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Targeted States High Impact Project (TSHIP) End-of-Project Evaluation Final Report December, 2015

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LIST OF ACRONYMS

ACCESS	Access to Clinical and Community Maternal, Neonatal & Women's Health
ACT	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
CBHV	Community-Based Health Volunteer
CHEW	Community Health Extension Workers
COMPASS	Community Participation for Action in the Social Sector
COP	Chief of Party
CSO	Civil Society Organization
CYP	Couple Years of Protection
DHIS	District Health Information System
DMMA	Drugs and Medical Consumables Management Agency
DPT3	Diphtheria, Pertussis, and Tetanus
EMAP	Expanded Males as Partners
EOC	Emergency Operations Center
EmONC	Emergency Obstetrics and Newborn Care
EOP	End of Project
FANC	Focused Antenatal Care
FGD	Focus Group Discussion
FOG	Fixed Obligation Grant
FOMWAN	Federation of Muslim Women Association of Nigeria
FP	Family Planning
FSS	Focus States Strategy
GON	Government of Nigeria
HF	Health Facility
HR	Human Resources
HMIS	Health Management Information System
HREC	Health Research Ethics Committees
HSS	Health Systems Strengthening
ITNs	Insecticide Treated Nets
IPT	Intermittent Preventive Treatment
ISS	Integrated Supportive Supervision

JNI	Jama'atu Nasril Islam
LEAD	Leadership, Empowerment, Advocacy and Development
LGA	Local Government Area
LHI	Life Helpers Initiative
LNGO	Local Non-Governmental Organization
LQAS	Lot Quality Assurance Sampling
MBEP	Ministry of Budget and Economic Planning
MCC	Male Community Champions
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
M&E	Monitoring and Evaluation
MEMS	Monitoring and Evaluation Management Services
MLG	Ministry for Local Government
MNCH	Maternal, Newborn and Child Health
MOU	Memorandum of Understanding
MSIN	Marie Stopes International Nigeria
MWASD	Ministry of Women Affairs and Social Development
NDHS	National Demographic and Health Survey
NEI	Northern Education Initiative
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PFD	Partners For Development
PHC	Primary Health Care
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMV	Patent Medicine Vendor
PPFN	Planned Parenthood Federation of Nigeria
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RI	Routine Immunization
SBA	Skilled Birth Attendant
SBMR	Standards-Based Management and Recognition

SIDHAS	Strengthening Integrated Delivery of HIV/AIDS Services
SMOH	State Ministry of Health
SOP	Standard Operating Procedure
SPHCDA	State Primary Health Care Development Agency
SSS	Salt-Sugar Solution
TMG	The Mitchell Group
TSHIP	Targeted States High Impact Project
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
USG	United States Government
WASH	Water Sanitation and Hygiene
WDCs	Ward Development Committees
WHO	World Health Organization
NAG-JNI	Nigerian Aid Group of Jama'atu Nasril Islam
SMOH	State Ministry of Health

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EXECUTIVE SUMMARY

BACKGROUND

The Targeted States High Impact Project (TSHIP) is a six-year, \$89,953,015 project which supported the integration of primary healthcare services to deliver maternal, newborn, and child health (MNCH) interventions and strengthen the health systems in Bauchi and Sokoto States. TSHIP supported USAID/Nigeria's former Strategic Objective 13 (now Development Objective 4): Increased use of social sector services. TSHIP's principle objective was to foster the use of high-impact interventions in the two focus states. TSHIP is an integrated package of health service improvement interventions, which helps state and local governments improve primary healthcare services by filling in capacity gaps, building on institutional strengths, and improving households' ability to protect and promote their own health.

PURPOSE OF THE EVALUATION

The purpose of the end-of-project performance evaluation was to determine if TSHIP had attained its development objectives; assess the strengths and weaknesses of TSHIP's implementation strategy; and determine best practices and lessons learned over the life of the project. The evaluation findings will be used to inform the design and implementation of future United States Agency for International Development (USAID) supported maternal, newborn, and child health/reproductive health/family planning (MNCH/RH/FP) activities.

METHODOLOGY

The Evaluation Team consisted of a five person external team (including two MEMS II Staff) and seven research associates. A mixed method (qualitative and quantitative) approach was used and included client exit interviews, a health facility survey, 21 focus group discussions (FGD), and key informant interviews (KII) with TSHIP staff and government officials at the state, local, and community levels; members of civil society organizations; community members; other donor organizations; and USAID. The team interviewed a total of 524 people in Sokoto (254) and Bauchi (253) from 20 Local Government Areas (LGAs) and met with 17 USAID officials and reviewed 68 documents and secondary data and analysis of performance indicators. The field work was carried out from June 29 – July 10, 2015.

KEY FINDINGS

While service delivery was found to have improved at the TSHIP-supported sites visited by the Evaluation Team, TSHIP was seriously hindered in achieving its expected health outcomes during the six years of the project because the project's critical assumptions failed to hold during implementation and because some indicators require longer

timelines to see an improvement. Also, while TSHIP ushered in new progressive health policies such as minimum coverage packages, they are still at too early a stage of implementation to be evaluated and to have delivered measurable health outcomes. The assumptions which have thus far been hard for the Government of Nigeria (GON) and LGAs to meet included the ability and willingness of the two states to provide adequate staff levels at the state, local government, and health facility levels; provide sufficient funding levels for high-quality service delivery; provide adequate commodities; and a functioning health management information system (HMIS). TSHIP met or surpassed expected outputs, with especially high praise for the project's community work and building effective community networks. The community work has laid the groundwork for the local governments to strengthen health services in the two states.

Improved Health Outcomes and Integration of Services: The following five indicators used by TSHIP to measure outcomes show a trend of increasing utilization and coverage over time:

- Percentage of children who received the Diphtheria, Pertussis, and Tetanus (DPT3) vaccine by 12 months of age
- Percentage of births attended by a doctor, nurse or midwife
- Percentage of children under five years old with diarrhea treated with oral rehydration therapy
- Couple years of protection (CYP) in USG-supported programs
- Modern contraceptive rate

While the measures of a) how many offered services are bundled together in health facilities and b) how often clients are offered other services when visiting health facilities show an improvement in integration, there has not been enough of an improvement to recognize these services as having been truly integrated. Service providers and clients agreed that malaria case management, antenatal care (ANC), immunization programs, and diarrhea treatment/management were the most utilized programs. However, trends from the National Demographic and Health Survey (NDHS) 2008, NDHS 2013, and TSHIP's Lot Quality Assurance Sampling (LQAS) surveys do not show significant improvement in health outcomes. Interventions that took place outside of health facilities played a big role in the TSHIP approach. The most frequently mentioned was the community-based distribution of misoprostol and chlorhexidine through the Community Based Health Volunteers (CBHVs).

