Planning services available	Policy, SOPs, Protocols, Supplies	Document review	Registers	Purposive	Record review

Sub-Objective	Approach Evaluated	Indicator	Evidence to be Collected	Method of Data Collection	Data Source	Sampling	Analysis
		ANC visits reported and IPT provision	Policy, SOPs, Protocols, Supplies	Document review	Registers	Purposive	Record review
		Supervised delivries at home and in facilities	Policy, SOPs, Protocols, Supplies	Document review	Registers	Purposive	Record review
		No postnatal visits	Policy, SOPs, Protocols, Supplies	Document review	Registers	Purposive	Record review
		Vitamin A provided	Policy, SOPs, Protocols, Supplies	Document review	Registers	Purposive	Record review
		Exclusive BF	interview Policy, SOPs, Protocols, Supplies w	Document review	Registers	Purposive	Record review
		Malaria diagnostic test performed and medicines available	Policy, SOPs, Protocols, Supplies	Document review	Registers	Purposive	Record review
		Mother's reported satisfaction with services reported	Quotes and comments from Mothers	FGD, Exit Interview	Analyis of Responses from FGD & Exit Int	Purposive	Pattern of responses
		Gender issues that prevent access being addressed	Mother's recant of experience	FGD, Exit Interview	Analyis of Responses from FGD & Exit Int	Purposive	Pattern of responses
	Targeting of Weakest links and Building on Existing Strengths	Weakest links indentified and targeted	Training, Supervion, tool, budget provision, Enhancing capacities of Civil society SMoH /SMo LG, LG PHC Dept	KII	KII Report	Purposive	Analysis of the KII data
		Strengths indentified and used	Training, Supervion, tool, budget provision, Enhancing Enhancing capacity of Civil society	KII	KII Report	Purposive	Analysis of the KII data
		No of Operational research studies conducted	OR Protocols & Reports	Document review	TSHIP Annual reports	N/A	Document review
		Knowledge management	Manual for KM Databank	Document review	Periodic (Annual Reports, Workplans)Unit Report	N/A	Document review
		M&E	Manual for M&E	Document review	Periodic (Annual Reports, Workplans)Unit Report	N/A	Document review
	Integration of MNCH/FP		Improved quality				
	Improved Referral	No of referrals in the 3 months prior to MTE recorded in PHC and referral level	Improved coverage	Visit to immediate referral level Survey : availability of magnesum sulphate and blood			
SO3 ***Strengthen the roles of households and communities in promotion,***	Harmonization of Community engagement and mobili-	No of WDC supported	Records of meetings with WDC	Interview with TSHIP Team	TSHIP records	NA	Qualitative

Sub-Objective	Approach Evaluated	Indicator	Evidence to be Collected	Method of Data Collection	Data Source	Sampling	Analysis
practice and delivery of high impact FP/RH/MCH and selected disease prevention/treatment interventions	zation	No of CH volunteers trained	Records of meetings with CHV	Interview with TSHIP Team	TSHIP records	NA	Qualitative
		No of TBAs trained	Records of meetings with TBAs	Interview with TSHIP Team	TSHIP records	NA	Qualitative
		No of Satisfied WDC members interviewed	Records of meetings with WDC	Interview with WDC	KII	NA	Qualitative
SO4 ***Improved policies, programming and resource allocation***	New polices	No of new policies development	Documents collected	TSHIP Team	KII	NA	Qualitative
	State plans	Plan available	Copy of 2012 State plan obtained	KII	State	NA	Qualitative
	State Budget	Increased budget allocation to health	Copy of 2012 budget	KII	State	NA	Qualitative
	Coordination with other USG projects	Coordination mechanism identified	Records of meetings with Partners	Interview with TSHIP Team	TSHIP records	NA	Qualitative

ANNEX 3

List of people contacted:

S/N	NAME	POSITION	ORGANIZATION
1	John Quinley	Current COTR	USAID Nigeria
2	Garba Abdu	Previous COTR	USAID Nigeria
3	Marc Okunnu	Previous COP	TSHIP
4	Nosa Orobaton	COP	TSHIP
5		Deputy COP	TSHIP
6		Senior Health System Advisor	TSHIP
7		Senior MCH Advisor	TSHIP
8		Senior FP/RH Advisor	TSHIP
9		Senior Policy Advisor	TSHIP
10		Senior Finance & Admin Specialist	TSHIP
11		*M&E Specialist	TSHIP
12	Jill Meeks	COP	NEI Project

Bauch State

S/N	NAME	POSITION	ORGANIZATION	Contacted by
1	Alhaji Muhammed Hassan	Perm Sec SMOH	SMOH	Travelled to Abuja Did not meet him but confirm with Dr Adewale
2	Dr Nisser Ali Umar	Executive Chairman SPHCDA	SPHCDA	- Dr Sanusi in person
3	Ayo Oladini	DCOP	NEI	- Dr Sanusi in person
4	Dan Seufert	DCOP LEAD	RTI/LEAD	Confirm with Dr Adewale
5	Usman Salisu	Exe Chairman	Hospitals Management Board	Confirm with Dr Adewale
6	Dr Mohammed S Liman	Chairman/Ex Secretary	BACATMA	- Dr Sanusi in person
7	Dr Adamu Usman Said	Zonal Coordinator	North-East Zonal NPHCDA	- Dr Sanusi in person
8	Alh Adamu Gamawa	MD	Bauchi State Drugs Management Agency	Confirm with Dr Adewale
9	- Mrs Maryam Iliya - Hajia Hadiza Musa - Silas Daniel - Konguda Ankale	- Executive Director, - Program Officer, - Account Officer (RAHAMA Grant manager) - M&E Officer	RAHAMA	- Dr Sanusi in person
10	- Hajia Muhammad Damina - Lami Baba Geidam, - Haliru Shehu, - Suleiman I Babaji, - Hayatu Ibrahim	- Chairperson, Health Committee	FOMWAN	- Dr Sanusi in person
11	- Hajia Rahina Aliyu - Mallam Abubakar Dabo	- State Health Educator - Member, State Social Mobilization Committee	Bauchi State Primary Health Care Development Agency	- Dr Sanusi in person
12	- Idris Abdulkarim - Hajia Lami Abubakar - Hannatu Ibrahim - Talatu Ahmad - Jummai Garba - Gambo Haruna	- Chairman - Woman Leader - Secretary, Women	WDC Kofar Dumi, Bauchi Bauchi State	- Dr Sanusi in person
13	- Maryam Lamido - Samaila Husseini - Ladi Habu, - Yusuf Tela	- Treasurer	WDC Giade –A, Giade LGA Bauchi State	- Dr Sanusi in person
14	- Saidu Idris - Lawal Garba - Ahmed Idi - Lawal B Ibrahim - Samuel Toma - Abdu Muhammad- - Ibrahim Muhammad Hassan - Kabiru Labaran	- PHC Coordinator - LGA M&E Officer - LIO - Health Educator - DSNO - Malaria Control Officer - LGA WATSAN Officer - LGA Cold Chain Officer	Darazo LGA PHC Team, Darazo LGA Bauchi State	- Dr Sanusi in person

15	- Dahe Kawuwa - Ibrahim Abubakar Halilu - Yusuf Abdullahi - Shehu Baffa - Abdullahi Mohd - Mohd Abdullahi - Habibu Kawuwa - Ahmadu Sarki - Badamasi Abdullahi - Jibrin Buba - Bello Baffa - Saminu Yunusa - Aishatu Haruna - Kulu Hudu - Maryam Bala - Haliru Kanya	- Chairman - Secretary, Darazo East - Secretary, Darazo West	WDC Darazo West & East, Darazo LGA Bauchi State	- Dr Sanusi in person
16	- Matron Maimuna G Lamido, - Hauwa Isa - Zaynab Muhammad	- Matron in charge	Maternity Unit, General Hospital Giade, Giade LGA Bauchi State	- Dr Sanusi in person
17	Matron Fatima Samaila Dan Gambo	- Matron in charge	Kofar Ran Maternity Unit, Bauchi State Specialist Hospital Bauchi State	- Dr Sanusi in person
18	Matron Maryam Babayo	- Matron in charge	Maternity Unit, General Hospital, Darazo, Darazo LGA Bauchi State	- Dr Sanusi in person

Sokoto State

S/N	Name	Position	Organization	Contacted by
1	Dadi Adare	DHPRS	Department of Health Planning Research & Statistics, SMOH	Dr Elvira in person
2	Buhari Shehu	State MDG Focal Person, Deputy Director Planning	MDGs/CGS , Sokoto State Ministry of Budget & Economic Planning	- Elvira by email - Dr Sanusi in person
3	Tijjani Muhammad	DCOP	LEAD office, Sokoto	Elvira by email
4	Muh'd Nura Ibrahim	DCOP	NEI office, Sokoto	Elvira by email
5	Dr Labaran	Director SSPHCDA	SSPHCDA, Sokoto	Elvira in person
6	Dr Abdullahi Gada	Director	Health Services Management Board, Sokoto State	Dr Sanusi in person
7	Haj Hafsat Halilu,	Project Coordinator	Planned Parenthood Federation of Nigeria, Sokoto State	Dr Said
8	Junaidu Mohammed,	Director PHC	Ministry for Local Government & Community Affairs	Dr Sanusi in person
9	Fati Bello Gummi,	Chairperson, Health Committtee	Federation of Muslim Women Associations of Nigeria, Sokoto (FOMWAN)	Dr Sanusi in person
10	Mustapha M Kurfi,	M&E	Pathfinder Int	Dr Said
11	Chukwuemeka Okolo,	TO M&E	FHI 360	Chris
12	Shehu Abdul Ganiyu	ZTO	NPHCDA Sokoto	Dr Sanusi in person
13	Yusuf Dayyabu		Society for Family Health, Sokoto	Said
14	Amina Ladan,	RH Coordinator	SPHCDA	Said
15	Mustapha Akeem		UNICEF, Sokoto	
16	Kabiru Rabiu	State Social Mobilization Consultant	UNICEF, Sokoto	Dr Sanusi in person
17	Garba Kadi	Former Director PHC	SPCDA, Sokoto	Dr Sanusi in person
18	Dr Bashir Abba	State Coordinator	WHO, Sokoto	Dr Sanusi in person
19	Dagang Gang Musa Muhammad Wammako Salisu Muhammad Calistus Donatus Gimba Goyo	- Senior Technical Manager - Senior Finance & Budget Specialist - Senior Civil Society Specialist - M&E Specialist - Senior Service Delivery Specialist	LEAD, Sokoto State Team	Dr Sanusi in person
20	- Abubakar Muhammad - Magaji Abubakar - Liman Ali - Hakimi Mande, - Hassan Noma, - Hakimi Shaaibu, - Muhammad Danfati, - Hakimi Dan Inna, - Wakili Umaru, - Alhaji Hano Jikada - Alhaji Barade - Bodi Dogari, - Bello S-Garba, - Bagga Bandado, - Umaru Yusuf, - Umar MaiDankali, - Mahmud Hassan, - Buba Alhaji Shehu, - Bello Alhaji Shehu, - Fati Sarki Aski, - Tamodi Bandado, - Yafara Sarkin Fawa, - Hauwa Iro, - Mairo Magaji, - Hauwa Mamman, - Yar Giwa, - Hauwa Maraki, - Adi Musa,	- Secretary	WDC, Bagarawa Sokoto State	Dr Sanusi in person

