



Process Monitoring Summary Results: Kebbi

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 activities 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 preliminary results from Kebbi where IHP, BA-N, and PSM are active.

Methods

Key informant interview (KII) guides were developed for each Activity that focused on how the Activities collaborate and coordinate 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, the portfolio-level TOC, and result areas.

Each Activity provided the names and contact details 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-level counterparts per Activity such that 12 interviews were planned. One State respondent was not available.

Eleven interviews were conducted (with two females and nine males) in March and April 2021. The selection of these key informants was based on the relevance of their roles and engagement with the evaluation objectives.

Due to COVID-19, the 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 are known as the “tripartite USAID project” in the State. Their main collaboration mechanism is a monthly coordination meeting organized by IHP. The purpose of the meeting is to:

- Share work done in the previous month and plan for the upcoming month.
- Harmonize workplans and ensure that the Activities' activities are complementing each other and that there is no “clash of activities.”
- Discuss ways to deepen collaboration to be more effective.
- Compare data and share feedback from the field.
- Discuss challenges and brainstorm solutions.

Monthly coordination meetings are supplemented by ad hoc meetings. The Activities also invite each other to their specific coordination meetings to further enhance coordination and effectiveness. For example, PSM invited IHP to its family planning coordination meeting and IHP subsequently addressed some challenges with Local Government Authority (LGA) family planning coordinators.

Coordination with the State

The Activities have a monthly briefing meeting with the State during which they present progress on their work. Activity respondents also mentioned several technical



working groups (TWGs) and State and local officials with which they coordinate on varying schedules.

BA-N and IHP provide technical assistance (TA) and coordinate with the State Ministry of Health (SMOH) and the Primary Health Care Development Agency (PHCDA) through two coordination units—the State Emergency Maternal and Child Health Intervention Center and the State Emergency Routine Immunization Coordination Center. Meetings were held daily, but with the emergence of COVID-19, are occasionally held every other week. They also use a WhatsApp platform to share information. In addition, BA-N and IHP provide TA and coordinate with the State through the Demand Generation TWG.

BA-N provides TA and coordinates with the State through the weekly Ward Development Committee (WDC) review meeting, the Community Capacity Building platform, and the Behavior Change and Advocacy Core Groups.

IHP provides TA and coordinates with the PHCDA through its monthly health sector partners meeting and TWGs; for example, the Gender and Social Inclusion TWG, Nutrition TWG, Malaria TWG, Child Health TWG, and Monitoring and Evaluation TWG. Most of these TWGs met bimonthly or monthly. IHP also facilitates the State Contributory Healthcare Management Agency (KECHEMA) forum and serves on the COVID-19 State Steering Committee.

IHP and PSM support the State Ministry of Budget and Planning by facilitating the quarterly partners forum (which is broader than the health sector), at which workplans and activities are shared.

PSM works directly with the State Logistics and Management Coordination Unit (LMCU) and provides TA and support to the State PSM TWG and to the regional PSM TWG. PSM also support the State's malaria, family planning, and maternal, newborn, and child health coordination meetings. IHP and BA-N attend many of these coordination meetings. PSM also coordinates with high-level stakeholders, including the Director of Health, Honorable Commissioner of Health, Director of Pharmaceutical Services, and the Executive Secretary of the PHCDA.

Coordination: What Worked Well

The Activities reported that their monthly coordination meetings help facilitate collaboration and partnership, help avoid clashes of activities, and provided an opportunity to share cross-cutting issues and develop solutions. The meetings also provide a forum for capacity strengthening.

The Activities reported that coordination meetings with the State allowed the State to see the individual contributions of each Activity and how their work is harmonized. Activity respondents said that coordination with the State through the various TWGs works well.

Both Activity and State respondents stated that the co-location of offices helps with communication and coordination. Some State respondents noted that the PSM is temporarily co-located with BA-N and IHP due to a fire. Normally, PSM is co-located with the LMCU. State respondents appreciated PSM's co-location with the LMCU because the activity provides direct technical support. IHP also has offices embedded in three LGAs, which facilitates communication and coordination with the State at that level.

State respondents reported good relationships with the Activities, but noted some challenges, which are discussed below.