Improved Health Systems: TSHIP strengthened the health systems in Bauchi and Sokoto States by advancing key policies, which improved allocation of resources for primary healthcare. However, release of these resources, oversight of their use, and overall adequacy for the task were insufficient. The most effective health system strengthening interventions included: community empowerment; health management

information systems (HMIS); policy work;¹ training, and capacity building; evidence-based budgeting and planning; and integrated, supportive supervision. The least effective interventions were health systems financing and human resources for health.

USAID's Focus States Strategy (FSS) Works: The partnership between TSHIP and other projects yielded synergies and efficiencies. For example, the Leadership Empowerment Advocacy and Development (LEAD) project supported TSHIP in its community [Ward Development Committees (WDCs)/Local Government Area (LGA)] and policy work. TSHIP taught LEAD about health systems governance and gave it credibility in more areas than it would have had otherwise. Other TSHIP collaborations also produced efficiencies: Northern Education Initiative (NEI), DELIVER, and Water Sanitation and Hygiene (WASH). Collaborations with Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) and the FISTULA project were less effective.

Best Practices: Activities that should be considered for future project design include: community mobilization programs, including community-based distribution of misoprostol and chlorhexidine through CBHVs; support for women's community initiatives; involvement of traditional and religious leaders; and support for sub-grantees. Support for continued HMIS strengthening, data analysis and quality control, and continued support for capacity building programs to strengthen these will address serious gaps. Male involvement in FP/ANC/women's health should continue to be supported. Programs to increase efficiency, transparency, and accountability, such as integrated supportive supervision, should also be continued.

Gender Integration: TSHIP addressed gender at multiple levels. At the state level, the project collaborated with FSS partners to facilitate a Gender Gap Assessment and Analysis. TSHIP also worked with the State Gender Technical Working Groups to move gender policy forward. TSHIP used sub-grantees to promote maternal, newborn, and child health (MNCH) and FP outreach. The project trained Expanded Males as Partners (EMAPs) and Male Community Champions (MCCs). TSHIP engaged organizations such as the Federation of Muslim Women Associations in Nigeria (FOMWAN) and the Nigerian Aid Group of Jama'atu Nasril Islam (NAG-JNI) to leverage these groups' access across gender and cultural barriers. The most effective gender activities conducted were: EMAPs; MCC; male inclusion; 100-Women Groups; CBHVs; use of

¹TSHIP defined its role in policy as: "Entrenching accountability within the public healthcare systems of the focus states. Functional Governance structures such as institutional arrangements, infrastructure, personnel and policies facilitate how the Project engages key actors within the health systems of Bauchi and Sokoto. These dynamics and mechanisms will ensure that the refocus initiatives of the Project are rooted, owned and sustained. Improved service delivery is catalyzed by good governance which translates to functional health systems. Through demand creation, policy advocacy and health financing, states are more likely to improve their availability of human resources for health (HRH) and essential commodities." Project Annual Report, Year Five, 42.

traditional and religious leaders to promote birth spacing; and proactive recruitment and inclusion of women in project activities. The least successful activities were WDC and LGA gender composition. Gender integration was not well defined in the project description and, therefore, not well defined by the project. As a result, gender activities appeared to be more opportunistic than strategic.

MAJOR CONCLUSIONS

There has been an improvement in service integration at the health facility level in both states, but not enough to recognize these services as having been truly integrated. Family planning and malaria services have been fully integrated, while ANC and immunization services have not. Trends from the 2008 and 2013 NDHS and TSHIP's LQAS surveys do not show significant improvement in health outcomes in the two states. For example, routine immunization remains stubbornly mired at unacceptably low levels in spite of the best efforts by TSHIP and many other programs.

Strengthening health systems needs to be combined with health governance for greater efficiency must be combined with governance improvements if the improved systems are to develop. Several of TSHIP's critical assumptions did not hold, which limited the health impact of the project.

The single biggest legacies of TSHIP include, but are not limited to:

- Revitalization and training of WDCs
- Use of CSOs, 100 Women Groups, sub-grantees, and other community groups to advocate and promote health
- Establishment of the CBHV program. This is a successful platform for the LGAs to launch and sustain services.
- Distribution of misoprostol and chlorhexidine for home delivery

TSHIP put maximum effort into training and capacity building. The scale of these efforts is impressive. Training CBHVs meant training ten CBHVs per ward across 323 wards, or 3,230 people. In the area of capacity building, TSHIP also created job aids; conducted extensive pre-service training; trained on and implemented Standards-Based Management and Recognition (SBMR); and provided on-the-job training, cross-visits, and workshops. TSHIP supported a wide range of policies, from simple standard operating procedures (SOPs) to legislation that created new agencies, such as the Drugs and Medical Consumables Management Agency (DMMA) in Bauchi State. All of these efforts were designed to strengthen and improve health systems or the context surrounding these systems. There is, however, no assurance that the state governments will fund these policies and agencies or continue necessary supportive supervision to monitor SOPs.

Despite TSHIP support, data quality remains a problem. Sustainability of HMIS gains is in question with the ending of the project, as many of the support functions, including

supportive supervision and follow-up, provision of forms, and occasional replacement of equipment provided by TSHIP, may not be picked up by the states and LGAs.

The revitalization of the WDCs (executed in collaboration with LEAD) in both states was successful and made important contributions to the success of the project. The WDCs took responsibility for and played an active role in project interventions. The WDC structure holds promise for sustainability of some of the project gains.

The community-based distribution of misoprostol and chlorhexidine using CBHV, which is a TSHIP innovation, is an effective and lifesaving intervention, which is widely appreciated by the communities served.

The Focus States Strategy is an effective framework for creating synergies and multiplying the outputs of investments by USAID. FSS made TSHIP more efficient, saving time and resources. The FSS was especially effective in TSHIP's work with LEAD, but was also effective with their other FSS partners.

TSHIP's sub-grants to WDCs, local non-governmental organizations (LNGOs), faith-based organizations, and others worked very well once the sub-grantees were able to begin their work. Sub-grantees show promise for sustainability since they are indigenous to the communities and not as reliant upon state funding.

Integrated supportive supervision is a powerful tool and it was used well by TSHIP. Its funding by the two states remains an issue.

Gender issues were and still are a barrier to improving health outcomes in the two states. While TSHIP made progress in this area, the problem is far greater than any health or development project can solve by itself. TSHIP made incremental improvements to gender integration and inclusiveness, and the use of men to promote the use and acceptance of child spacing stands out. Had TSHIP been equipped with a well-articulated gender strategy and a gender specialist on staff to turn the strategy into action, the project could have done more to integrate gender into its implementation.

KEY RECOMMENDATIONS

Follow-on activities should be designed in collaboration with the key stakeholders (state and local governments and civil society) in the two states. This will increase ownership and sustainability and can be used to address some of the shortfalls in the critical assumptions for TSHIP. States' responsibilities need to be negotiated and should include provisions for staffing, commodities, and the timely release of funds while ensuring transparency and accountability. Ward Development Committees should be given responsibility for holding health officials accountable for results.

