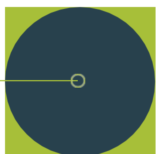


June 2021

Process Monitoring Summary Results: Ebonyi

Introduction

Data for Impact (D4I) is conducting a mixed methods, portfolio-level evaluation of four United States Agency for International Development (USAID) Health, Population, and Nutrition Activities in the Nigerian States of Ebonyi, Zamfara, and Kebbi. The programs are the Integrated Health Project (IHP), the President's Malaria Initiative for States (PMI-S), Breakthrough ACTION-Nigeria (BA-N), and the Global Health Supply Chain Program – Procurement and Supply Management (GHSC-PSM, henceforth PSM). The evaluation includes a process monitoring component designed to help answer evaluation questions, monitor the implementation of activities, provide contextual information, and explore the validity of critical implementation assumptions identified during the development of a portfolio level theory of change (TOC). The first round of process monitoring focused on coordination among Activities, work planning, and areas of joint implementation to describe coordination processes and to determine whether assumptions made about how the activities work together to achieve desired outcomes were accurate. This brief shares the results from Ebonyi where all four Activities are implementing.

Methods

Interview guides were developed for each Activity focusing on how the Activities collaborated and coordinated with each other and the State during planning and implementation to achieve desired outcomes. The guides were informed by the Activities' Monitoring, Evaluation, and Learning plans and result areas, and the portfolio-level TOC.

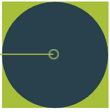
Each Activity provided the names and contact information for potential Activity and State respondents, and information on their responsibilities and areas of engagement and collaboration. Two respondents were selected from each Activity, along with two State counterparts per Activity. A total of 16 interviews were conducted (with 6 females and 10 males) in January and February 2021. The selection of respondents was based on the relevance of their roles and their engagement with the objectives of the evaluation, and the gender of the respondent, with the aim of having a balance of men and women, to the extent possible.

Due to COVID-19, interviews were conducted virtually via Zoom. After each interview, notes were summarized using a reporting template developed by D4I. A matrix—where each respondent was a row and each column was related to an interview topic—was used to facilitate analysis across cases (respondents) and to sort the data by theme.

Coordination Among Activities

The Activities' main collaboration mechanism is a monthly coordination meeting. The purpose of the meeting is to:

- Review progress made in the previous month.
- Share work plans for the coming month to avoid any "clash of activities" (shift and adjust activities when they are targeting the same participants, if needed), leverage resources, and "collapse" similar activities to avoid duplication.
- Identify threats to implementation and develop solutions.
- Ensure that a unified message is presented to the State.
- Coordinate their agenda for advocacy.
- Share and address challenges from the field. For example, when issues of poor service delivery are brought to BA-N's attention, they share the information with IHP/PMI-S so that they can strengthen capacity at the health facility. Similarly, when IHP/PMI-S/PSM have issues that need to be addressed at the community level, they partner with BA-N; for example, when they need to engage in advocacy with opinion leaders to engender confidence in health facilities.



In between monthly meetings, the Activities communicate via one-on-one ad hoc meetings and a WhatsApp group to address any emerging issues.

Coordination with the State

The Activities have quarterly meetings with the State during which each presents their contribution to desired outcomes.

The Activities provide technical (and financial) support for numerous State coordination meetings, such as those of the Advocacy, Communication, and Social Mobilization group, Malaria Technical Working Group (TWG), Malaria and Reproductive, Maternal, Newborn and Child Health TWG, Health Finance TWG, Primary Health Care Development Agency (PHCDA), State Malaria Elimination Programme (SMEP), and the Department of Planning, Research, and Statistics. Multiple Activities serve on many of these groups. The Activities build capacity of members and ensure that action points are followed up.

IHP supported the development of the Memorandum of Understanding (MoU) with USAID. They also supported the steering committee for the MoU to monitor progress against targets.

Coordination: What Worked Well

The Activities reported that their monthly coordination meetings provided a useful forum for presenting successes, gaps, and sharing insights to find ways to address gaps. The meetings allowed them to harmonize their work plans to avoid duplication and leverage resources.

Coordination meetings with the State allowed the State to provide input and to recommend ways to solve challenges.

The Activities and the State felt that co-location of Activity offices with the State helped them have strong relationships, promoted integration between the State Ministry of Health and key Activity staff, and facilitated coordination. The Activities reported that they had a good understanding with the State and Local Government Authorities (LGAs) and that they (State and LGAs) were taking ownership of programs.