Coordination: Challenges

One Activity respondent reported that, at times, the three Activities invited the State to the same meeting. The Activities also advised that there were months when they did not meet because of competing demands. The Activities' WhatsApp listserv was described as "not very active."

One Activity respondent said that State satisfaction with coordination was about 70 percent, noting that the State is reluctant to fund activities. The State's reluctance to take ownership and to fund activities was echoed by respondents from the other Activities. One Activity respondent reported a need for high-level advocacy with top government officials to address issues around funding.

Responses from IHP and State interviewees suggest that



there was a difference in the State's versus IHP's interpretation of IHP's scope and role, and a tension around how IHP's funding procedures differ from those of other funders. These differences in expectations may be partly due to the way the State engages with other development partners. The differing expectations about IHP procedures was confirmed by two State respondents. One respondent elaborated, "They [IHP] are the ones coordinating, not the State, which is supposed to coordinate....The whole responsibility of coordination is under them; there is no ownership by the State." This respondent felt that IHP and the State need to develop a shared understanding similar to that with other partners: "Nongovernmental organizations come to liaise with the State to carry out their implementation, because they are to support and finance whatever [the Department of Planning, Research, and Statistics] DPRS office arranges but IHP is not like that." These two respondents noted that IHP does not provide daily subsistence allowances (DSAs) like other partners. One explained that "There is a need to do something to motivate to get better results." A third State respondent echoed concerns about the lack of funds for transportation and DSAs, and felt that a "serious meeting" was needed to review these concerns.

A State respondent suggested that all IHP work should go through the PHCDA because IHP is tasked with improving primary health care. Another State-level respondent reported that IHP took some activities to the SMOH and KECHEMA that they believed should have been coordinated by the PHCDA. They also noted that IHP does not contact them directly when they have activities in LGAs. Instead, they find out when health workers request approval to attend. These concerns may partly reflect fragmentation in government agencies, as reported by national-level respondents, and different expectations about the roles of different agencies that affect IHP's activity implementation when working across a complex system portfolio.

Activity Work Planning

BA-N

The 2019 State plan for Kebbi was developed with BA-N headquarters staff during a retreat. The State Health Educator presented during the retreat to communicate

the State's activities of interest. In 2020, BA-N reviewed the 2019 plan and determined which activities to carry forward. This time, the State was not involved. Once the plan was approved, it was shared with the State and the areas to be supported were highlighted. After USAID approved all Activities' workplans, the Activities reviewed and harmonized their activities.

What worked well:

- The Activities worked closely to ensure that their workplans were harmonized, duplication was reduced, and that they leveraged each other's strengths.
- The Memorandum of Understanding (MoU) with USAID was helpful because BA-N's workplan could be tracked by the performance of the MoU.

Challenges:

- Some activities were suspended or the number of target beneficiaries was reduced (e.g., from 20 to 10 or 15) due to funding constraints.

IHP

IHP respondents reported that the State was more involved in the development of IHP's previous workplan. Much of the current year's workplan was repeated from the previous year. IHP developed the workplan and shared the final document with the State. One IHP respondent stated that the reason for not including the State earlier in the current year was because the content was mostly repeated. However, one State respondent reported that they did participate in activity planning for leadership and governance as the State's PHCDA officers met with IHP's program officer and discussed how to develop the minimum service package (MSP) for health facilities.

IHP's workplan was included in the State Annual Operational Plan (AOP) and District Health Information System (DHIS2) data informed the development of the plan. Other Activities were not involved in the development of IHP's workplan; however, the plan contains specific areas for collaboration with other Activities.

What worked well:

- IHP staff were committed to the planning process.

The review of the previous workplan to identify areas where outcomes were not achieved was helpful because these activities were carried forward in the current workplan.

- IHP has a quarterly “pause and reflect” activity to which the State is invited. This activity allows the State to know what has been achieved and what has not, and to review plans for the upcoming quarter.

Challenges:

- One IHP respondent noted that the workplan was developed in separate States; they would have liked to have developed it with all States together.
- A State respondent reported that IHP’s final workplan was not shared with the PHCDA.