S/N	Name	Position	Organization	Contacted by
	- Inno Umaru			
21	- Jinaidu Abdur-Rauf - Abubakar Maccido, - Sanusi DanModi - Aminu Yari - Bala Damisa- - Ladan Magatakarda, - Abubakar Danjeka, - Dan Haruna Isa, - Faruk Abdur-Rauf, - Labbo Yari, - Ibrahim Atiku, - Badamasi Magaji, - Labaran Ibrahim, - Aliyu Dodo, - Aliyu Musa, - Malami Hassan	- Chairman - Vice Chairman - Secretary - Treasurer	WDC, Bodinga Town Bodinga LGA Sokoto State	Dr Sanusi in person
23	Risikatu Suleiman	- Matron	Maternity Unit, General Hospital, Bodinga Bodinga LGA Sokoto State	Dr Sanusi in person
24	Matron Talatu Suleiman	- Acting Matron in charge	Maternity Unit, Sokoto State Specialist Hospital Sokoto State	Dr Sanusi in person
25	- Shaaibu Sahabi-, - Bala Umar	- Deputy PHC Director - LGA M&E Officer	Bodinga LGA- PHC Team Bodinga LGA Sokoto State	Dr Sanusi in person

S/N	Name	Designation	Tel. No	Email Address
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2	Abdulahi Hassan	Senior Finance & Grant Specialist (Bauchi)	08065025555	alhassan@tshipnigeria org
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4	Daniel Yerima	Finance & Admin Specialist (Sokoto)	08037765999	dyerima@tshipnigeria org
5	Egbodo Iji	Finance & Admin Specialist (Sokoto)	08036653668	iegbodo@tshipnigeria org
6	Salihu A Nasir	Organizational Development Specialist (Sokoto)	08034516502	snasir@tshipnigeria org
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8	Mukhtar Ahmed Wali	Accountant	08037024029	mwali@tshipnigeria org
9	Mr Tayo Fatinikun	Project Director (Life Helpers Initiative—a sub-grantee in Sokoto)	08035049086	lifehelpersinitiative@yahoo co uk
10	Mr Bala Dada	Project Manager (Mariestopes Nigeria— a sub-grantee in Sokoto)		bala dada@mariestopes org ng
11	Hafsatu Haliu	Project Coordinator (PPFN—a sub-grantee in Sokoto)	08032902002	ppfnsokoto@yahoo com
12	Victoria David	Assistant Project Manager (Mariestopes Nigeria)		victoria david@mariestopes org ng

LIST OF BAUCHI & SOKOTO KEY STAKEHOLDERS & THEIR INFORMATION MET BY TSHIP MTE TEAM

WARD DEVELOPMENT COMMITTEE, PHC DAN CHADI, BODINGA LOCAL GOVERNMENT AREA, SOKOTO STATE

S/N	NAME	DESIGNATION	LOCATION	TELEPHONE
1	Muhammadu Dangaladima	Chairman	Dan Chadi Village	0810 478 3571
2	Kabiru Muhammad	Member	Dan Chadi Village	0708 781 6131
3	Umaru Muhammad	Member	Dan Chadi Village	0708 440 2651
4	Sodangi Kwando	Member	Dan Chadi Village	
5	Fadi Umaru	Member	Dan Chadi Village	

WARD DEVELOPMENT COMMITTEE, PHC SALOME, GWADABAWA LOCAL GOVERNMENT AREA, SOKOTO STATE

S/N	NAME	DESIGNATION	LOCATION	TELEPHONE
1	Dalhatu Buhari	Chairman	Salome Ward	
2	Shehu Umar	Member	Salome Village	
3	Isah Shehu	Member		
4	Abdullahi Madawaki	Member	Tunga Shanu Village	
5	Dankane Abdullahi	Member	Gijiya Village	

MARYAM ABACHA WOMEN & CHILDREN HOSPITAL, SOKOTO SOUTH LOCAL GOVERNMENT AREA, SOKOTO STATE

S/N	NAME	DESIGNATION	LOCATION	TELEPHONE
1	Dr Abba Wali	Medical Director	Sokoto South LGA	0805 363 4994

SOKOTO SOUTH LOCAL GOVERNMENT AREA, SOKOTO STATE

S/N	NAME	DESIGNATION	LOCATION	TELEPHONE
1	Muslim Adamu	Director PHC	LGA PHC Department	0803 807 3617
2	Kabiru Abubakar	LGA M&E Officer	LGA PHC Department	0812 329 6390
3	Hon Usman Ibrahim	Councillor Health	LGA Admin Dept	0806 590 0160
4	Aishatu Abubakar	MCH Coordinator	LGA PHC Department	0703 495 6067
5	Nasiru Altine	RBM Officer	LGA PHC Department	0803 083 7375
6	Abubakar Wali	ADD Officer	LGA Admin Dept	0808 567 7140
7	Ibrahim M Yusufu	Environmental H Officer	LGA PHC Department	0808 674 9780
8	Chika Mahe	LGA HIV/AIDS Officer	LGA PHC Department	0803 445 2719
9	Usman Faruk Umar	Zonal Manager	TSHIP Zonal Office	0703 888 5091

GWADABAWA LOCAL GOVERNMENT AREA, SOKOTO STATE

S/N	NAME	DESIGNATION	LOCATION	TELEPHONE
1	Abdullahi Garba	LGA Council Chairman	Gwadabawa LGA Secretariat	0806 480 2325
2	Nasiru Umar	Acting Director PHC	LGA PHC Department	0808 828 1773
3	Isah Sanusi	LGA Staff Officer	LGA Admin Dept	0809 575 8561
4	Lawali Umar Bungudu	Zonal Manager	TSHIP Zonal Eastern Office	0806 5669 4964
5	Abdullahi Aliyu	Service Improvement Facilitator	TSHIP Zonal Eastern Office	0803 684 1287
6	Luba Bello Muhammad	Community Mobilization Associate	TSHIP Zonal Eastern Office	0803 746 4180
7	Don-Aki Jennyfer	Service Improvement Facilitator	TSHIP Zonal Eastern Office	0803 666 4033

BODINGA LOCAL GOVERNMENT AREA, SOKOTO STATE

S/N	NAME	DESIGNATION	LOCATION	TELEPHONE
1	Na'abu Shehu D	LGA Council Vice Chairman	Bodinga LGA	0703 501 6411
2	Sh'uibu Sahabi	Acting Director PHC	LGA PHC Department	0806 024 4426
3	Bala Umar	LGA M&E Officer	LGA Admin Dept	0706 430 5541
4	Bello A Kilgori	Zonal Manager	TSHIP Zonal Office	0706 372 3460
5	Hafsat Bukar	Service Improvement Facilitator	TSHIP Zonal Office	0706 755 1804
6	Samuel M Bello	Community Mobilization Associate	TSHIP Zonal Office	0803 507 3609
7	Taiwo Adujobi	Service Improvement Facilitator	TSHIP Zonal Office	0803 331 6436
8	Margaret Julde	Service Improvement Facilitator	TSHIP Zonal Office	0706 933 8104
9	Amuratu Yakubu	Community Mobilization Associate	TSHIP Zonal Office	0806 647 8446
10	Dabbi Abubakar	Councillor	Bodinga LGA	0706 475 5336
11	Hon Umaru Bala	Councillor	Bodinga LGA	0806 030 2585

SERVICE DELIVERY TEAM MANAGERS/ADVISORS, TSHIP PROJECT, SOKOTO STATE

S/N	NAME	DESIGNATION	LOCATION	TELEPHONE
1	Fatima Inuwa	SFPRHA	TSHIP Sokoto	0803 358 8834
2	Dr Zainab Mohammed	MACHS	TSHIP Sokoto	0803 339 5181
3	Dr Mohammed A Ibrahim	SMCHA	TSHIP Sokoto	0803 301 4093
4	Dr Kamil Shoretore	SMNHA	TSHIP Sokoto	0803 324 8084
5	Dr Sharifah Ibrahim	SQMA	TSHIP Sokoto	0803 284 8740

SERVICE DELIVERY TEAM MANAGERS/ADVISORS, TSHIP PROJECT, BAUCHI STATE

S/N	NAME	DESIGNATION	LOCATION	TELEPHONE
1	Juliana Nathaniel	SFPRHA	TSHIP Bauchi	0706 605 8070

2	Abubakar Mu'azu	SHSSA	TSHIP Bauchi	0803 539 1646
3	Amos Bassi	SMCHA	TSHIP Bauchi	0803 517 0807
4	Dr Ibrahim A kabo	SMNHA	TSHIP Bauchi	0806 566 7373

WARD DEVELOPMENT COMMITTEE, MODEL PHC ZABI, GIADE LOCAL GOVERNMENT AREA, BAUCHI STATE

S/N	NAME	DESIGNATION	LOCATION	TELEPHONE
1	Alhaji Shehu Zaki	Chairman	Zabi Ward	
2	Jauro Modibbo	Member	Zabi Ward	0817 252 1367
3	Sabo Muhammed D	Member	Zabi Ward	0818 756 1316
4	Adamu Roka	Member	Zabi Ward	
5	Tukur Mohammed	Member	Zabi Ward	0809 503 5496
6	Mohammed Bodore	Member	Zabi Ward	0809 274 4867
7	Buba Garba	Member	Zabi Ward	
8	Mai Unguwa Umaru	Secretary	Zabi Ward	0809 598 0479
9	Mohammed Nyago	Member	Zabi Ward	
10	Habiba Mohammed	Member	Zabi Ward	0809 239 8806
11	Bappa Yahansi	Member	Zabi Ward	0809 686 5338

ANNEX 4

List of Health Facilities Surveyed in Bauchi and Sokoto States

State	Senatorial Zone	Local Government Area	Primary Health Care Facilities	Secondary or Referral Health Facilities	Comments
Bauchi State	Bauchi South	Bauchi LGA	a. Yelwa Domiciliary Clinic b. Kofar Dumi MCH Clinic c. Doya MCH Clinic	Maternity Unit, Kofar Ran, Bauchi State Specialist Hospital	Actually done
	Bauchi Central	Darazo LGA	a. Under Fives Clinic, Darazo East b. Darazo Town Maternity c. Kari PHC	General Hospital, Darazo	Actually done
	Bauchi North	Giade LGA	a. Giade Maternity Clinic b. Zabi Model PHC c. Isawa PHC	General Hospital, Giade	Actually done
Sokoto State	Sokoto East	Gwadabawa LGA	a. RHC Gwadabawa b. Huchi Dispensary c. Salabe Dispensary	No General Hospital or secondary referral facility at Gwadabawa	Actually done and some Team members visited Ranganda Dispensary
	Sokoto North	Sokoto	a. Aliyu Jodi BHC b. Maryam Abacha Women & Children Hospital c. Mabera BHC d. Gidan Dahana Dispensary	Sokoto Specialist Hospital	Actually done
	Sokoto South	Bodinga LGA	a. Bagarawa Model PHC b. Sifawa Dispensary c. Dan-Chadi PHC	General Hospital, Bodinga	Actually done