The Focus State Strategy should be continued as a strategic approach, not a project approach. Objectives should be clearly articulated and there should be greater oversight from USAID on FSS implementation. Health governance is the single biggest problem in the Nigerian health system. Governance is a unifying theme of the FSS and should be a unifying theme of future projects' designs under FSS.

Future health projects should have gender strategies and work plans integrated into project design. Projects with large gender components should have a gender specialist on staff. Projects should establish benchmarks and indicators for gender integration and inclusion to be measured and reported over their lifespan. It would be useful to have periodic external assessments of gender activities and strategies.

Ward Development Committees proved to be a valuable asset and a powerful tool for TSHIP and the entire health system strengthening/development process. This should be replicated in all future projects working at the ward level, not just those with a health focus.

EVALUATION PURPOSE AND EVALUATION QUESTIONS

EVALUATION PURPOSE

The purpose of the Targeted States High Impact Project (TSHIP) end-of-project performance evaluation is to determine if the project attained its development objectives; assess the strengths and weaknesses of TSHIP's implementation strategy; and identify best practices and lessons learned during the life of the project. The evaluation's findings will be used to inform the design and implementation of future USAID-supported maternal, newborn, and child health/reproductive health/family planning (MNCH/RH/FP) activities.

EVALUATION QUESTIONS

1. To what extent has TSHIP's integrated services approach led to improved health outcomes in Bauchi and Sokoto States?

1a. Which interventions have been most (and least effective) and why?

In answering this question address the effectiveness of USAID's Focus States Strategy (FSS).

2. How did TSHIP impact Bauchi and Sokoto States' health systems?

2a. which health system strengthening interventions have been most (and least) effective and why?

2b. How (if at all) did collaboration with other USAID projects and partners in the states impact the health systems. If not, why?

In answering this question address the effectiveness of USAID's Focus States Strategy.

3. What best practices, if any, can be learned from TSHIP to inform the design of new activities?

4. How well has TSHIP integrated gender into its implementation?

4a. Which approaches have been the most effective at integrating gender (and least effective) and why?

4b. What could the project have done better to improve gender integration?

PROJECT BACKGROUND

The Development Context

Nigeria accounts for only two percent of the world's population, but contributes about 10% of global infant, child, and maternal mortality. Every year, about one million children who are under five years old die and some 33,000 women die of pregnancy-related conditions—most of which are preventable deaths. Nigeria has been grouped among the 68 countries that are unlikely to attain the Millennium Development Goals Four and Five (MDGs) on child and maternal survival by 2015. In nearly every area of primary healthcare, there is low coverage of high impact interventions. Coverage tends to be substantially lower in the North East and North West zones of the country where TSHIP is implemented.

TSHIP, as amended, is a six-year \$89,953,015 project which supported the integration of primary healthcare services to deliver maternal, newborn, and child health (MNCH) interventions and strengthen the health systems in Bauchi and Sokoto States. It was expected that at the end of TSHIP that strong and durable bonds between community institutions and the healthcare delivery system would exist in every ward of Bauchi and Sokoto States, with measurably improved household practices and increased use of services. Bauchi and Sokoto would have improved health systems and higher quality service delivery for family planning (FP), antenatal care (ANC), complicated pregnancy, emergency obstetrics and newborn care (EmONC), routine immunization (RI), Vitamin A, and child health. Taken as a whole, TSHIP's inputs would form an integrated package assisting state and local governments to improve primary healthcare (PHC) services by filling in capacity gaps, building on institutional strengths, and improving household ability to protect and promote their own health in different "focus states," with the goal of reducing overlap and duplication.

TSHIP was designed, in part, based on lessons learned from three preceding USAID-funded projects: Community Participation for Action in the Social Sector (COMPASS), Access to Clinical and Community Maternal, Neonatal and Women's Health (ACCESS), and Immunization Basics. The key lessons learned from these projects is that an integrated approach to addressing primary healthcare and strengthening the overall health system leads to better health outcomes than does a more vertical approach focusing on selected interventions.

The development hypothesis underlying the TSHIP project design was that if TSHIP accomplished systems strengthening and other supporting activities according to plan, and if critical assumptions held, then health outcomes in the two states would improve.

TSHIP supported USAID/Nigeria's former Strategic Objective 13 (now Development Objective 4): Increased use of social sector services. Its principle objective was to foster the use of high-impact interventions in the two focus states. Program activities were organized under four sub-objectives.

1. State and local government capacity to deliver and promote use of high-impact MCH/FP/RH interventions strengthened.
2. Delivery and promotion of high-impact FP/RH/MCH interventions at PHC strengthened and essential referral levels established.
3. Strengthened roles of households and communities in promotion, practice, and delivery of high-impact MCH/FP/RH interventions.
4. Policies, programming, and resource allocation at state and federal levels improved.

Critical to the success of TSHIP were six critical assumptions:

1. The socio-political context in Nigeria remains reasonably stable.
2. Staffing levels at the State and LGA and health facilities are adequate.
3. There are sufficient funding levels for high quality health service delivery.
4. Supplies of commodities are available.
5. NHMIS is functioning and is a reliable source of data for TSHIP.
6. Community structures are existing or able to be put in place.

"A midterm evaluation conducted in 2012² revealed that TSHIP was not on track to achieve its planned goals and objectives. A number of key sustainability-focused activities were yet to be implemented and key milestones were far from being reached.

Despite these findings, a number of interventions demonstrated promise if the project were extended. Some of these included the introduction of chlorhexidine and misoprostol—drugs that are instrumental in reducing maternal and child mortality; the significant strengthening of community structures, which created demand for services; and improving acceptance of FP services in the two focus states."³ Other



Figure 1: Map of Focus States Strategy Implementation

²Target States High Impact Project Mid-Term Evaluation, Final Report; The Mitchell Group, MEMS II; November 2012.

³USAID Nigeria, [Targeted States High Impact Project (TSHIP)] Evaluation Scope of Work, [End-of-Project Evaluation, March

areas that showed promise with additional time included: routine immunization; coverage of facility-based ANC and maternal care; vitamin A distribution; routine health information; management of childhood illness; and essential commodities and logistics. Based on the potential for these promising interventions, TSHIP was extended to August 11, 2015, at an extra cost of \$4.5 million. After the mid-term evaluation, the Performance Monitoring Plan (PMP) and Results Framework were amended to reflect changes in emphasis away from qualitative outputs to more quantitative results. The amended Results Framework is included in the following section.