PSM

PSM is active in 36 States. Its workplans are developed at the central level. Most of the activities in the State plan are routine (e.g., bimonthly Logistics Management Information System [LMIS] review meeting, last mile distribution monitoring, proof of delivery review). There may be a few small additions and/or subtractions to this routine workplan in each State plan, which are communicated by the PSM Regional Director. The PSM workplan is aligned with the State AOP because the routine activities of PSM are aligned with the LCMU.

What worked well: Not mentioned.

Challenges: None mentioned.

State AOP

The AOP development process was supported by development partners. Their engagement in the process was comprehensive. The Activities provided funding and technical input in their thematic areas. For the most part, each Activity’s workplan was reflected in the relevant thematic area of the State AOP. The AOP was informed by federal government health policies, the State’s strategic health development plan, National Health Management Information System data, the Malaria Indicators Survey, and the National Immunization Coverage Survey, among other data.

One PSM respondent reported that they were initially

not invited to the AOP planning retreat. When they were later invited, the dates coincided with PSM’s regional meeting and PSM staff could not attend.

What worked well:

- Development of the Malaria AOP was comprehensive because relevant stakeholders were engaged. (Activity respondent)
- Use of data in developing the plan (Activity respondent).
- Invitation to and participation of a representative from the Federal Ministry of Health and the National PHCDA. (Activity respondent)
- Using a consultant and conducting the process away from the State capital to get full participation from stakeholders. (Activity respondent)
- Gender and social inclusion were incorporated in all IHP planned activities. (Activity respondent)
- Availability of Activity workplans and the MoU with USAID to inform the development of the AOP. (State respondent)
- Activities’ technical support. (State respondents [2])

Challenges:

- Managing expectations of State stakeholders, including on DSAs/allowances. (Activity respondent)
- Development of the AOP is supposed to be driven by the State’s 5-year strategic plan but in many areas it is not. (Activity respondent)



Areas of Joint Implementation Among Activities

Areas of Collaboration Among All Activities

The Activities participate in each other's activities and training programs, especially when they require each other's technical expertise. When USAID visits a facility, the Activities coordinate to show USAID how they work together.

IHP and BA-N use the PSM TWG to discuss supply chain issues in the State, e.g., which commodities and services are in greater demand and what clients are saying about availability). BA-N and IHP also collaborated with PSM and the State on piloting the warehousing that will be used for the Drug Revolving Fund (DRF).

Areas of Collaboration Between BA-N/IHP

BA-N and IHP coordinate their system strengthening activities for demand creation and for building the capacity of State staff to implement activities.

IHP leverages BA-N's relationship with existing community structures (traditional and religious leaders) and BA-N leverages IHP's gender focal person.

IHP collaborates with BA-N by informing BA-N about the kinds of services that are available in the facilities that they support, on which BA-N then sensitizes the community. IHP also collaborated with BA-N on an audio job aid, where a caller uses a short code to access recorded information on what services the caller needs. This resource was advertised on BA-N demand creation radio programs.

IHP and BA-N jointly carried out a baseline study of the WDCs and facility management committees (FMCs) in the facilities that IHP is supporting. Through the WDCs and FMCs, BA-N receives feedback on the quality of services at health facilities supported by IHP. IHP then addresses the issues raised. When a facility has a structural defect, the WDC, through BA-N engages IHP to have it resolved.

Areas of Collaboration Between BA-N/ GHSC-PSM

BA-N and PSM collaborate on the distribution of long-lasting insecticidal nets. They also coordinate to

generate demand at health facilities where family planning commodities were available. In addition, BA-N informs PSM when they learn from a community that a facility has stockouts and informs PSM where they are working on demand creation so that they can anticipate an increase in clients.

Areas of Collaboration Between IHP/PSM

IHP gathers feedback on commodities during supportive supervision activities and shares this information with PSM. PSM ensures that the facilities supported by IHP are supplied with commodities regularly, and IHP staff embedded in LGA offices confirm the distribution of commodities to facilities by PSM.

IHP participates in PSM's LMIS meetings and will be providing technical support in a forthcoming DRF training that will be organized by PSM.