ANNEX 5

LIST OF DOCUMENTS REVIEWED

S/N	DOCUMENT TITLE:
1	ANNEX I. STAFFING PLAN
2	NAMES OF TRADITIONAL BIRTH ATTENDANTS (TBAS) IN SOKOTO NORTH LGA
3	MANAGEMENT SYSTEMS TRAINING FOR LGA PHC DIRECTORS IN BAUCHI STATE
4	SUPPORTIVE SUPERVISORY CHECKLIST FOR TRAINING
5	USAID 508 COMPLIANT REPORT TEMPLATE
6	JSI RESPONSE TO QUESTION
7	JSI TECHNICAL APPLICATION INTRODUCTION (PDF)
8	JSI TECHNICAL APPLICATION
9	PY 1 WORK PLAN JUNE 2010
10	PY 2 WORK PLAN FINAL
11	PY 3 WORK PLAN FINAL
12	CHECKLIST FOR ASSESSING THE USE OF HOUSEHOLD COUNSELLING CHART
13	FOLLOW-UP OF HEALTHCARE PROVIDERS TRAINED IN EMERGENCY OBSTETRIC AND NEWBORN CARE
14	MAKING MEDICAL INJECTION SAFE
15	MISSION OR USAID/NIGERIA STRATEGY 2010 – 2013
16	TBAS DATA BASE
17	TBA RABAH LOCAL GOVERNMENT AREA SOKOTO STATE
18	TBA SILAME LGA 1
19	TSHIP DESIGN DOCUMENT NEW DRAFT
20	USAID NIGERIA HPN STRATEGY
21	TSHIP FPRH SUPERVISION MANUAL
22	REPORT OF NHIS/MDG
23	NUTRITION STAKEHOLDERS MEETING FEB 2012
24	REPORT OF COURTESY VISIT TO THE BAUCHI STATE HOUSE OF ASSEMBLY
25	REPORT OF PARTICIPATION AT THE 2010 COMMUNICATION ANNUAL WORKPLAN
26	REPORT OF PARTICIPATION IN FGN UNICEF MEETING C4D REVIEW 09
27	BAUCHI STATE STAKEHOLDERS CONTACTS INFORMATION
28	TSHIP STAKEHOLDERS – SOKOTO STATE CANTACT INFORMATION
29	TSHIP RELATED ACTIVITIES FUNDED BY USAID 7 SEPT 2009
30	SOKOTO LIST OF DONOR AGENCIES
31	BROAD CONTEXT KEY PARTNERS
32	FIRST JOINT TSHIP – SFH 1
33	BROCHURE 25 OCT MEETING
34	REPORT OF PARTICIPATION AT A TOWN HALL
35	NOTE COORD MEETING 2011
36	WARD MINIMUM HEALTH CARE PACKAGE
37	MENATRICVAC WORKSHOP
38	MSS – HARMONIZED CONCEPT FNAL
39	CONCEPT NOTE STUDY ON RETENTION IN KEBBI AND SOKOTO
40	CONCEPT NOTE FOR THE NATIONAL REVIEW OF PRIMARY HEALTH CARE
41	NOTE ON MEETING WITH NPHCDA
42	COLLABORATION MEETING BETWEEN TSHIP AND NPHCDA
43	VILLAGE HEALTH WORKERS PROJECT IMPLEMENTATION BY NPHCDA
44	NICAB/TSHIP MEETING ON COLLABORATION
45	IPS COLLABORATION PRESENTATION
46	JOINT LEAD NEI & TSHIP PRESENTATION

S/N	DOCUMENT TITLE:
47	REPORT OF COLLABORATION MEETING BETWEEN BT2M, NEI AND TSHIP PROJECTS
48	JOINT ACTIVITIES JAN 2011
49	ACTION _POINT_ POST IPS
50	REPORT OF PARTICIPATION AT NEI YEAR TWO WORK PLANNING
51	LEAD PY 3 WP TRIP REPORT
52	MEETING NOTES OF TSHIP DELIVER
53	DRAFT QUALIFICATION AGENDA BAUCHI STATE FREE-MCH PROGRAM
54	TSHIP VISIT NOTE
55	CONTRACEPTIVE SUPPLY UPDATE
56	PARTICIPANTS LIST FOR BAUCHI STATE MEDICAL PRODUCTS SELECTION & QUANTIFICATION WORKSHOP TRIP REPORT FOR BAUCHI PREQUALIFICATION
57	REQUEST FOR QUOTE
58	DRAFT REPORT OF COLLABORATION MEETING HELD BETWEEN BASPHCDA AND TSHIP ON WEDNESDAY 23TH JUNE, 2010
59	SOW 23 JUNE MEETING
60	REPORT OF MEETING WITH BASPHCDA TOWARDS ADOPTION OF THE WARD MINIMUM HEALTH PACKAGE (WMHP) IN BAUCHI STATE HELD AT TSHIP
61	INSTRUCTION SWG EXERCISE
62	REPORT OF MEETING WITH THE EXECUTIVE CHAIRMAN, BAUCHI STATE PHDCA
63	TSHIP AND BACATMA COLLABORATIVE MEETING DRAFT REPORT
64	REPORT OF PRESENTATION ON TSHIP TO LGA OFFICIALS AT BACATMA OFFICE ON 16TH DECEMBER, 2009
65	TSHIP PY2 ANNUAL REPORT1
66	TSHIP FIRST ANNUAL REPORT
67	TSHIP 1ST ANNUAL PUBLIC
68	BAUCHI REPORT OF RAPID POLICY ASSESSMENT
69	NICS 2010 REPORT PRESENTATION
70	PNADQ923
71	TRENDS IN MATERNAL MORTALITY
72	NIGERIA NATIONAL MALARIA CONTROL
73	9789241563901 ENG
74	REPORT OF THE OPERATIONAL BARRIERS
75	OR STUDY IN FAMILY PLANNNING IN BAUCHI
76	SOKOTO UMIMUNIZIED 2011 ANAYSIS
77	NIGERIA CAMPAIGN STATU
78	VSI PRHP MISSION HOME BIRTHS BRIEFING
79	CHLORHEXIDINE IN ORTHOPAEDICS
80	CHX REGINAL MGT SEPTEMBER 15TH
81	EFFECT OF CHLORHEXIDINE ON WOUND HEALING
82	2008 NIGERIA DEMOGRAPHIC & HEALTH
83	2005 NATIONAL ANTMALARIAL TREATMENT
84	LIST MODEL FOR HIGH IMPACT
85	LIST OF HFS BAUCHI
86	ORT CONERS BAUCHI 2010
87	DRATF 2012 6 MONTHS EMERGENCY PLAN
88	LIST OF ORT CONERS FOR STUDY BAUCHI
89	FACILITIES PROVIDING RI IN SOKOTO OCT 2011
90	LIST OF TBAS IN 4VHR LG AIN BAUCHI
91	SOKOTO SUMMARY TARGETS
92	LIST OF WD SIN BAUCHI & TORO
93	COUNSELING KEY POINT ON THE USE
94	OR STATUS MAY 2012
95	REPORT OF THE TRAINING WORKSHOP
96	CAPACITY BUILDING WORKSHOP

S/N	DOCUMENT TITLE:
97	DISTRIBUTION PATTERN OF ADDITIONAL EQUIPMENT AND SUPPLIES TO SUPPORT SMOH
98	DISTRIBUTION PATTERN OF PROCURED EQUIPMENT AND SUPPLIES TO SUPPORT SMOH
99	EQUIP DISTRIBUTION
100	TSHIP EQUIPMENTS FOR DONATION TO GENERAL HOSPITALS
101	EQUIPMENT AND SUPPLIES SUPPORT TO ATBUTH, BAUCHI
102	TSHIP SUPPORT TO IMPROVE MATERNAL AND NEWBORN CARE AT ATBU
103	DISTRIBUTION LIST OF PROCURED CHILD HEALTH EQUIPMENTS TO SUPPORT SMOH
104	RENOVATION CONTRACT DOCUMENTATION CHECK LIST
105	HEALTH FACILITY IMPROVEMENT/RENOVATION APPROACH
106	MEMO ON EMERGENCY TROLLEYS
107	MEMO EMERGENCY TROLLEYS FOR GH
108	DISTRIBUTION OF CHILD HEALTH EQUIPMENTS TO SUPPORT SMOH
109	ITEMS FOR EACH EMERGENCY TROLLEY
110	LIST OF RENOVATED HEALTH FACILITIES BY TSHIP
111	REVISED TSHIP PMP JUNE 13
112	TSHIP MANAGEMENT INDICATORS REVISED
113	TSHIP QUARTERLY REPORT APRIL TO JUNE
114	SEVENTH QUARTERLY REPORT
115	FIFTY QUARTERLY REPORT
116	THIRD QUARTERLY REPORT
117	FIRST QUARTERLY REPORT
118	SECOND QUARTERLY REPORT
119	CAC TRAINING REPORT NABORDO
120	PPFN SOKOTO GRANTS REPORT
121	FOMWAM JUNE 12 TECH
121	APRIL 12 TSHIP GRANTS
122	TSHIP GRANTS REPORT TEMPLATE
123	SOKOTO PPFN TECHNICAL REPORT JUNE
124	MAY 12 TSHIP GRANTS REPORT
125	SOKOTO GRANTS TECHNICAL REPORT MAY 12
126	PPFN SOKOTO TECHNICAL REPORT APRIL 12
127	JUNE REPORT 2012
128	APRIL REPORT
129	JUNE PROGRESS REPORT
130	MAY REPORT
131	APRIL PROGRESS
132	CAC TRANING REPORT GUMA MAY 2012
133	APRIL – JUNE QUARTER PROGRESS
134	ACTIVITY REPORT FROM APRIL – JUNE 2012
135	UPDATE & REVIEWED WDC STATUS IN SOKOTO NOV 2011
136	UPDATE ON WDC IN BAUCHI STATE JUNE 2012
137	TSHIP PY2 ANNUAL REPORT DEC 1
138	TSHIP PY2 ANNUAL REPORT
139	TSHIP FIRST ANNUAL REPORT
140	TSHIP FIRST ANNUAL REPORT PUBLIC
141	COPY – EDITED ENABLE COMMUNITY ACTION
142	HOME MANAGEMENT MALARIA
143	TANADAIN HAIHUWA
144	PREPARE SALT & SUGAR SOLUTION
145	HOME MANAGEMENT MALARIA 2
146	AVOID UNWANTED PREGNANCY
147	AVOID UNWANTED PREGNANCY_
148	BASSHDP21102010 FINAL FINAL
149	STRATEGY 11