Focus States Strategy: USAID/Nigeria, is implementing the Focus State Strategy (FSS) in Bauchi and Sokoto States. The objective of the FSS is to create a governance model to demonstrate and achieve effectiveness, efficiencies, and synergies in programming by concentrating USAID resources on two Focus States where the Mission believes resources can be effectively utilized. Given Nigeria's size, the goal of FSS is to demonstrate that if the bulk of USAID's limited resources are utilized and implemented in these two Focus States, rather than spread across all of Nigeria, the result will be significant impact. Three existing regional projects valued at \$169 million were incorporated into the FSS in 2010: Targeted States High Impact Project (TSHIP); Northern Education Initiative (NEI); and Leadership Empowerment Advocacy and Development (LEAD). In addition, three national-level projects, already operational in Bauchi and Sokoto, were incorporated into the FSS: Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS); Water Sanitation and Hygiene (WASH); and Fistula Care. The Focus States Strategy was assessed in 2013.⁴

2015, p5.

⁴Focus States Assessment, Final Report; The Mitchell Group, MEMS II; March 2013.

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. Percentage of children who received DPT3 vaccine by 12 months of age **(IIP 3.1.6.4-1)**
2. Percentage of births attended by a skilled doctor, nurse or midwife **(IIP 3.1.6.1-1)**
3. Percentage of children under five years old with diarrhea treated with oral rehydration therapy (ORT) **(IIP 3.1.6.7-1)**
4. Couple years of protection (CYP) in USG-supported programs **(IIP 1.7.1)**
5. 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:

6. Number of people trained in FP/RH with USG funds (male and female) **(IIP 1.7.2)**
7. Number of health workers trained in malaria case management with artemisinin-based combination therapy (ACT) using USG funds (male and female) **(IIP 1.3.3-1)**
8. Number of health workers trained in malaria laboratory diagnostics [rapid diagnostic test (RDT)] or microscopy with USG funds (male and female) **(IIP 3.1.2.1-5)**
9. Number of people trained in maternal/newborn health through USG-assisted programs (male and female) **(IIP 1.6.3)**
10. Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds (male and female) **(IIP 3.1.3.4-1)**
11. Number of people trained in child health and nutrition (male and female) **(IIP 1.6.5)**
12. Percentage of HMIS indicators reported on a timely manner.
13. 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:

15. Number of children under 12 months who received DPT3 through USG-supported programs **(IIP 1.6.11)**
16. Number of deliveries with a skilled birth attendant in USG-assisted facilities **(IIP 1.6.4)**
17. Number of counseling visits for FP/RH as a result of USG assistance (male and female) **(IIP 1.7.3)**
18. Percentage of USG assisted service delivery points providing FP and/or counseling services
19. Number of ANC visits by skilled providers from USG-assisted facilities **(IIP 1.6.2)**
20. Number of pregnant women who attend at least one antenatal care (ANC1) visit
21. Number of women receiving active management of third stage of labor through USG-supported programs **(IIP 1.6.6)**
22. Number of newborns receiving essential newborn care through USG-supported programs **(IIP 1.6.8)**
23. Number of children under 5 years of age who received vitamin A through USG-supported programs **(IIP 1.6.12)**
24. Number of cases of childhood diarrhea treated in USAID programs **(IIP 1.6.14)**
25. Number of cases of diarrhea in children under five years treated with oral rehydration preparation.
26. Rate of non-polio AFP cases
27. Number of wild polio virus cases in USG-assisted states **(IIP 1.6.B)**

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

Indicators:

31. Proportion of Ward Development Committees (WDCs) that are active during the reporting quarter.
32. Number of households visited by volunteers.

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

Indicators:

33. Number of policies that are developed or adapted to support improved RH/FP/MCH services.
34. 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

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

EVALUATION METHODS & LIMITATIONS

OVERVIEW

The Evaluation Team developed a work plan and methodology to answer the evaluation questions. Specifically the Evaluation Team:

1. Assessed the project's results against defined targets contained in the amended Performance Management Plan (2013).
 - Assessed the effectiveness of the project's integrated approach.
 - Assessed the project's impact on health systems development.
 - Assessed the impact of coordination and collaboration with other donors under the Focused States Strategy.
 - Assessed the project's impact on gender.
 - Provided guidance and options for future MNCH/RH/FP program interventions.

The Evaluation Team focused on determining the observable intended and unintended outcomes of the TSHIP operations at the state, local government, and community level in selected Local Government Areas (LGAs) in Sokoto and Bauchi States.

METHODOLOGY

The Evaluation Team used a mixed (qualitative and quantitative) approach to determine if TSHIP had attained its objectives, intermediate results, and indicators in the project's Results Framework. The methodology consisted of interviews and focus group discussions with TSHIP staff members; key government officials at the state, local, and community levels; members of civil society organizations; community members; other donor organizations; and USAID. The Evaluation Team developed twelve data collection tools/guides for use in the field. These included both structured and semi-structured discussion guides for client exit interviews, service provider interviews, health facility assessments, focus group discussions (FGD), and key informant interviews (KIIs). Please see Annex III for these instruments. The Evaluation Team conducted a thorough desk study of relevant documentation and analysis of performance indicators. The Team interviewed a total of **507 people**: 254 in Sokoto, 253 in Bauchi, and 3 USAID officials. The Team also reviewed **68 documents** including data quality analysis (DQA) reports. Please see Annex IV (a): List of Persons Interviewed and Annex IV (b): Bibliography of Documents Reviewed for further information. The Team conducted **21 FGDs**: 11 in Sokoto and 10 in Bauchi. Each FGD lasted for an average of 45 minutes, with an average of 12 participants from 5 ward development

committees in each LGA (with a minimum of 4 female health volunteers [CBHVs]). See methodology matrix in Annex III for further details.

Review of Background Materials and other Relevant Documentation: Project documents relevant to the evaluation were collected for review and analysis. These included project design, scope of work, annual and quarterly reports, annual work plans, technical and training materials, TSHIP gender and social inclusion materials, and technical and statistical documents relevant to the evaluation.

Interviews and Field Visits: In collaboration with USAID/Nigeria and the TSHIP team, the Evaluation Team selected 20 LGAs (10 LGAs each in Sokoto and Bauchi States) for the field work. The Team randomly selected 40 health facilities from the 20 LGAs (two health facilities in each LGA) for assessment. The Evaluation Team conducted both individual interviews and focus groups. These included meetings with USAID staff in Abuja; TSHIP project staff; and state, LGA, civil society organization (CSO), and NGO leaders in Sokoto and Bauchi. The Team conducted field work in Sokoto from June 29–July 3 and in Bauchi from July 6–10. Field work included joint and individual meetings with management and relevant staff of the TSHIP project. Subsequent meetings were held with state and local government officials and civil society organizations. The Evaluation Team organized and conducted community-level FGDs with local government leaders, officials, WDC members; state government desk officers for the TSHIP project; representatives of CBOs, and beneficiaries (women) attending the health facilities. Also a facility survey was conducted to review the quality of healthcare services provided. The Evaluation Team recruited and trained female facilitators for effective interaction with female clients at the health facilities visited. The Team visited LGAs supported by both LEAD and TSHIP as well as those supported by TSHIP only to try to determine the impact of FSS. In Sokoto, the LGAs visited were Bodinga, Dange-Shuni, Gwadabawa, Kware, Rabah, Sokoto North, Sokoto South, Wamakko, Wurno, and Yabo. In Bauchi, the Team visited Alkaleri, Bauchi, Darazo, Dass, Giade, Misau, Ningi, Shira, Tafawa Balewa, and Warji.