Implementation

The Activities supported the State to lead activities in the AOP. They conducted training of trainers activities with State/LGA staff (e.g., on provider behavior change) so that the State can roll out the training to health facilities.

Implementation: Worked Well/Successes

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

- Overall coordination and collaboration among Activities.
- Training of the LGAs' reproductive health coordinators on the new model of reporting family planning and a steady improvement in the reporting rate.
- Making use of all structures that the State had. For example, involving State leaders, religious and traditional leaders, and key health experts in advocacy and demand generation for family planning and maternal and child health services.
- Delivering commodity supplies to the 225 facilities supported by IHP and information sharing among Activities about commodities.
- Improved LMIS reporting, which helps ensure



commodity security in the health facilities and reduced commodity expiration at the LGA level.

- Improved relationship between WDCs and FMCs.
- USAID's MoU with the State helped the State understand the need for funding Primary Health Care (PHC) facilities, and enrollment of PHC facilities to access the Basic Health Care Provision Fund (BHCPF).
- Improvement in the quality of services at supported PHC facilities.

State respondents reported the following successes:

- BA-N collaborated with the State to create the Advocacy Core Group (ACG). Key members are religious leaders, the wife of the State Governor, and the Emir of Gwandu. The ACG works to change providers' behavior that is preventing women from attending antenatal care or delivering at health facilities. The Activities leverage the ACG to see top government officials.
- Community empowerment for women is improving, (e.g., some have motorcycles, grinding machines, sewing machines, and domestic animals).
- The jingle radio segment called Albishinku is popular and effective in changing people's attitudes related to health.
- Interpersonal communication and counseling work with providers is improving their communication with clients, which in turn makes clients seek more services at facilities.
- The low dose, high frequency approach to building the capacity of providers is effective. In terms of IHP's training to improve quality of care, "the State will say bravo to IHP."
- The State (PHCDA) is happy with the development of the costed MSP and the development of business plans for 225 PHC facilities.
- DHIS data quality has improved.
- Training of health workers on LMIS data collection across the State and data validation exercises are success stories.
- PSM is a strong project and commodity supply is very good.
- The reporting rate for family planning commodities has increased to 100 percent under PSM, whereas

before it was between two percent and ten percent.

- PSM and other Activities played a key role in ensuring that the State created a budget line for the LMCU. Previously, the LMCU did not have a budget and could not take ownership of activities.

Implementation: Challenges

Both the State and BA-N reported that the State would like BA-N to work in all 21 LGAs (it is in 11 LGAs).

Activity respondents reported the following challenges:

- The State is not acting as the driver of implementation and lacks the capacity to implement fully; the State relies too much on the Activities.
- Government staff need close supervision to ensure that activities are carried out with full fidelity.
- The transfer of health facility staff resulted in new staff that did not understand the Activities' activities.
- Late release of funds by the State.
- Getting the State to understand the need for the establishment of a BHCPF oversight committee (of which all Activities are members).
- Activities' tight schedules affect their ability to hold their regular meetings. Consequently, there are gaps in coordination and collaboration, which could be more robust.
- Security issues (kidnapping, banditry, violence).

State respondents reported the following challenges:

- The State wants the Activities to involve the State in their workplans before they are finalized to improve working relationships and activity implementation. The involvement should include both top officials and those who go to the field.
- IHP collaborates with KECHEMA on health financing. The PHCDA wants more coordination going forward with IHP (monthly or quarterly meetings).
- IHP's policy of not providing transportation for those travelling less than 50 kilometers is an issue; people do not attend their meetings. Other donors (UNICEF, World Health Organization, and Nutrition International) pay for transportation.



- IHP's mode of operation is creating problems in the State with vendors. For example, UNICEF and the State bargained with vendors to pay lower rates than IHP does. This was an issue because the State or any Activity that is not as financially as strong as IHP would have a problem with vendors.
- The DRF only includes commodities for reproductive and maternal and child health (RMCH). The State wanted a more comprehensive, holistic approach through the development of an essential drugs list beyond just RMCH.
- The Activities coordinate but there are gaps. The State would like USAID to sit together with them to enhance harmonization.

For more information

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