A State respondent noted, "They behave as if they are the same family and I believe they are the same family." Another State respondent commented that they were very satisfied with the Activities because "They take the time to meet, interact, and coordinate."

Coordination: Challenges

Activity respondents reported that they had no challenges coordinating with each other. However, one Activity respondent noted that although the Activities worked to avoid the "clash of activities," it happened on occasion because each Activity has a monthly mandate to report on progress and achievements to USAID.

COVID-19 reduced the number of quarterly meetings with the State. It also meant that more meetings were virtual and Internet connectivity was occasionally a problem.

One Activity respondent noted that some State program officers did not send their assistants to participate in meetings when they were not available, and their input was consequently lost. They would like to be able to invite both officers and assistants to the coordination meetings.

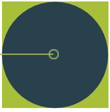
Activity Work Planning

BA-N

BA-N's work plan was based on BA-N's intermediate results (IRs) and activities that contribute to the IRs. The plan was drafted in Abuja and shared with the State for input and with other Activities (through virtual meetings). To examine progress and identify gaps, the plan was informed by BA-N's previous work plan, DHIS data, the family planning dashboard, and a survey done by the National Population Commission. Work plan activities were incorporated in the State Annual Operational Plan (AOP) in the appropriate thematic areas.

What worked well:

- State priorities were taken into account in developing the work plan.
- Work was aligned with the work of other Activities. Activities understood each other's responsibilities.



Challenges:

- Funding constraints. The State had ambitious goals (e.g., wanting BA-N to work in all LGAs).
- COVID-19 meant that some meetings were virtual and were affected by Internet issues.

IHP

The planning process was partly virtual because of COVID-19. A desk review of State policies and reports from previous projects was conducted to look for gaps and challenges to address with evidence-based interventions. The draft work plan was shared with the State for input and then revised at IHP headquarters. The work plan was shared again with the State and other Activities to learn about their work and to identify and bridge gaps before being finalized. The IHP work plan feeds into the State AOP.

What worked well:

- Coordinating with other Activities.
- One-on-one meetings with program officers.
- The State was enthusiastic and readily shared documents (policies, reports, etc.).
- A State respondent commended IHP for taking the time to engage with the State. "We are part of that plan. The level of involvement of the Agency in the planning process is commendable." Another State respondent reported that the work plan was responsive and that IHP was inclusive.

Challenges:

Virtual engagement due to COVID-19 proved harder than in-person meetings. Many meetings were by Zoom and there were Internet issues.

PMI-S

PMI-S first met with State representatives (SMEP and PHCDA) to find out their priorities They then had an in-house meeting to review their previous work plan to identify achievements, best practices, gaps, and challenges. They also reviewed Nigeria DHIS, Health Management Information System (HMIS), Multiple Indicator Cluster Survey (MICS), and Logistics Management Information System (LMIS) data, after which the work plan was drafted. PMI-S then held consultations with other Activities to identify areas for collaboration and leveraging. This was followed by a second in-house review and a second round of stakeholder input, after which the plan was finalized. The PMI-S work plan is aligned with the SMEP AOP.

What worked well:

- Involvement of the State (especially program officers) and consultation with other Activities enabled PMI-S to avoid duplication with other Activities and identify areas for leveraging. PMI-S also worked well with their State counterparts with whom they have a good relationship.
- A State respondent noted that the process was transparent and that they had a good relationship with PMI-S because of the co-location of their offices.
- Another State respondent reported that PMI-S's inclusion of State priority areas was a plus.

Challenges:

- A State respondent noted that PMI-S is not able to support all 700+ health facilities in the State and that private health facilities are not part of the data validation process.
- Virtual meetings due to COVID-19 were impacted by Internet issues.

PSM

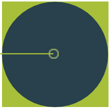
PSM is co-located with the Logistics Management Coordination Unit (LMCU). PSM helped the LMCU develop its work plan and shared it with other Activities so that they could provide input on how the different programs could be supported with commodities. PSM then "extracted" its work plan from the LMCU's work plan (identified activities that it could support). State LMIS data and last mile delivery (LMD) data were used to inform planning.

What worked well:

- The State understood that PSM is pushing for sustainability and ownership. PSM is also advocating for funds for the LMCU so it can take over when PSM is not there.
- There is a good relationship between PSM and LMCU, which facilitates the planning process.