DATA ANALYSIS

The qualitative data collected through FGDs and KIIs was analyzed and synthesized, while themes and patterns were identified from the responses. A matrix was created to map (link) each question on the evaluation tools with a corresponding evaluation question. The quantitative data collected from health facilities rapid assessment (survey), service provider questionnaires, and client exit interviews were analyzed using the Statistical Package for the Social Science (SPSS) software. Respondents' demographic information and satisfaction with service, along with some key indicators of availability, accessibility, and quality of service delivery were analyzed. This helped in determining the least and most effective/utilized service by clients.

Also the trends of select performance indicators from the 2008 and 2013 National Demographic and Health Survey (NDHS), and TSHIP's Lot Quality Assurance Sampling (LQAS) surveys were analyzed and compared with TSHIP's routine monitoring data, which was extracted from the National Health Management Information System. (See Annex VII for summary of analyses of both qualitative and quantitative data collected during the evaluation.)

LIMITATIONS

TSHIP covered the entirety of both Sokoto and Bauchi and provided one or another form of support to all health facilities in each state. Therefore, the findings from a sample of 40 health facilities were not sufficient to draw inferences on the entire population of health facilities, which number in the hundreds in each of the two states.

The Evaluation Team selected the randomized sample of LGAs, wards, and health facilities in order that "LEAD+TSHIP" LGAs (those where TSHIP and LEAD projects were both present and worked together) and "TSHIP-only" LGAs (those where LEAD was not present) were sampled. In addition, health facilities were chosen randomly from a list of facilities implementing a minimum of four (ANC, Immunization, Delivery, and FP) TSHIP project interventions. This resulted in a selection bias.

Due to difficult terrain and, in some instances, security concerns, the Evaluation Team had to replace some of the selected health facilities. However, the health facilities used as replacements were also selected from the randomized list. Please see the full list of health facilities in Annex V.

Due to time constraints, some aspects of the project were not included in the evaluation including: Standards Based Management and Recognition (SBMR), pre-service training, and policies pursued or enacted under the enabling environment component.

TSHIP reported HMIS/District Health Information System (DHIS) data, often measuring progress against targets that were established by projecting population (denominator) figures obtained by estimating population growth using the 2006 census as a baseline. The HMIS data has serious accuracy and reliability issues (see *Findings* section, below). The targets were carefully considered, but usually not objectively verifiable by the TSHIP team due to cost factors. Often the eligible population for an intervention (e.g., number of children 12-23 months of age) was not known and the number of that population actually reached by an intervention may not be reliably measured or reported. Measuring progress against targets over time does show change and trends, but can be misleading.

The Evaluation Team was not able to find an explanation and did not have the time to delve further into some key anomalies in the data between TSHIP reports of significant improvement on some key indicators, such as antenatal care or percent of deliveries attended by a skilled birth attendant and the LQAS or DHIS survey information. Where anomalies were found they were noted by the evaluators.

FINDINGS, CONCLUSIONS, & RECOMMENDATIONS

OVERVIEW

Following the mid-term evaluation there was a significant refocusing of project efforts for the second half of the project, during which TSHIP concentrated on a smaller set of interventions that had a better promise of success. This refocusing improved project results. TSHIP was successful to a reasonable extent in improving health systems and supporting the development and implementation of policies in collaboration with the states, LGAs, WDCs, communities, and other stakeholders. TSHIP had a major policy component, which was part of a larger strategy for improving the enabling environment by improving policies, programming, and resource allocation. TSHIP succeeded in developing and institutionalizing policies in many areas such as state strategic health development plans; minimum health care packages; state gender policies; establishment of state drug procurement agencies; and many others. The long-term impact of these is not yet possible to evaluate because they are either still being introduced or have only been implemented for a short time. TSHIP had limited success in integrating services in health facilities. TSHIP was tasked with integrating and improving service delivery, with special emphasis on MCH/ANC. This was accomplished, but with mixed results. TSHIP's successes in health systems strengthening and service delivery integration did not lead to improvements in health outcomes in many important indicators as measured in population-based surveys such as the NDHS and TSHIP's own LQAS. For example, routine immunization remains stubbornly mired at unacceptably low levels despite the best efforts of TSHIP and many other programs. The reason for the limited success of TSHIP at the institutional level is a function of the failure of several critical assumptions that formed an integral part of the project design. These include:

1. **Socio-political context in Nigeria remains reasonably stable.** This assumption remained true for the most part throughout the life of the project. There were a few exceptions in Bauchi.
2. **Staffing levels (state, LGA, and HF) are adequate.** This assumption did not prove to be the case. Inadequate staffing of health facilities greatly impaired services and, subsequently, the success of TSHIP. The lack of female staff in health facilities was an issue particularly in Sokoto. The female staff in the system tend to concentrate in the cities, making the gender imbalance in rural areas even worse.

There is an absence of accountability among health facility staff. Health staff often realize that there are no consequences for bad behavior (laziness, absenteeism, disrespect, and poor record keeping).⁵ Good and bad staff both get paid. This demoralizes good staff. Integrated supportive supervision worked and is very popular. It is a fragile construct, however, due to the unwillingness

⁵Interviews with state officials, TSHIP staff, health facility staff (see Annex VII[c])

of agencies/offices to fund it.

At the state level, continuous change of the Commissioner for Health and the Chairman of the State Primary Health Care Development Agency (SPHCDA) in both Sokoto and Bauchi had a detrimental impact on leadership. Elections further aggravated this, with changes in leadership and leadership direction.

3. **There are sufficient funding levels for high-quality health service delivery.** During the TSHIP period of implementation, the amount of funds budgeted for health increased in the two states. Even when funds were budgeted in sufficient amounts, the release of funds as reported by respondents was often uneven. There is a persistent lack of oversight on the use of funds once released, although LGAs said this improved somewhat with TSHIP inputs. Inconsistent funding and lack of oversight on use of funds continues to be a drag on the system.
4. **Supplies of commodities are available.** Commodity supplies improved somewhat over the life of the project, but stock-outs persisted throughout and were noted in reports by both TSHIP and the USAID-funded DELIVER Projects.
5. **Health Management Information System (HMIS) is functioning and is a reliable source of data for TSHIP.** While the HMIS has made great strides, the quality and accuracy of data are not yet acceptable. There is no reliable denominator data for planning or calculating coverage. This results in claims of 75% coverage for the DPT3 vaccination when the NDHS 2013 reported 12.5% for Bauchi and 2.6% for Sokoto. Even population figures are unreliable. Nigeria needs a reliable census, urgently. Health facilities need to track their service areas.
6. **Community structures are existing or able to be put in place.** This assumption held and some of TSHIP's best work was in the area of community participation and community engagement.