S/N	DOCUMENT TITLE:
150	STRATEGY 7
151	STRATEGY 12-1
152	STRATEGY 6
153	STRATEGY 5-2
154	STRATEGY 8 – 1
155	STRATEGY 10
156	STRATEGY 9
157	COPY – EDITED ENABLE COMMUNITY ACTION
158	POLICY, ADVOCACY AND RESOURCE STRATEGY
159	HMIS CONCEPT NOTE & STRATEGY
160	TSHIP KMC STRATEGY PDF
161	DRAFT TSHIP MNH2B REPORT
162	TSHIP GRANTS STRATEGY FINAL
163	DRAFT 2 HRH POLICY & PLAN
164	TSHIP ARH STRATEGY MAY 2011
165	MALARIA STRATEGY FEB 2 2012
166	CHILD HEALTH STRATEGY REVIEW DRAFT
167	TSHIP FAMILY PLANNING AUGUST 16 2012
168	OD TSHIP INTERVENTION 0510
169	TSHIP OPERATION RESEACH STRATEGY
170	PSE DRAFT STRATEGY DOCUMENT
171	FOLLOW UP %20 OF %20 HEALTH CARE %20
172	USAID TSHIP FP&RH SUPERVISION MANAGEMENT
173	TBA DATA BASE FINAL
174	PY3 TRAINING PLAN
175	MAKING MEDICAL INJECTION SAFER 2
176	TBA DATA BASE TRT
177	TBA RABH LGA
178	TSHIP POLIO PROGRAMME SKO KWARE LGA TBA
179	HEALTH MANAGEMENT INFORMATION SYSTEM TRAINING RECORDS
180	PRETEST MGT SYSTEM
181	SUPPORTIVE SUPERVISION FROM ZINCFANT
182	CHECKLIST FOR ASSESSING THE USE OF HOUSEHOLD
183	YEAR ONE WORK PLAN
184	TSHIP PY3 WORK PLAN REVISED FINAL
185	REVISED PY2 WORK PLAN
186	PY3 ZONAL WORK PLAN
187	TSHIP DESIGN DOCUMENT DRAFT NEW
188	SP 2010 – 2014 FINAL DRAFT
189	ORG STRUCTURE EFFECTIVE OCT
190	STAFF LIST SEPTEMBER FINAL
191	CONSOLIDATION ORGANGRAM FINAL
192	FIELD OFFICE OG 050311
193	DOCUMENTATION LIST
194	TSHIP Grant Manual
195	TSHIP Cost Sharing Manual
196	TSHIP Grant Strategy
197	Operation Manual
198	JSI Nigeria/TSHIP Finance Manual
199	TSHIP Security/Emergency plan
200	Life helpers initiative (A sub-grantee in Sokoto) Progress report
201	FOMWAN BAUCHI (A sub-grantee in Bauchi) Quarterly Report

S/N	DOCUMENT TITLE:
202	RAHAMA Women Development Programme (A subgrantee)-Report
203	PY4 Work Plan

ANNEX 6
Quotes from Focus Group Discussions:

Sokoto

1. "In the older days we don't visit hospitals because we don't face difficulties during delivery" - Non-user
2. "I don't visit hospital because the health personnel are not friendly due to the fact that some are not sympathetic in attitudes" – Non-user
3. "I visit hospital for family planning because if you visit a pharmacist for it, it may be dangerous because the pharmacist does not test the blood and also prevention is better than cure" - User
4. " In the past I don't visit hospital but now I do and experience its benefits" - Non-user
5. "The health facilities take good care of the patient at the right time" - User
6. "The local herbs are effective because we don't face problems and make us healthy and strong" - Non-user
7. "The local herbs are effective to some mothers while to some they causes rashes to the private, madness and sometimes leads to death" - Non-user
8. "The local herbs sometimes causes many diseases like malaria" - Non-user
9. "The local herbs like Garin lalle (henna) when soaked and inserted into private parts after delivery will serve as the known Detol of nowadays" - Non-user
10. "Doctor is not regular at work" – Adolescent user
11. "There is need for power supply because some drugs needs to be refrigerated" - Adolescent user
12. "If the mother or child is sick as they visit hospital when the doctor prescribe drug it work effective, and in the case of pregnant woman it ease delivery because of the anti-natal care, there is a great difference between hospital users and non-users" – Non-user
13. "Because there was rumors that if during your first delivery you visited the hospital and the health personnel gave you detol to use during next delivery the wound healed in the fast will return back new and if pregnant woman did not use the local medicine the baby will not have enough breastfeeding and I now discover that all the rumors a lies because the young mothers now visiting hospital are stronger than us after and before delivery" – Non-user
14. "Because of financial problems and un-educated in-laws" – Non-user
15. "Because of illiterate parents"-Non-user
16. "Because there was rumors that if you visit hospital during antenatal care, they will give you an injection that you will not born again" - Non-user
17. "There is need for beds and chairs for patients to seat, and no shelter for the staff" - User

18. “There is need for toilets and beds for the patients in the labor room” - User
19. “There is need for beds for admission and clean environment because the hospital is smelling and dirty” – User

Bauchi

1. “Sincerely speaking the health care provider treat us without respect ,they shout at us without respect ,they are not friendly .When we hear that there is free drug and we visit ,they often refuse to give us instead they write it down for us to go and buy.” – Non-user
2. “I don’t go or visit the clinic because the caregivers don’t treat us well, they rain abuses on us and don’t pity our condition.” – Non-user
3. “I prefer to give birth in my room than being insulted and treated without pity and respect.” – Non-user
4. “They refuse to assist me and said I should go away .We hear it in the media (Radio) that we should visit the hospital for antenatal care when we are pregnant so as to to have a safe delivery but when you visit the nurses abuse, ignore or even send you away.” – Non-user
5. “To me within Bauchi metropolis, there is no clinic that gives maximum attention than this clinic and I doubt if there s any health facility that provides this kind of services ,care and concern to patients.” - User
6. “They really try their possible best to see that they treat you well.” - User
7. “They treat us with respect and sympathy.” - User
8. “I will never use this toilet again because it dirty and offensive smell.” - User
9. “They don’t get to meet the nurses at night because they close early by 10pm when asked why, she said it was because of the area boys around called (sara suca) who threaten to beat or kill them most especially during night shift .She said no security is available and the boys operate without fear.” – Adolecent user
10. “The provision of security men to enable the worker run night shift” – Adolescent user
11. “They need more nurses to ease the long queues before seeing a doctor or nurse.” – Adolescent user
12. “They are always caring and understanding to me.” - Non-user
13. “My husband does not allow me to visit the hospital.” - Non-user
14. “My husband never allows me so I see no reason to visit. He only buys drug from patient medicine stores.” - Non-user
15. “When you come for delivery and you have no relative the worker serve as our relative by helping with our errands.” -User
16. “Because the care givers are good to us and respect us.” - Adolescent user
17. “Because they are free with us and do tell us all that we need when we ask them.” - Adolescent user

18. “There is one problem, the attitude of the health workers ,when a patient comes for delivery they usually ask then to go round even when they are in labour tired.” - Adolescent user
19. “I visit the general hospital because they have qualified doctors and nurses and when they write drugs for you ,you get a relief.” – Non-user
20. “The environment is clean and conducive all the time ,that is why I visit this facility.” - User
21. “I visit because of its cleanliness, I hate dirty environment” - User
22. “They are always very caring and attend to me on time, they go round to visit us on our sick bed and often explain things to us, before doing it. They make sure the environment is clean and always quarrel with people who throws dirt’s and dirty water around.” -User
23. “We need treated insecticides nets on the hospital bed because of the mosquitoes around.” - User
24. “Because it is neat and clean and they give free drugs and take of the patients.” - Adolescent user
25. “Provision of portable water for use like borehole.” - Adolescent user
26. “The provision of bed-sheets, blanket and mosquito net” - Adolescent user
27. “We need a doctor and more health workers.” - Adolescent user

ANNEX 7
Detailed Methodology to Respond to MTE Questions:

b. **TSHIP management structure, including organizational structure, staffing and skills mix.** *In addition to reviewing the project's documentation (RFA, proposal, work plans, annual reports, etc.), the MTE Team compared the structure and Team composition with the objectives to be achieved and the degree of progress achieved based on project indicators, State health information and indicators and data field visits. The MTE Team also interviewed each TSHIP member by email and then develop an in-depth interview to assess their degree of personal effectiveness. We believe this MTE activity was important because the degree of effectiveness of each TSHIP Team member impacts on the project's overall effectiveness.*

c. **Strategies and approaches, including technical interventions. This analysis should not only consider the appropriateness and effectiveness of a given strategy, approach and intervention, but equally assess the level of effort against the planned results/outcomes.** *The MTE Team has developed an "expected results matrix"(See Annex 1) to ensure the MTE Team gathered evidence of the effectiveness of all the strategies and approaches used by the TSHIP as well as the quality and effectiveness of every technical intervention, most of which have already demonstrated their efficacy. The MTE Team used this matrix to measure and report on the effectiveness of each intervention, as well as the Level of Effort (LOE) used to achieve each result or intermediary measure towards the final results.*

d. **Partnerships, coordination and collaboration within the TSHIP and with USG, e.g., LEAD, NEI, WOFAN, government, civil society and private sector partners.** *Interviews with representatives of all the TSHIP stakeholders will be conducted. The list of people to be interviewed was based on the list proposed by USAID and subject to their approval (See Annex 2). The list includes the Commissioners of Health and other local authorities, as well as COPs of other projects and representatives of development agencies working in health (DfID, UNICEF, etc.). A master list of questions was developed to ensure all stakeholders are asked the same questions so their perceptions and opinions could be compared. The stakeholders were asked what the "Most Significant Change" they attributed to the TSHIP to assess the degree to which the TSHIP has been communicating, collaborating and creating synergy with other actors in the two States.*

e. **Performance monitoring and evaluation, including results framework, quality and relevance of indicators (impact/outcome/process) and operational research.** *The MTE M&E expert assessed the projects M&E plan and performance measures and assessed the validity, consistency, and relevance of the original results framework to achieve the intended results. The "Critical Path" method was used to analyze the sequence of actions the TSHIP has taken to implement the project's results framework and achieve the observed results to date. Operational research conducted was assessed in terms of the methodology used, the results found and the utilization of those results to inform the project's activities. Project documents were mined using the MTE questions for evidence of the TSHIP achievements. A form was developed for this purpose.*

f. **The impact of the conflict environment on project performance.** *Evidence from interviews with selected communities, project records and stakeholders was used to assess the impact of conflict on the TSHIP performance and health service delivery, and interviews with the Team to find out about current conflict related limitations.*

2. How has TSHIP and its partners defined sustainability and how has the project progressed in this area? In particular, how is the project building capacity at the State-level and how has this translated to improvements in program management and in service provision? *The MTE Team conducted a survey that included interviews with health workers in 9 facilities in each State to gather evidence of the project's activities regarding the introduction of high impact MNCH/FP interventions, activities to sustain these interventions, as well as efforts to strengthen the local health system to ensure they develop the capacity to take over the interventions in the shortest time possible. Specifically, the MTE Team looked for policies that institutionalized the interventions, written operating procedures, revised supervision checklists and guidelines, revised job descriptions, training and*

follow up to ensure new integrated processes are being delivered according to the training received and quality standards, as well as the feedback and recognition of the local health authorities and providers.