Challenges:

Funding for the LMCU is a challenge because staff lack Internet data, android phones, and a computer system.



Support for the State AOP Process

The Activities' work plans are developed first and are reflected in the State AOP. All the various AOPs are harmonized in one State AOP.

The Activities provided logistical/financial support for the AOP meeting and technical support to their various counterparts/program officers (malaria, RMNCH, nutrition, LMCU, behavior change, etc.). They guided them to complete the documents with feasible activities, assisted with budgeting, and ensured that their activities were captured in the State AOP. DHIS, national HMIS, LMIS, family planning dashboard, and other data played a key role in determining what activities to scale up and where (geographic targeting). IHP used the Lives Saved Tool to help prioritize high impact interventions by estimating how many lives would be saved if the interventions were implemented.

What worked well:

- The Activities noted that the development of the harmonized AOP stimulated better collaboration within different health units of the State.
- Both Activities and State respondents reported that the review of previous State AOPs and the use of data for decision making were helpful.
- The Activities praised the State for its leadership, participation, and enthusiasm.
- The Activities reported that knowledge sharing about how issues can be addressed by activities in the work plan was effective. The Activities supported and guided the State to come up with solutions when gaps were identified. This provided an opportunity for capacity building with the State.
- State respondents appreciated the Activities' technical assistance and inclusiveness (all major stakeholders invited).
- PSM pushed for the LMCU to be invited and that worked well.

Challenges:

- Both Activity and State respondents reported that time was limited (3-day non-residential planning meeting instead of 5-day residential meeting) and that people coming late and leaving early was a distraction. They also noted that Internet was a problem during virtual sessions.
- An Activity respondent noted that State program officers' assistants were not invited and their participation was missed. Some key State officials also did not attend.
- The State is not satisfied with Primary Health Care (PHC) coverage; it would like all PHCs covered.
- State respondents stated that they preferred to have a residential planning meeting to avoid distractions.

Areas of Joint Implementation Among Activities

Areas of Collaboration Among All Activities

The Activities conduct joint entry meetings at the State and LGA levels. Presentations are made by each Activity on their program focus areas to explain how each Activity contributes to each other's work. The Activities also collaborate on advocacy visits to the State.

An Activity leading an activity invites the other Activities to send a representative so that they have a strong sense of what each other is implementing.

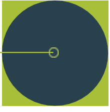
IHP, PMI-S, and BA-N provide PSM with information from health facilities and the community on stockouts, commodity mismanagement, imbalances, or expirations so that they can intervene. Technical assistance to LMCU is led by PSM and supported by the other Activities.

The Activities are jointly involved in the training of community volunteers, with BA-N leading and IHP bringing in gender; PSM explaining how commodities are supplied and monitored; and PMI-S providing information on malaria prevention and treatment. For maternal health quality, IHP works with PSM for commodities, BA-N on access and community engagement, and PMI-S for malaria.

Areas of Collaboration Among BA-N/IHP/PMI-S

IHP and PMI-S attended BA-N-led improved provider interpersonal communication and counseling training programs.

BA-N's assessment of Ward Development Committees (WDCs) was done in collaboration with IHP and PMI-S because WDCs have overlap with health facilities.



Areas of Collaboration Between BA-N/PSM

BA-N and PSM collaborated on the distribution of long-lasting insecticidal nets (LLINs).

BA-N and PSM adopted a strategy to work with WDCs so that they can monitor commodities. WDCs will countersign the receipt of commodities and monitor their usage. This aligns with requirements of the Basic Health Care Provision Fund (BHCPF).

Areas of Collaboration Between BA-N/IHP

BA-N and IHP worked to harmonize State data in terms of the names of facilities and wards (addressed the disparity in State and LGA data).

They collaborate on gender and social inclusion (e.g., how gender affects the ability to adopt behaviors) and jointly observed Global Gender Week.

BA-N shared information on providers gathered from the community with IHP. BA-N and IHP plan to hold cluster meetings with providers so that those from different communities can share information. IHP is working with BA-N to identify a sustainable emergency transport system and a mobile referral system.

Areas of Collaboration Between BA-N/PMI-S

BA-N and PMI-S collaborate on ward data validation.

They jointly identify stakeholders working in the malaria space, such as professional organizations, private hospitals, etc., for joint advocacy. They also collaborate on provider adherence to intermittent preventive treatment of malaria in pregnancy (IPTp) through clinical meetings.