TSHIP did excellent work building the capacity of all levels of HMIS in the two states. This process is not complete, however. Accuracy, reliability, and data quality are not at acceptable levels. The gains in HMIS/DHIS may well prove to be fragile as ownership of the activities and processes did not transfer well to the states. Ownership was better at the LGA and health facility levels.

TSHIP had significant success in strengthening community-based healthcare delivery. The work that TSHIP did with LEAD to revitalize the WDCs went very well and contributed to project outcomes. The community distribution of misoprostol and chlorhexidine through the CBHVs is an effective, lifesaving intervention and is widely appreciated by communities in the states. The CBHV program was a success and the volunteers are making a difference in the health of their communities. This program is very popular but may have funding difficulties with the ending of TSHIP. The use of

sub-grantees worked well but much more could have been done if they had been engaged earlier and in more locations. This was a missed opportunity.

TSHIP's achievements are appreciated by both states on many levels. The CBHVs are very popular. However, ownership of the activities by the beneficiaries is mixed with many communities unwilling or unable to pay for services, and funding of CBHVs is a big issue with the states and LGAs. Elections and the resultant changes in the governments of both states have contributed to funding constraints. In fact, at the time of the evaluation, state government employees' salaries have been in arrears for several months in both states.

Use of Sub-grantees: The use of sub-grantees worked well, according to respondents from KIIs and FGDs. A wide range of people, from the community level to high state officials, noted that they felt this way. This information was usually offered unprompted. The evidence, while subjective, followed a definite pattern. Sub-grantees filled a gap. Project staff simply could not be in enough places at enough times. HF staff were low in number. Sub-grantees filled the void.

The FSS works. The partnership between TSHIP and LEAD yielded synergy and efficiencies. LEAD supported TSHIP in its community (WDC/LGA) and policy work. TSHIP taught LEAD about the health side of health governance and gave LEAD credibility in more areas than it would have had otherwise. Other TSHIP FSS collaborations also produced efficiencies: (NEI, DELIVER, and WASH). Collaboration with the SIDHAS and FISTULA projects was less effective.

FINDINGS

Question 1

To what extent has TSHIP's integrated services approach led to improved health outcomes in Bauchi and Sokoto states?

Integrated Services

TSHIP defined integration as "having key Maternal and Child Health (MCH),

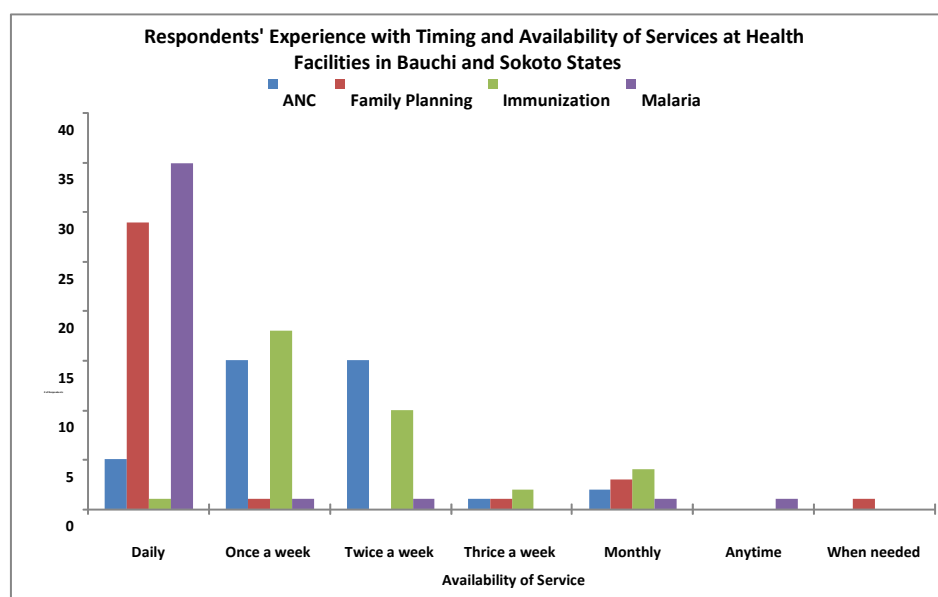


Figure 2: Service Availability

immunization and Family Planning (FP) 'high impact' services **integrated in space and time.**" A service delivery site which, for example, has FP and well-child care in the same facility but only on different days, or where each additional service engendered another long wait, was not considered integrated. Using the above definition of integrated services, the Evaluation Team examined the integration of services from several different approaches. One was to visit 40 health facilities, in order to find out how frequently services were offered or available and whether these were offered at the same time. The Team asked clients to list the services they used at the health facilities, describe their satisfaction with those services, and recall what services they were offered other than the one(s) they came for on that day (see Annex VII(a)). The Team also asked service providers, WDC and LGA representatives, and TSHIP program staff to give their impressions of the most successful interventions and levels of service integration.

As shown in **Figure 2**, the largest numbers of respondents (health facility clients and staff) reported that malaria and FP services were offered on a daily basis in the surveyed health facilities, which shows good integration and availability for these services. ANC and immunization services were much more likely to be offered only once, or perhaps twice, a week.

Improved Health Outcomes

The objective of TSHIP was to increase the use of high-impact interventions in Bauchi and Sokoto. This was measured through five indicators:

1. Percentage of children who received DPT3 vaccine by 12 months of age
2. Percentage of births attended by a doctor, nurse, or midwife
3. Percentage of children under five-years old with diarrhea treated with oral rehydration therapy (ORT)
4. Couple years of protection (CYP) in USG-supported programs
5. Modern contraceptive rate

Percentage of children who received DPT3 vaccine by 12 months of age

TSHIP did strengthen some components of routine immunization (RI) in the two states. They did well with community linkages and demand creation; personnel capacity building; data recording; and cold chain improvements and maintenance. These efforts were not enough to overcome weak governance, including the absence of accountability in the

Table 1: DPT3 Coverage According to NDHS and LQAS Surveys in Bauchi and Sokoto

Source	Bauchi	Sokoto
NDHS 2008	1.0%	2.0%
NDHS 2013	12.5%	2.6%
LQAS 2012	10.5%	4.1%
LQAS 2013	n/a	4.6%
LQAS 2014	12.0%	n/a
LQAS 2015 ⁶	13.5%	4.6%

⁶LQAS 2015 data had not been released at the time of writing this report. Data for this year should be considered preliminary, subject to finalization from TSHIP. It is included as illustrative only, to show trends over time.

expenditure of funds; inconsistencies in funding headed for the LGA level; inadequate numbers of staff; and irregularities in vaccines supply. The Evaluation Team found that the DPT3 vaccine was not in stock in 28.2% of the facilities visited and 36% had vaccine that was expired. Nine (22.5%) facilities reported stock-outs during the past six months. Please see Facilities Checklist Analysis, Annex VII (b) for further information. Service delivery integration with RI did not happen in many facilities, and only partially when it did (see **Figure 2: Service Availability**). The polio eradication campaign also had a negative effect on RI efficiency. Health facility staff spend half of their time planning and implementing a house-to-house campaign, which is implemented several times during the year (see Annex VII (d)). In the case of routine immunization, therefore, health outcomes did not appreciably improve.