3. To what extent are clients satisfied with services provided through facility and community services? Do services provided to pregnant women and children in the primary health care centers and hospitals meet their needs and expectations in a timely manner and at the expected quality? *The MTE Team conducted focus groups with mothers that have delivered a baby in the last 3 and 12 months to assess their satisfaction with the antenatal and delivery services, and with the services their infants have received. Three discussions were held with each group: one with a group of users; another with non-users; and one discussion with adolescent girls. The discussions were held in each of the three LGAs visited in each State, and were conducted in the areas of more intense project activity in each State for a total of 18 focus group discussions (See Box 2.). The trained moderators asked about the women's experiences with the health facilities and probed for examples of their experiences that justify their level of satisfaction. In addition, exit interviews with up to 10 mothers were conducted in visited facilities.*

BOX 2. FOCUS GROUP DISCUSSIONS: PURPOSE; MEASURE SATISFACTION AND LEARN ABOUT THEIR EXPERIENCES WITH THE LOCAL HEALTH SERVICES

1. Users: Mothers that delivered a baby in the last 3 to 12 months at a facility
2. Non-users: Mothers that delivered a baby in the last 3 to 12 months at home
3. Adolescent girls

4. To what extent are the project interventions and activities gender sensitive and transformative?
Interviews with the TSHIP staff and with health service delivery staff included questions about gender sensitive behaviors such as facilitating privacy of FP consultations, care of fistula patients, FGM-related activities, use of gender-segregated utilization and mortality data, etc.

In addition, the MTE Team asked the TSHIP Team and stakeholders for their understanding about gender sensitive activities.

The MTE Team also assessed the TSHIP vision of success, that is, the tangible and visible transformation of the PHC system in the targeted States that is expected at the end of TSHIP. The Team also elicited in every interview the degree of confidence the TSHIP Team and stakeholders have that the degree of transformation will be achieved.

5. Based on the evidence generated from the evaluation, what specific approaches and strategies are recommended:

a. **for the remainder of the life of TSHIP project?**
b. **in terms of additional operational research studies, surveys, assessments, etc. that would better inform TSHIP's project?**
c. **for USAID to consider in supporting health planning, in general, beyond the scope of TSHIP?**

The MTE Team assessed the findings of the evaluation and prepared actionable recommendations in the light of the objectives of the Global Health Initiative (GHI) and the GHI strategy for Nigeria; the new USAID Forward policy; Nigeria's Strategic Health Development Plan (2010-2015); the strategic plan of USAID/Nigeria; and "Saving a Million Lives" vision of the Federal MOH. The MTE Team's methodology complied with USAID ADS 200 and revised M&E policy, as well as the new Global Health Bureau Strategic Framework 2012-2016.

MTE Tools

The following tools have been developed:

1. Document review and data mining form
2. TSHIP Team email survey
3. Key Informant interview form

4. Facility questionnaire
5. Questionnaire for Health care providers
6. Exit interview for female clients
7. Guide for Focus Group discussions
8. Equipment and commodities inventory
9. Statistics and local documentation checklist

Email Survey

Dr. Elvira

Field visits and Health Facility Survey

Purposive sample: The unit of study was the PHC center. Nine PHC facilities were chosen within a one hour drive radius of the State capital in three LGAs, one in each of the three senatorial zones. In the morning, the MTE Team visited the LGA and met with the local authorities and then divided into teams of two MTE Team members to visit the PHC facility; while one of them interviewed the person in charge to assess the capacity of the facility, the other gave the exit interview of up to 10 mothers. Then each of the MTE Team members interviewed up to four of the health workers: ANC nurse, Child health Nurse, FP nurse, and a CHEW or labor room nurse. Then at least one of the MTE Team members made a quick visit to the immediate essential referral facility to measure the time of travel and assess their referral records and capacity to provide EOC. In the afternoon, the MTE Team members met with the Ward Development Committee (WDC) and other stakeholders in the community and conducted interviews. We had three pairs of MTE members and thus visited 3 facilities in each LGA over three days for a total of 9 facilities in each State. Focus group discussions were conducted by trained moderators recruited locally.

MTE Team and Roles

Dr. Elvira Beracochea: Team leader
Dr. Adeogun Adewale: Focus Groups Coordinator, Collaboration and Evaluator of the Health Information System
Mr. Apantaku Foluso: Sokoto MTE implementation Coordinator and Grant Management Specialist
Mr. Chris Olusola Ogedengbe: M&E methodology expert and survey data collection supervisor
Mr. Nura Nassir: Bauchi Survey Coordinator and Data Quality Control and Analysis Expert
Dr. Abubakar Sanusi: Bauchi MTE Implementation coordinator and Community Health System Specialist
Dr. Chichi Azuike: Pharmaceutical System and Supply Chain Specialist
Dr. Ahmad Said: Saving one million lives coordinator and Sokoto Survey Coordinator

MTE Schedule

Day 1. 9/17 - Team planning meeting
Day 2. 9/18 - Meeting with USAID/Nigeria: Dr. Garba Abdu and Mr. John Quinley
Day 3. 9/19 - Team planning meeting. Meeting with TSHIP COP, field testing of data collection tools, and send out TSHIP staff email questionnaire.
Day 4. 9/20 - Work plan preparation, document review and finalization of data collection tools
Day 5. 9/21 - Work plan review, interview with previous COP and presentation and discussion of MTE work plan at USAID/Nigeria.
Day 6. 9/22 - Finalize work plan with comments from Mission, document review and travel preparations

Day 7. 9/23 - Travel to Bauchi and meeting with TSHIP Team and interview stakeholders. Training of FG moderator and note taker.
Day 8. 9 and 10. 9/24-26 - Field Data Collection
Day 11. 9/27 - Analysis and feedback to TSHIP Bauchi Team
Day 12. 9/28 - Travel back to Abuja
Day 13. 9/29 - Rest
Day 14. 9/30 – Travel to Sokoto and meeting with TSHIP Team and interview stakeholders
Day 15, 16 and 17. 10/1 – 3 – Field Data Collection
Day 18. 10/4 - Analysis and Feedback to TSHIP Sokoto Team
Day 19. 10/5 - Return to Abuja
Day 20. 10/6 - Analysis
Day 21. 10/7 - Rest
Day 22- 27. 10/8 to 10/13 –Data analysis and draft report preparation
Day 28. 10/14 - Rest
Day 29- 31.10/15 -16 - Team reviews draft report and prepares debriefing PowerPoint presentations
Day 32. – 10/17 Debrief MEMS
Day 33. 10/18 Incorporate comments into report and presentation
Day 33. – 10/19 - Debrief USAID/Nigeria and incorporate comments
Day 34. – 10/20 = Team Leader departs from Nigeria
USAID/Nigeria reviews draft report
Day 35 to 40. Incorporate USAID/Nigeria comments and produce final report

Data collection instruments

TSHIP MTE Document Review Form: Sokoto ☐ Bauchi ☐ Both ☐

Document Number:		Reviewer
Title of the document		
Evaluation Questions	**Evidence (quote and or page #)**	
Sub-Objective 1: strengthen State and local government capacity and promote the use of high impact FP/RH/MCH interventions?		
Sub-Objective 2: Strengthen the delivery and promotion of high impact MNCH/FP/RH and selected prevention and treatment interventions (malaria, HIV/AIDS) at PHC and essential referral levels		
Sub-Objective 3: Strengthen the roles of households and communities in promotion, practice and delivery of high impact MNCH/FP/RH and selected disease prevention and treatment interventions		
Sub-Objective 4: Improved polices, programming and resource allocation		
Evidence of improved quality of the services in _________		
Evidence of effective community engagement in ________		
Evidence of effective collaboration and coordination strategies		
Evidence of effective gender sensitive strategy and transformation		
Strengths of TSHIP and how they built on these strengths		
What are the weaknesses of the health system in ______? What has TSHIP done to address them?		
Evidence of satisfaction		
Evidence of sustainability and ownership		

<table>
<tr><td colspan="2">Document Number:</td><td>Reviewer</td></tr>
<tr><td colspan="2">Title of the document</td><td></td></tr>
<tr><td>Evaluation Questions</td><td colspan="2">Evidence (quote and or page #)</td></tr>
<tr><td>Recommendations</td><td colspan="2"></td></tr>
<tr><td colspan="3">Other observations</td></tr>
</table>

TSHIP MTE Team Email Pre-visit Interview:
☐ Bauchi ☐ Sokoto ☐Both

Team Member Information	Contact information
Name : Position : Date of hire :	Email : Phone :

Evaluation Questions	Team member's response
a What is your main role on the TSHIP?	
b What has been your main contribution to the project so far?	
c How would you rate the project's performance and the results achieved so far?	
d What have been the three main successes of the project? In your opinion, are these sustainable? Why or why not?	
e What have been the three main challenges the project has faced or is facing?	
f If you had to give a % for the time you spend on an average week on each of the following activities, what would it be? What activities do you perform?	i Strengthening local capacity to deliver high impact interventions % ii Strengthening PHC services % iii Strengthening households and the community % iv Improving policies, programming and resource allocation %
g 1 Do you have a written job description? If yes, please attach it to this questionnaire 2 How well does this job description reflect your everyday activities? 3 what criteria are used to assess your performance?	
h How do you ensure gender sensitivity in your work?	
I What do you think will be the main legacy of the project that will be still ongoing 1 year after the project, 5 years after the project?	
J What is important for the MTE Team to know and consider when evaluating the progress of the project so far?	

Team Member Information		**Contact information**
Name : Position : Date of hire :		Email : Phone :
Evaluation Questions	**Team member's response**	
Any questions you would like to ask the MTE Team?		
Suggestions		
Other observations		

COMMUNITY LEVEL INTERVIEW GUIDE

MIDTERM EVALUATION OF TARGETED STATE HIGH IMPACT PROJECT

QUESTIONNAIRE FOR COMMUNITY LEVEL

Introduction: My name is (***Name of the interviewer***); I am working for Monitoring and Evaluation Management Services (MEMS), an agent of the funding agency of TSHIP (USAID). We are interviewing individuals taking part in TSHIP in order to improve the impact of the project.
Confidentiality and consent: I am going to ask you questions some of which may be very personal. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You may need to know that this exercise is taking place in other health facilities that are involved in the project in Sokoto and Bauchi States as well. I would greatly appreciate your help in responding to this survey

A. Identification

1. Questionnaire number: ______________________ (***Skip this question***)
2. State:________________________ LGA:____
3. Name of the WDC:____
____
4. Sector: Rural ----------- 1, Urban------------------2
5. Name of the interviewer:____

Sub objectives	Questions	Stakeholders
SO4: To improve policies, programming and resource allocation at the community level	1. *How active and highly regarded is your committee/group in this community? Please give examples* 2. Are community members aware of the MNCH/RH/FP services provided in this health facility? 3. Are there any supports (financial or activities) that you or committee/group members give to help improve MNCH/RH/FP services in this community? *Please give examples*	TSHIP zonal community specialists, WDC/VDC members
SO3: Strengthen roles of communities and households in use, promotion and delivery of high impact interventions	1 Does your community/group collaborate in any way with the Health Facility to increase public awareness and utilization of MNCH/FP/RH services? *Please give examples* 2 *Does the community utilize these services? Please give examples* 3 Is your community/group active in sharing community information with Health Facilities? *Please give examples*	
SO2: Supporting the provision of high impact interventions including strengthening community linkages	1. Are Health Facilities involving your community/group in improving and providing MNCH/FP/RH services? If yes, what are they doing? *Please give examples* 2 What are your thoughts on other ways that your community/group can participate in improving MNCH/FP/RH in this community? 3 Does committee or group liaise with other community organizations to support local MNCH/FP/RH activities?	
SO1: Capacity building	1 What are some ways that the project has contributed to strengthening your capacity to support MNCH/FP/RH for your community/group? 2 What recommendations do you have for TSHIP to improve your community's/group's capacity in supporting MNCH/FP/RH?	