BA-N and PMI-S collaborated on the implementation of the behavior economics prototype to improve service provider malaria case management adherence. They jointly conducted training of trainers (TOTs) for State and LGA partners, who will then roll out the training to health facilities.

Areas of Collaboration between IHP/PSM

IHP and PSM collaborated to train 172 health facility staff on commodity management. When PSM visits health facilities, they provide additional on-the-job training.

They also coordinate on data quality and with the LMCU to implement commodity management training in all 13 LGAs.

PSM is preparing to revamp the Drug Revolving Fund (DRF) and IHP is working to strengthen the BHCPF and DRF system so that health facilities can operate both properly.

Areas of Collaboration Between IHP/PMI-S

IHP and PMI-S conducted data validation in LGAs, sharing resources and personnel. They also collaborated on IHP-led HMIS training for health facilities. They support the State data quality meeting and are working to reactivate the State Health Data Governance Council.

They also collaborate on RMNCH for integrated Community Case Management, a key component of malaria case management.

Areas of Collaboration Between PMI-S/PSM

PMI-S and PSM visit health facilities together for supportive supervision to ensure commodity availability (especially for IPTp), triangulate HMIS and LMIS data, redistribute commodities, and for LMD. They jointly developed tools for SMEP, focused on key indicators for malaria services and the quantity of malaria commodities consumed.

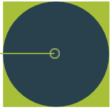
Implementation

The Activities support the State to lead activities in the AOP. They conduct TOTs with State/LGAs (for example, on provider behavior change) so that they can roll out the training to health facilities.

Implementation: What Worked Well/Successes

The Activities reported that the following activities worked well or were successes:

- Sharing of work plans among Activities; leveraging activities of other Activities; information sharing and cross learning among Activities.
- Activities conducting joint capacity building for State/LGAs.
- Activities' advocacy efforts.
- LLIN campaign.
- All Activity collaborations previously mentioned



were said to be successes.

State respondents reported the following successes:

- Improved commodity availability.
- Improved capacity of providers and State officials (improved case management, improved use of data for logistics management, improved planning capacity at State and LGA levels, development of a pool of trained State staff who can roll out training).
- Increase in reporting rates.
- Activity support for the AOP process.
- Introduction of WDC validation meetings and data triangulation.
- Implementation of directly observed therapy for IPTp at health facilities.
- New pool of trained supervisors for malaria case management.

One State respondent reported that "[The Activities] hold their hands together and try to achieve something together." Another said, "The four [Activities] in the State work like sisters. One can't hold activities without involving the others."

A State respondent noted, "[The Activities] encourage us and we are at the driver's seat." Another State respondent echoed this sentiment, "The State is in the driver's seat and [Activities] are the passengers with know-how."

Implementation: Challenges

Both State and Activity respondents reported similar challenges:

- The State lacks human resources for health. The lack of funding and the late release of funds were also major challenges.
- The State wanted BA-N's presence in the entire state, which was not possible.

Activity respondents also reported the following challenges:

- Transfer of State/LGA and health facility staff who have been trained and the need to train new staff.
- National (Federal Ministry of Health) activities sometimes clashed with planned Activity activities and took precedence, such as national immunization efforts.

State respondents reported that COVID-19 hindered the delivery of key activities, as did some political issues in the State (politicians defecting from one political party to another).

Sustainability

State respondents lamented that in the spirit of USAID's sustainability efforts, some Activities were not paying transport for personnel who came from within 50 kilometers for the AOP planning meeting. The State's dissatisfaction was also noted by the Activities. However, one State respondent reported that the Activities "preach" about sustainability and ownership and through frequent messaging, government workers were coming to understand it. "By the time you finish listening to them, you have to give a thought to what they are saying. Was a bitter pill to swallow. But the way they approach [us] and their attitude and willingness to assist [helps]."

Activity and State respondents also noted that some Activities were having residential meetings and others were not (due to per diem issues). They reported that the different payment structures of Activities were a challenge andit would be good if all practices were the same.

For more information

D4I supports countries to realize the power of data as actionable evidence that can improve programs, policies, and—ultimately—health outcomes. We strengthen the technical and organizational capacity of local partners to collect, analyze, and use data to support their move to self-reliance. For more information, visit https://www. data4impactproject.org/

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