TSHIP has reported quarterly on the number and percent of children who received the DPT3 vaccine by 12 months of age throughout the project. However, these figures are based on the number of vaccines 'distributed', rather than the number of doses administered to children. Based on the estimated number of at-risk children younger than 12 months per state, the vaccination coverage for DPT3 in Bauchi is 60% and Sokoto is 85%.⁷ However, a different story is told if coverage is calculated using the 2008 and 2013 NDHS reports and two LQAS reports. According to the NDHS surveys, DPT3 coverage in Bauchi was 12.5% in 2013 and 2.6% in Sokoto. Preliminary 2015 LQAS calculations show 13.5% coverage in Bauchi and 4.6% in Sokoto.⁸

This difference between project data (HMIS data) and surveys illustrates the wider problem in assessing data and project performance. TSHIP reported data from the HMIS/DHIS2 systems that are, at times, very misleading and, at other times, inaccurate. While the population-based surveys cited here provide valuable insight into the realities underlying the true situation, they, too, have limitations. The timing of the surveys does not correspond exactly to the timing of the project reporting. Also, the samples sizes are sometimes too small. This issue is addressed further under Evaluation Question 2a, below.

Births Attended By a Doctor, Nurse, or Midwife

TSHIP emphasized ANC and attended deliveries, focusing its resources, expertise, and energy on improving these service areas. In the field, the Evaluation Team heard at every level that facility-based ANC and outreach had improved.

Table 2: Births Attended by an SBA: Survey Data		
Source	Bauchi	Sokoto
NDHS 2008	15.7%	5.1%
NDHS 2013	16.3%	5.5%
LQAS 2012	17.9%	12.1%
LQAS 2013	n/a	14.9%
LQAS 2014	25%	n/a
LQAS 2015 ⁹	26.6%	18.0%

⁷TSHIP Year Four Progress Report.

⁸USAID/TSHIP Routine Immunization Review in Bauchi and Sokoto States, Review Report 2013.

⁹ LQAS 2015 data had not been released at the time of writing this report. Data for this year should be considered preliminary, subject to finalization from TSHIP. It is included as illustrative only, to show trends over time.

The number of deliveries attended by skilled birth attendants (SBA) has been one of the indicators most resistant to showing improvement, especially in Sokoto. TSHIP has reported the percentage of births attended by a doctor, nurse, or midwife against a target. This is helpful for showing a trend (**Table 3**), and project documents show a steady and substantial progress against their targets, achieving as much as 95%. Once again, these measurements against targets look odd when compared with the survey data for both states, which tell a different story. While the NDHS shows no statistically significant change in the number of deliveries attended by SBA between 2008 and 2013, the LQAS surveys show improvement. The 2012 LQAS in Sokoto found 12.1% of mothers had attended deliveries. This contradicts the 2013 NDHS, which estimated 5.5%. The Evaluation Team was not able to find an explanation for this anomaly.

Table 3: Number of Deliveries with a skilled birth attendant in USG Programs					
State/FY	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Bauchi	12,075	51,291	65,492	72,299	85,782
Sokoto	5,693	42,175	31,245	51,615	36,005

Percentage of Children under Five-Years Old with Diarrhea Treated with ORT

"An ORT corner is a designated area within a health facility where caregivers can receive practical demonstrations on how to prepare ORS solutions and access lifesaving rehydration for sick children under the supervision of a healthcare provider."¹⁰ They are usually stocked with manufactured oral rehydration solution (ORS) and ingredients for home-based ORS (salt, sugar, water, measuring containers), zinc, and educational materials. "ORT corners were set up in 214 health facilities (94 in Bauchi and 120 in Sokoto) in the first year of the project." LGAs and WDCs reported (Annex VII) that TSHIP trained them to prepare ORS. Some LGAs and WDCs actively participated in establishing the ORT corners and establishing drug funds that included provision of ORS and zinc. CBHVs and sub-grantees raised awareness on diarrheal disease and taught home management of diarrhea to tens of thousands of caregivers (TSHIP Annual Reports).

In the project's Results Framework for the first three years, the indicator reads, "Number of cases of childhood diarrhea treated in USAID programs." When the framework changed, an objective-level indicator was added that read, "Percentage of children under-five years old with diarrhea treated with oral rehydration therapy (ORT)." TSHIP started reporting on both indicators at that time and did so for years three and four. In project year five, the annual report does not report on the percentage figure, but reverts back to the count of childhood cases alone. This makes it somewhat difficult to assess TSHIP's progress in the use of ORT for the treatment of childhood diarrhea.

¹⁰ Zulfia Charyeva, et al., "Reducing the burden of diarrhea among children under five years old: lessons learned from oral rehydration therapy corner program implementation in Northern Nigeria," *Journal of Health, Population and Nutrition* (2015), 34:4, 2.

Table 4: Number of childhood diarrhea cases treated and % treated with ORT by Year							
State	2010	2011	2012	2013	% Treated with ORT		
					2012	2013	2014
Bauchi	16,279	53,689	54,043	45,950	16.4%	31%	73,678
Sokoto	33,377	69,773	70,219	86,475	26%	67%	57,306
Total	49,656	123,412	124,262	132,425	21%	47%	130,984

Measurement issues aside, project documents and the field data reveal that TSHIP carried out a range of activities in an effort to treat childhood diarrhea. The number of cases reported as treated shows a marked upward trend. What may not be captured is the number of cases managed at home by caregivers who participated in community-based trainings or outreach aimed at teaching caregivers to treat diarrhea episodes at home using either a salt-sugar solution (SSS) or commercially prepared oral rehydration solution (ORS) and, when available, zinc. The TSHIP project dealt with supply chain problems related to the LGA's procurement and distribution of ORS and zinc during implementation. The struggle to maintain adequate supplies of these two illuminates some of the difficulties of the health system. These are inexpensive commodities with a long shelf-life. They need neither refrigeration nor specialized storage or shipment. Given the staffing and supply issues in health facilities in the two states, home management of diarrhea may provide one of the more lasting impacts of TSHIP.