MIDTERM EVALUATION OF TARGETED STATE HIGH IMPACT PROJECT

EXIT INTERVIEW FOR FEMALE CLIENTS

Introduction: My name is (***Name of the interviewer***); I am working for Monitoring and Evaluation Management Services (MEMS), an agent of the funding agency of TSHIP (USAID). We are interviewing individuals taking part in TSHIP in order to improve the impact of the project.
Confidentiality and consent: I am going to ask you questions some of which may be very personal. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You may need to know that this exercise is taking place in other health facilities that are involved in the project in Sokoto and Bauchi States as well. I would greatly appreciate your help in responding to this survey

B. Identification

6. Questionnaire number: ______________________ (***Skip this question***)
7. State:______________________ LGA:____
8. Ward:______________________ Community:____
9. Location: Rural ----------- 1, Urban------------------2
10. Name of the interviewer:______________________

C. Background characteristics

1. **Age as at last birthday**:________
2. **Marital status**: Single: -----1, Married: -----2, Separated: -----3, Divorced: ---4, widowed: -----5
3. **Highest education completed**
   No education------1. Quranic -----2, Primary ------3, Secondary------4, post secondary-----5, Graduate----------6
4. **Occupation**: Schooling------1, Unemployed-------2, House wife------3, Trading-----4, Professional-------5

D. Effects of TSHIP activities on women

1. How did you know about the services provided in this facility?
   Radio-----1, Television----2, Relatives------3, Friends-------4, Community awareness activities-----5, TBA--------6, Others (Specify) _________________________7
2. How far is this facility to your house?
   (1-3) km----1, (4-6) km----2, (7-9) km-----3, 10km and above------4
3. What kind of services did you receive in this facility? (***Cycle as many as appropriate***)
   MNCH------1, FP------2, Malaria--------3, RH --------4, Immunization----------5
   Others (Specify)______________________6
4. Who attended to you on your services: (***Cycle as many as appropriate***)
   Doctor-----1, Nurse-----2, Midwife-------3, CHEW-------4, Others (Specify) ____________5
5. How long were you on admission in the facility? (women who were admitted)
   (1-3) days-----1, (4-6) days----2, (7-9) days---3, 10 days and above -------4
   Not applicable----------5

E. Clients Satisfaction

1. How do you describe the services you received in the facility?
   Very satisfied----1, Satisfied-------2, Dissatisfied------3, Very dissatisfied--------4
2. Are you satisfied with the services provided in the facility? Yes-----1, No----2, Don't know-----3
3. Give reasons for your answer.
   ____
   ____
4. Was the Service Provider easy to understand when s/he explained things?
   Easy to understand------1, Difficult to understand-----2, Don't know------3 No answer--------4

5. How was the staff's attitude toward you?
   Friendly-------1, Partially friendly----3, Not friendly------4, Don't know------4,
   No information------5
6. Will you encourage your friends or relatives to visit the facility for services?
   Yes-----1, No------2, Undecided---------3.
7. Do you have any suggestions for the improvement of services offered in this facility?
   Yes--------1, No-------2,
8. If yes, what are your suggestions?
   ____
   ____

Gender Sensitivity

1. During your visit to or stay in the facility were you treated differently because you are a woman?
   Yes-----1, Never-----2, I did not notice it ------3.
2. If yes, was the treatment positive or negative? Positive----1, Negative----2
3. Explain your answer
   ____
   ____

4. Did a male or female healthcare service provider attended to you in the facility?
   Male----------1, Female---------2
5. Did you have preference for either of the health care workers based on the services you received or on their gender? Yes-------1, No--------2.
6. Has your husband ever (or recently) been invited to the facility to attend to you during your stay or visit to the facility?
   Yes----1, No----2.
   If yes, has the visit improved his attitude towards the use of the facility?
   Yes----1, No------2. Not applicable-------3.

   Thank you for your time and attention

MIDTERM EVALUATION OF TARGETED STATE HIGH IMPACT PROJECT (TSHIP)

GRANT MANAGEMENT INTERVIEW

STAKEHOLDERS: Senior Finance/Grant Officers

1. What guides your financial planning and operations?
2. Do you know of the grant policy document?
3. To what extent does your financial operations comply with the grant management policy
4. Kindly inform me about your cost sharing policy
5. How accountable is TSHIP to stakeholders? Explain.
6. How accountable is TSHIP to beneficiaries? Explain.
7. Kindly explain to me how you keep your accounting records?
8. Do you have suggestions on how to improve the grant management process?

Thank you.

MIDTERM EVALUATION OF TARGETED STATE HIGH IMPACT PROJECT

TSHIP MTE Interview Form: Sokoto ☐ Bauchi ☐

Interview Agenda and Minutes	**Date:**
Interviewee's Name : Email : Phone : Cell:	Interviewer (s):

Questions / Topics	**"Quote" and Notes**
What is the most significant change you have observed due to the TSHIP?	
Is the project on track to achieve Sub-Objective 1?	
Is the project on track to achieve Sub-Objective 2?	
Is the project on track to achieve Sub-Objective 3?	
Is the project on track to achieve Sub-Objective 4?	
What do you know about how effective has TSHIP been in improving the quality of the services in ________?	
What has been your experience with how TSHIP has engaged the community in _______?	
How has THSIP collaborated with other organizations and projects in ________?	
What gender issues has TSHIP addressed and what have been the results so far?	
What are the strengths of the health system in _____? How has TSHIP built on these strengths?	
What are the weaknesses of the health system in _____? What has TSHIP done to address them?	
How satisfied are you with the assistance you have received from the TSHIP? Can you give my an example?	

<table>
<tr><td colspan="2">Interview Agenda and Minutes</td><td>Date:</td></tr>
<tr><td colspan="2">Interviewee's Name :
Email :
Phone :
Cell:</td><td>Interviewer (s):</td></tr>
<tr><td>Questions / Topics</td><td colspan="2">"Quote" and Notes</td></tr>
<tr><td>What recommendations would you give to the TSHIP Team to improve MNCH/FP/RH service in ________?</td><td colspan="2"></td></tr>
<tr><td colspan="3">Other questions or comments:</td></tr>
</table>

LOCAL GOVERNMENT LEVEL INTERVIEW GUIDE FOR TSHIP EVALUATION - 2012

Intervention	Key questions and areas of interest	Targeted Stakeholders
SO – 1 : **Sub-objective1: Institutional capacity building**	1) What has been identified by PHC coordinator as institutional capacity gaps and deficiencies that impede the ability of PHC dept to address MNCH/RH/FP needs at the LGA level? 2) Has the project been successful in its support to PHC dept in addressing those needs? 3) What more can be done and how? 4) Ask for LGA quarterly/annual/Training reports, work plans or any other supporting health statistics	**LGA PHC Coordinator, Deputy Coordinator, MCH, LIO, Social mobilization officer (LGSMC), M&E**
SO – 2B : **Sub-objective 2B: Strengthened delivery and promotion of high impact maternal and newborn health interventions**	• What has been identified by PHC Coordinator as needs, gaps and weakest links in addressing the issues of planning, coordinating, supervising, staffing, training etc for MNCH/RH/FP interventions (e g focused antenatal care/clean & safe deliver) including referral systems in the LGA? • Has the project been assisting in the above efforts and in what ways? • What more can be done and how? • Ask for quarterly/annual reports or any other supporting health statistics	
SO – 3 : **Sub-objective 3: strengthen roles of communities and household in use, promotion and delivery of high impact interventions**	• Relevant needs gaps and weak links in social mobilization activities at LGA level identified by PHC coordinator and whether the project has been supportive in addressing them and in what ways? 1 Social mobilization - 2 Community participation – 3 BCC/IEC - 4 NGO/CBO participation – • What more can be done to support these activities?	
SO – 4 : **improve policies, programming and resource allocation at the LGA level**	• Are there needs, gaps and weak links identified by PHC coordinator in the implementation of the MNCH/RH/FP policy and whether the project has been supportive in addressing them and in what ways? (budgets, work-plans, staffing etc) • What more can be done and how? • What will be the one thing that will make the biggest impact in the LGA? • What will be the one thing that can be done to your staff that will make the biggest impact?	

MIDTERM EVALUATION OF TARGETED STATE HIGH IMPACT PROJECT

QUESTIONNAIRE FOR HEALTHCARE PROVIDERS

Introduction: My name is (***Name of the interviewer***); I am working for Monitoring and Evaluation Management Services (MEMS), an agent of the funding agency of TSHIP (USAID). We are interviewing individuals taking part in TSHIP in order to improve the impact of the project.
Confidentiality and consent: I am going to ask you questions some of which may be very personal. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You may need to know that this exercise is taking place in other health facilities that are involved in the project in Sokoto and Bauchi States as well. I would greatly appreciate your help in responding to this survey

F. Identification

11. Questionnaire number: ______________________ (***Skip this question***)
12. State:________________________ LGA:____
13. Name of the facility:____
____
14. Location: Rural ----------- 1, Urban------------------2
15. Name of the interviewer:____

G. Background characteristics

5. **Sex:** Male------1, Female---------2. 2. **Age** as at last birthday:________________
3. **Marital status**: Single: -------1, Married: -----2, Separated: -----3, Divorced: --------4, Widowed: ---------5
4. **Category of health provider**:
Doctor---------1, Nurse/Midwife------2, Nurse-----3, Midwife--------4, CHEW-------5
Others (Specify) ____________________________6
5. Year of graduation:_________________
6. How long have you been working in this facility? ____________________________
7. May I know the department where you work:___________________________________

H. Participation in TSHIP Program

6. Are you aware of any TSHIP activities in this facility? Yes----------1, No-------------2
7. If yes, give the activities you know (***Cycle all responses***)
   a. Maternal and Newborn Child Health-------------1
   b. Family Planning--2
   c. Malaria---3
   d. Immunization---4
   e. Reproductive Health----------------------------------5

8. Are members of staff organized in the different departments? Yes----1, No------2
9. Do you have a job description? Yes--------1, No-------2 (***Sight the document***)
10. When was the last time you received supervisory visit? _______________________(week)
11. Have you participated in any training in the past two years? Yes------1, No.........1
12. If yes, mention the training; ____
____
13. What challenges have you observed in this unit? _________________________________

____

14. What step(s) have you taken to address the challenges______________________________

15. Have you observed any significant changes in the unit in the past two years?
    Yes------1, No--------2.
16. If yes, what are these changes? ____

    ____

17. Have you noticed any issues relating discrimination between males and females or more attention being given to either of the sexes in the provision of services in this unit? Yes----------1, No--------2
18. If yes, kindly mention the issues:____
____
19. Do you have any relationships with community members apart from the women who come for services?
    Yes-----------1, NO-------------------------2
20. If yes, can you mention the categories of members of the community ________________

    ____
21. Do you know other donors or projects supporting this facility?
    Yes-------1, No--------2
22. If yes, kindly give us the names of the donors or the projects
    ____
    ____
23. Kindly give any suggestions you know that will help to improve the quality and the quantity of services rendered in this unit and in the facility.
    ____

Thank you for your time and attention

MIDTERM EVALUATION OF TARGETED STATE HIGH IMPACT PROJECT

QUESTIONNAIRE FOR SECONDARY HEALTH FACILITY

Introduction: My name is (***Name of the interviewer***); I am working for Monitoring and Evaluation Management Services (MEMS), an agent of the funding agency of TSHIP (USAID). We are interviewing individuals taking part in TSHIP in order to improve the impact of the project.
Confidentiality and consent: I am going to ask you questions some of which may be very personal. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You may need to know that this exercise is taking place in other health facilities that are involved in the project in Sokoto and Bauchi States as well. I would greatly appreciate your help in responding to this survey

I. Identification

16. Questionnaire number: ______________________ (***Skip this question***)
17. State:________________________ LGA:____
18. Name of the Secondary Health Facility:
____
____
19. Sector: Rural ----------- 1, Urban------------------2
20. Name of the interviewer:____

Section B: Assessment of Referral and EOC Services at Essential Referral Facility

1. Is there blood transfusion services?

Yes, within the health centre …..1
Yes, in another building …..3
No …..9
Comment : (Include purpose of the transfusion services, NBT policy, stock out of blood/blood products, consumables for screening etc):

………………………………………………………………………………………………

……………………………………………………………………………………………….

2. Is there anesthesia services?

Yes, within the health centre …..1
Yes, in another facility within reach …..3
No …..9
Comment : (Specify type of anesthesia used for CS, e.g., spinal block/epidural, Ketamine, number of anesthetic nurses etc):
---…………………………….
…….

3. Is there theatre facility for Caesarean Section?

Yes, within the health centre …..1
Yes, in another building …..3
No …..9
Comment : (Specify common reasons for CS e.g. eclampsia, obstructed/prolonged labour, available doctors trained to do CS etc):

4. **Abstract and record the following for <u>the last 3 months</u>**

FOR THE YEAR 201____

Health services provided	Available	Number
1. Referrals for pregnancy or delivery -related complications from PHCs	Yes No	
2. Counter referrals for pregnancy or delivery –related complications to PHCs		
3. Maternal deaths among referrals from PHCs		
4. Newborn deaths among referrals from PHC		
5. Health facility maternal audits		

CONCLUSION

Thank you for your assistance in this survey. The results will be analyzed and a summary, without names or identifying characteristics will be feedback to you and to the managers of the services at district and provincial level. Do you have any questions or other comments? Please feel free to ask them or talk about them now.

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MIDTERM EVALUATION OF TARGETED STATE HIGH IMPACT PROJECT

FOCUS GROUP DISCUSSION SESSION

USERS OF SERVICES AT TSHIP SUPPORTED PHC FACILITIES

Purpose: Assessment of client's satisfaction with and benefit from services provide through health facility (Evaluation Question 3)
Participants: Mothers (receiving or have received pre, intra and post partum care, pediatric, Nutrition and Family Planning services at TSHIP supported health facility)
Moderator: TBC
Venue: TSHIP supported PHC Facility

INTRODUCTION

Good day all. We are from the State Ministry of Health and TSHIP MTE Team. We are here to conduct an assessment of the health services provided to you as well as find out generally about your experiences at the health facility you visit in your community.

Focus Group Discussion Guide Questions

1. Can you briefly tell us why you have been visiting this health facility?
2. What were the services you have received or still receiving at this health facility?
3. Tell us your general experiences at the health facility during your visits. Please give me example(s).
4. Those (health facility staff) providing these services for us, what do we have to say about them? Why?
5. What are your suggestions towards improvement of services at the health facility?

Ask WHY? WHY?

FOCUS GROUP DISCUSSION SESSION

NON-USERS OF SERVICES AT TSHIP SUPPORTED PHC FACILITIES

Purpose: Assessment for client's satisfaction of access of health services outside TSHIP by mothers
Participants: Mothers [did not give birth at the facility (probably gave birth at home or private health) facility but received other health services at the PHC facility] nutrition and family planning services from private health facility and other sources).
Moderator: TBC
Location/Venue: Community through WDC focal person/TBD

INTRODUCTION

Good day all. We are from the State Ministry of Health and TSHIP MTE Team. We are here to conduct an assessment of the health services provided to you as well as find out generally about your experiences at the health facility you visit in your community.

Focus Group Discussion Guide Questions

1. Can you briefly tell us where you regularly visit for your health need services?
2. What were the services we have received from this health facility (source)?
3. What are your general experiences at this facility? Please give example(s).
4. What do you know about the PHC facility in your community?
5. Why have you not being visiting the PHC facility in your community for your health needs? Give reason(s).

Ask WHY? WHY?

TSHIP MTE
CHECKLIST FOR PRIMARY HEALTH CENTRE

INSTRUCTIONS TO DATA COLLECTOR

This checklist should be completed by observing the facilities that are available and through discussions with the person in charge of the facility on the day of the visit. In all cases you should verify that the items exist by actually observing them yourself - if you are not able to observe them, then code accordingly. Remember that the objective is to identify the facilities that currently exist and not to evaluate the performance of the staff or clinic.

For each item, circle the response or describe as appropriate.

1. FACILITY Visited (Name) ____

2 Name of Observer: ____

Checked by Team Leader: ____________________________________

SECTION 1 FACILITY

22. **Is a staff member always available at night for official call?**

Yes …..1 (Go to Question 8)
No ......2 (Skip to Question 11)

23. **If yes, does that staff member live or stay at this health centre when on night call?**

Yes …..1
No …..2

24. **Does he/she have housing provided by the local government authority?**

Yes …..1
No …..2
Comment ____

25. **Is the house what the staff expected?**

Yes …..1
No …..2

26. **Can you tell me when this health centre was renovated?**

____

____

27. **What parts of the building were renovated?**

____

28. **Do you think the renovation improved the quality of care? Why or why not?**

Yes …..1
No …..2
Comment ____________________

---

29. **Do you think that the renovation improved how much the communities use the health centre? Why or why not?**

Yes …..1
No …..2
Comment ____________________

---

30. **Is there a waiting area in this health centre?**

Yes …..1
No …..2
Comment ____________________

31. **What is the main source of water for the facility?** ***(Note to interviewer: the water source that is relied upon for most of the year for most of the water)***

Tank water …..1
Well …..2
River/stream/spring …..3
Piped water …..4
Bore water …..5
Other rainwater collection …..6
Other stored water …..7 (collected from somewhere else and stored)
Other …..8
No water source …..9 (Skip to question 19)
Comment ____________________

32. **Is the drainage for water adequate?** ***(Adequate means that there is no flooding of water, no leaking pipes, no blockages , and the water drains away from the health centre)***

Yes …..1
No …..2
Comment
____

33. **Toilets:** **a) Are toilets available for patients?**

Yes …..1
No …..2 (If no skip to question 19)

b) Are these toilets able to be used at present?

Yes …..1
No …..2
Comment
____

34. **What is the source of power for the health centre?** ***(More than one answer is allowed)***

a. National Electricity grid …..1
b. Generator …..2
c. Kerosene …..3
d. Bottled gas …..4
e. Solar …..5
f. Wood …..6
g. Other …..7
Please specify ______________________________
h. No energy source …..9

35. **Is there a place for counseling?**

Yes …..1
No …..2

Comment ______________________________

36. **Do you have a place where you can talk with a patient and others CANNOT hear the conversation?**

(Note for interviewer: Auditory privacy is defined as conversation between the client and the health worker cannot be understood by other clients. The other clients may see that a conversation is taking place but cannot hear what is being said. If possible please view this place and test the privacy level).

Yes …..1
No …..2

Comment ______________________________

37. **Is there a place where you can talk with a patient and others CANNOT see who are talking?**

(Note of for interviewer: Visual privacy is defined as other clients cannot see the interaction between a client and a health worker. Please try to examine this room for yourself to see the level of privacy).

Yes …..1
No …..2

Comment ______________________________

38. **Is there a separate room /area for examinations?**

Yes …..1 (Skip to Question 21)
No …..2 (Go to Question 24)

Comment ______________________________

39. **(IF NO) Is there a separate area within the counseling room for examinations (e.g. a curtained area)?**

Yes …..1 (Go to question 25)
No …..2 (Skip to question 26)

Comment ____

40. **Do you have a place where you can examine a patient and others CANNOT hear the conversation?**

(Note for interviewer: Auditory privacy is defined as conversation between the client and the health worker cannot be understood by other clients. The other clients may see that a conversation is taking place but cannot hear what is being said. If possible please view this place and test the privacy level).

Yes …..1
No …..2

Comment ____

41. **Is there a place where you can examine a patient and others CANNOT see what is happening?**

(Note of for interviewer: Visual privacy is defined as other clients cannot see the interaction between a client and a health worker. Please try to examine this room for yourself to see the level of privacy).

Yes …..1
No …..2

Comment ____

42. **(Note to interviewer : Please go to the examination room and check the answer to this question yourself) Is the examination area clean?**

(NOTE: "Clean" means fresh linen at start of day, floors swept and mopped, no dust on window sills and tables, rubbish bins empty)

Yes …..1
No …..2

Comment

____

(Note to interviewer: Please go to the examination room and check the answer to this question yourself)

43. **Is there an adequate source of light in the examination area?**

(NOTE: "Source" is any source of light. Adequate means a functioning electric light, hurricane lamp, torch, candles, or sufficient natural light).

Yes …..1
No …..2

Comment : (Including what is the source of light, e.g., sunlight, torch, angle poised lamp etc)

____

44. **Where is most equipment stored?**

In a locked cabinet/cupboard …..1
In an unlocked shelf …..2
Other …..3(Please specify) ____

45. **Where is equipment sent for repairs?**

Repaired here …..1
Sent to the nearest health centre …..2
Sent to the district health centre …..3
Sent to the district health officer …..4
Sent to the provincial health office …..5
Sent to the provincial hospital (PMGH) …..6
Sent to the Church workshop …..7
Sent to private/commercial workshop …..8
Not sent for repairs …..9 (Skip to question 38)
Don't know/cannot remember …..9 (Skip to question 38)

46. **How long, on average, does it take from being to sent and returning from repairs?**

(Note to interviewer: Fill in one of the two –DAYS OR WEEKS)

_______________days

OR _______________weeks

47. **May I see your equipment? I need to check how many of each of the following types of equipment are available for health services.**

(Note for interviewer: Please walk with someone into each room and check the list against the equipment available in that room. If they have an item extra, please list it at the end of the table. If it appears in a room different from that listed in the table, please fill in the details but place into the table where is presently is marked)

SECTION III. EQUIPMENT AND COMMODITIES INVENTORY

TYPE OF EQUIPMENT/SUPPLIES	HOW MANY IN STOCK (a)	NUMBER IN WORKING ORDER (b)	**Is it reliable?** (Please write Yes, No or DK for don't know) **(c)**
1. .Air Ways Infant			
2. .Airway Resuscitation			
3. Albumin sticks for testing urine for protein			
4. Ambubag (resuscitation bag)			
5. Extractor Vacuum Obstetric			
6. Foley catheter (urine collection)			
7. Fridge / Freezer Electric, Gas, Kerosene or Solar			
8. Gloves Surgeon (Different Size)			
9. Hurricane Lamp – Kerosene Operated.			
10. Intravenous Administration Set			
11. Microscope/RDTs			
12. Oxygen BP 3,800 L (**full**)			
13. Refrigerator – electric			
14. Is the refrigerator level?	Yes ...1 No ...2 Don't know ..3		
15. Refrigerator – solar powered			
16. Cold Chain Equipment for vaccines & drugs e.g. a. Thermometers b. Temperature Indicators c. Temperature registers	Yes ....1 No ……....2 Don't know ..3		
17. Refrigerator - kerosene			
18. Is the refrigerator level?	Yes ...1 No …..2 Don't know .3		
19. Vaccine cold boxes			
20. Vaccine ice packs			
21. Vaccine carrier			
22. **Delivey (Mama) kits**	Yes ....1 No …..2 Don't know .3		
23. **Long lasting Insecticidal Nets (LLINs)**	Yes ....1 No …..2 Don't know .3		

Are the following drugs and supplies available for health services? (Please note the level of services at which you are working)

Drug	**Available** (a)	**Expired (b)**	**Was there a stock out in the last six months?(no/yes/ don't know/not applicable)**(c)
Albendazole tablets	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Amoxicillin capsules 500mg	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Chlorhexidine	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Condoms (number of single pieces) _____________	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Contraceptive, (oral and injectables)	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Cotrimaxazole tablets 80mg	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Coartem	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Diazepam injection – for ivi, rectal use	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Ergometrine 0 5mg injection	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Ferrous sulphate/iron	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Intravenous fluids	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
MgSO4	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Misoprostol	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Oral rehydration therapy	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Oxytocin (Pitocin, syntocinon)	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Paracetamol paediatric elixir	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Paraldehyde IMI 5 mls	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Pethidine 500mg/1 ml injection	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Quinine - 600mg in10 ml vial	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Sulphadoxine with pyrimethamine	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Vitamin K injection 1 mg in 0 5 or 1 ml	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2

Drug	Available (a)	Expired (b)	Was there a stock out in the last six months?(no/yes/ don't know/not applicable)(c)
			Don't know … 3
Water for injection, 10ml vial	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3

30. **Are the following vaccine stocks available?**

Vaccine	Available (a)	Useable (that is not expired) (b)	Was there a stock out in the last six months?(No/Yes/ Don't know/Not applicable) (c)
BCG	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
DPT	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Hepatitis B	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Measles	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Polio	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Tetanus toxoid	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3
Yellow Fever Vaccine	Yes … 1 No … 2	Yes … 1 No … 2	Yes … 1 No … 2 Don't know … 3

31. **(If there is a storage facility, including cupboard) Are storage facilities for commodities adequate?**

Note to Interviewer: adequate means no exposure to rain and sun, protected from rats and pests, off the floor, floors and shelves kept clean, boxes dry, secure, rubbish bins empty)

Yes …..1
No …..2
Comment ____________________

32. **How often does the facility get fresh supplies of drugs?**

Every week …..1
Every months …..2
Every quarter …..3
Cannot recall last time received …..4
Don't know …..5

33. **How often does the facility get fresh supplies of vaccines?**

Every week …..1
Every months …..2
Every quarter …..3
Cannot recall last time received …..4
Don't know …..5

34. **Does your facility experience stock outs?**

Every week …..1
Every months …..2
Every quarter …..3
Cannot recall last time received …..4
Don't know …..5

35. **Is there a system in place that tracks the medicines coming in and out of the pharmacy?**

Yes …..1
No …..2

Comment ______________________________

36. **Does the actual "on-hand" inventory match the inventory data (includes drugs and counts)**

Yes …..1
No …..2

Comment ______________________________

37. **Is "on hand" inventory checked on a regular basis? i.e. Pull expireds, counts**

Every week …..1
Every months …..2
Every quarter …..3
Cannot recall last time received …..4
Don't know …..5

38. **Are patients counseled when being dispensed their medication?**

Yes …..1
No …..2

Comment ______________________________

39. **Does the pharmacy have appropriate reference books/tools?**

Yes …..1
No …..2

Comment ______________________________

33. **Are consumables like disinfectant, cotton wool, gauze, soap and gloves available?**

Yes …..1
No …..2

Comment ______________________________

34. **Have you had to interrupt services in the last 6 months?**

Yes …..1
No …..2

35. **What was the reason?**

Reason	Has this been fixed?
1 Shortage of gas	Yes ……1 No …..2 Don't know …..3
2 Shortage of kerosene	Yes ……1 No …..2 Don't know …..3
3 Shortage of vaccines	Yes ……1 No …..2 Don't know …..3
4 Shortage of needles and syringes	Yes ……1 No …..2 Don't know …..3
5 Shortage of petrol/diesel	Yes ……1 No …..2 Don't know …..3
8 Shortage of vaccine carriers or ice packs	Yes ……1 No …..2 Don't know …..3
.9 Shortage of drugs 2	Yes ……1 No …..2 Don't know …..3
10 Lack of transport	Yes ……1 No …..2 Don't know …..3
11 Fridge breakdown	Yes ……1 No …..2 Don't know …..3

36. **Were community outreach activities carried out by the health centre in the past 3 months?**

    Yes …..1
    No …..2
    How many?................................
    Comment ____

37. **Was a "health talk" (group lecture or discussion with clients) held today?**

    Yes …..1
    No …..2 (Skip to question 57)

    Comment ____

38. **Is some record kept for each consultation?**

(NOTE for interviewer only: Obtain and attach an example of a client record form and of the reporting forms used.)

    Yes …..1
    No …..2

    Comment ____

39. **Is this record updated?**

Yes, for all consultations …..1
Yes for some consultations …..2
No …..3

Comment ____________________

40. **Are there mosquito nets over ALL the beds in the health centre?**

Yes …..1
No …..2

If no, how many have beds and nets did you see?

Beds	Mosquito Nets

Comment____________________

42. Are there any of the following ?

61.1 Medical Records Yes …..1
No …..2

61.3 Immunization record Yes …..1
No …..2

61.5 ANC Register Yes …..1
No …..2

61.7 Delivery Register Yes …..1
No …..2

61.8 Child register Yes …..1
No …..2

61.9 Rx Dispensing report Yes …..1
No …..2

41. **In what condition is the record card system? (Note to interviewer : Please examine the system yourself to answer this question)**

No records …..1
Well ordered …..2
Partially ordered, still useable …..3
Disordered, not useable …..4

Comment ____________________

42. **Who is responsible for keeping client records?**

All health staff …..1
One person …..2 (specify position) ____________________

Don't know …..9

43. **If records are used to send reports, is feedback received on reports?**

Yes, always …..1
Yes, sometimes …..2
No …..3

Comment ____

44. **Is there a daily activity register?**

Yes …..1
No …..2
Comment ____

45. **What is the target population covered by the centre:**

1. Children aged 0 – 11 months __________ Don't Know

2. Children aged 1 – 5 years __________ Don't Know

3. Women aged 15 – 49 years __________ Don't Know

4. Catchment population __________ Don't Know

46. **Abstract and record the following health statistics for <u>the last complete month</u>**

FOR THE MONTH OF _______________ YEAR 20_______

Health services provided	Available		Number
1. Antenatal visits	Yes	No	
2 Immunisations of children	Yes	No	
3. MALARIA cases in outpatients	Yes	No	
4. Number of deliveries	Yes	No	
5. TOTAL OPD attendances	Yes	No	
6. Family planning consultations	Yes	No	
7. MICROLUT	Yes	No	
8. COMBINATION PILL	Yes	No	
9. INJECTABLE	Yes	No	
10. IUD	Yes	No	no
11. VASECTOMY /TUBAL LIGATION	Yes	No	no
12. STI	Yes	No	
14. Maternal deaths	Yes	No	
15. Referrals for pregnancy or delivery -related complications	Yes	No	
16 infant deaths (0-11 months	Yes	No	
17. child deaths (12 to 59 months/under 5)	Yes	No	

Comment (include here if data not available and why, if it was an average month, if it was an unusual month and why)

____

____

47. **Abstract and record the following immunization data for the last 3 months.**

(Note to interviewer; if it is recorded for some other time period , please list the duration of that time period here now : ____)

Immunisation	Available	Number
1. BCG	Yes No	
2. DPT 1	Yes No	
3. DPT 2	Yes No	
4. DPT 3	Yes No	
5. Measles	Yes No	
6. Polio 1	Yes No	
7. Polio 2	Yes No	
8. Polio 3	Yes No	
9. Tetanus 1	Yes No	
10. Tetanus 2	Yes No	
11. Tetanus 3	Yes No	
12. Tetanus 4	Yes No	
13. Tetanus 5	Yes No	
14. Hepatitis B	Yes No	

48. **Abstract and record the following health statistics for <u>the last complete year</u>**

FOR THE YEAR 20____

Health services provided	Available	Number
1. Antenatal visits	Yes No	
2. Immunisations of children	Yes No	
3. MALARIA cases in outpatients	Yes No	
4. Number of deliveries	Yes No	
5. TOTAL OPD attendances	Yes No	
6. Family planning consultations	Yes No	
7. MICROLUT	Yes No	
8. COMBINATION PILL	Yes No	
9. INJECTABLE	Yes No	
10. IUD	Yes No	
11.VASECTOMY /TUBAL LIGATION	Yes No	
12. STI	Yes No	
14. Maternal deaths	Yes No	
15. Referrals for pregnancy or delivery -related complications	Yes No	
16 infant deaths (0-11 months	Yes No	
17. child deaths (12 to 59 months/under 5)	Yes No	

CONCLUSION

Thank you for your assistance in this survey. The results will be analyzed and a summary, without names or identifying characteristics will be feedback to you and to the managers of the services at district and provincial level.

Do you have any questions or other comments? Please feel free to ask them or talk about them now.

FOCUS GROUP DISCUSSION SESSION

TEENAGE GIRLS ACCESSING SERVICES AT TSHIP SUPPORTED PHC FACILITIES

Purpose: Assessment for Adolescent Girl's satisfaction about services received from TSHIP
Participants: Teenage Girls visiting TSHIP supported PHC in their community for health services.
Moderator: TBC
Venue: TSHIP supported PHC Facility

INTRODUCTION
Good day all. We are from the State Ministry of Health and TSHIP MTE Team. We are here to conduct an assessment of the health services provided to you as well as find out generally about your experiences at the health facility you visit in your community.

Focus Group Discussion Guide Questions

1. Can you briefly tell us why we have been visiting this health facility?
2. What were the services we have received or still receiving at this health facility?
3. Tell us your general experiences at the health facility during your visits especially as a young woman.
4. Those (health facility staff) providing these services for us, what do we have to say about them and why?
5. Can use tell me any other services you would like to receive?
6. What are your suggestions towards improvement of services at the health facility?

Ask WHY? WHY?

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