Couple Years of Protection in USG-Supported Programs/Modern Contraception Rate

Interviews and FGDs conducted by the Evaluation Team revealed a varied, sometimes contradictory, set of responses about FP. Many service providers, LGA officials, sub-grantee CSOs, and other community-level respondents reported progress and acceptance of FP, which was almost invariably called "birth spacing" outside of facilities. At the community level, religious and traditional leaders, Expanded Males as Partners (EMAPs), champions, 100 Women Groups, and CBHVs all advocated for, or raised awareness of, child spacing. Clients surveyed (who were not involved directly in supporting project activities) reported that while FP was one of the least-utilized services at health facilities, it scored well on integration and availability (see **Figure 2: Service Availability**). The data show little difference in outcomes between the two states.

Family planning is another area where the outcome data from surveys paint a different picture from state and project data. **Table 5** shows the trend over time of couple years of protection reported by the TSHIP project. Bauchi shows a steady increase, while Sokoto declines in year five. These data paint a confusing picture. The LQAS surveys (**Table 6**) present a much higher modern contraceptive prevalence rate than the two NDHS surveys. What is clear is that despite what appears to be some increases in CYP, overall contraceptive prevalence rates are still very low despite FP commodities

becoming more accessible during the life of the project. This points to other factors impeding family planning usage that were reported anecdotally to the evaluation team, including women using contraceptives but not wanting to report it during surveys.

Table 5: Couple Years of Protection (CYP)					
	2010	2011	2012	2013	2014
Bauchi	2,246	4,599	17,724	35,562	56,786
Sokoto	1,755	9,404	40,716	66,668	50,610
Total	4,001	14,003	58,440	102,230	107,396

Other Outcome Indicators

In addition to the five principle overall indicators from the results framework, the Evaluation Team is including brief descriptions for Vitamin A and malaria. Vitamin A is of interest because TSHIP worked in a collaborative role for the life of project in developing and strengthening systems and Vitamin A was not part of an integrated, facility-based service. Malaria is the leading cause of death and was frequently cited by clients as the principle reason for going to a health facility.

Table 6: Contraceptive Prevalence Rates from Population Based Surveys		
Source	Bauchi	Sokoto
NDHS 2008	2.0%	1.9%
NDHS 2013	2.2%	1.1%
LQAS 2012	6.8%	6.9%
LQAS 2013	na	7.8%
LQAS 2014	4.7%	na
LQAS 2015 ¹¹	9.8%	7.8%

Vitamin A

Vitamin A capsules are distributed through Maternal Newborn Child Health Weeks twice a year in Bauchi and Sokoto. TSHIP played a supportive role in the two states' vitamin A programs, providing technical support, planning and supervision, and data tools.

TSHIP calculated coverage by estimating a denominator based on a population projection for the year being reported, calculated from the 2006 census. Using this method, they reported that "Vitamin A coverage in children under 5 increased from 69% in 2010 to 86% in 2014."¹² The NDHS 2013 reports 36.3% of respondents receiving vitamin A supplement in the past six months in Bauchi, once again demonstrating inconsistencies in the results reporting. The LQAS Survey Report 2014 for Bauchi reports coverage as 31%, which is consistent with the NDHS 2013 but far from the coverage rates in the project annual reports. The LQAS 2013 for Sokoto reported 30.2% coverage.

¹¹LQAS 2015 data had not been released at the time of writing this report. Data for this year should be considered preliminary, subject to finalization from TSHIP. It is included as illustrative only, to show trend over time.

¹²Source, "Reaching More Women and Children with Health Services in Bauchi," TSHIP brochure.

Figure 3 was constructed using data from TSHIP annual reports, years one through five. In four of the five years, TSHIP averaged the number of vitamin A capsules distributed by taking the total numbers from two rounds per year and dividing by two. In year two of the project, they did not use an average, but reported the total of the two rounds, hence double counting. Vitamin A coverage has not changed significantly in five years.

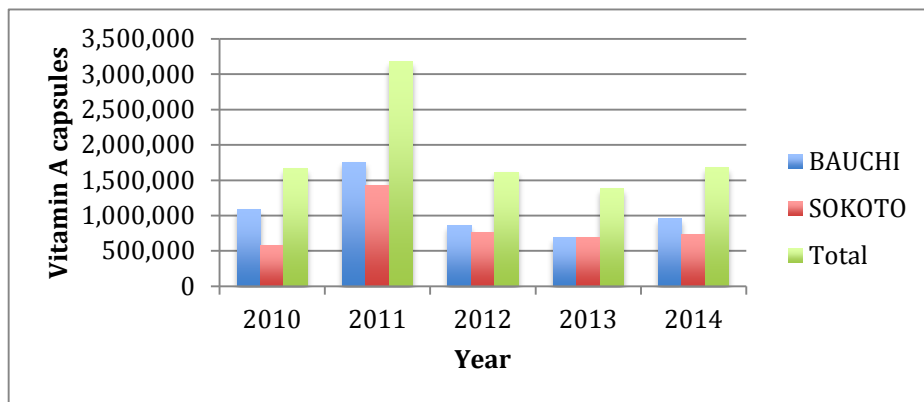


Figure 3: Distribution of Vitamin A Supplements

The Evaluation Team did not have an opportunity to observe an MNCH Week. Health facility observations found that 20 out of the 40 visited had vitamin A capsules in stock (see Annex VII (b)). Vitamin A capsules are supplied by UNICEF and by a nonprofit called Vitamin Angels. TSHIP staff reported in interviews with the Evaluation Team that the supply of vitamin A was erratic.

Malaria

When the Evaluation Team asked what service is most used in health facilities, malaria was reported as the highest by both clients and service providers (although nearly tied with ANC). TSHIP worked with the President's Malaria Initiative (PMI) to train and equip service providers with the skills, test kits, and medicines to diagnose and treat malaria. It is interesting to note that the results in the two states are strikingly different. One possible reason for this was the availability of Artemisinin-Based Combination Therapy (ACT), as reported by respondents. The facilities' checklists showed that 33 of 40 (82.5%) facilities surveyed had ACTs in stock at the time of the survey.

A study of malaria treatment seeking behavior and outcomes in Bauchi and Sokoto published by the *Malaria Journal* in 2014 showed that, "Of children under five who had a fever in the last two weeks (814), 47.2% (384) sought prompt treatment; of those that sought prompt treatment, 4.8% (39) of the total sample received a blood test; of those that received a blood test, 1.0% (8) of the total sample received an ACT."¹³ The article noted that, "Children were most likely to receive a prompt ACT if they received treatment at a health facility (10.6%, 29), next a private doctor (7.1%, 1), and last a PMV (5.3%, 15)."¹⁴ The article notes that there is little difference between the states and

¹³ Millar et al. *Malaria Journal* 2014, 13:447, 7.

¹⁴ Ibid.

shows clearly that there is much room for improvement.

These seven indicators all show a trend of increasing utilization or coverage over time. Using the measures of how many of them are offered together (at the same time) in health facilities, and how often clients are offered other services when visiting health facilities, they show an improvement in integration, but not enough to be called truly integrated. Trends from the NDHS 2008 and 2013, and the LQAS surveys, do not show significant improvement in health outcomes.

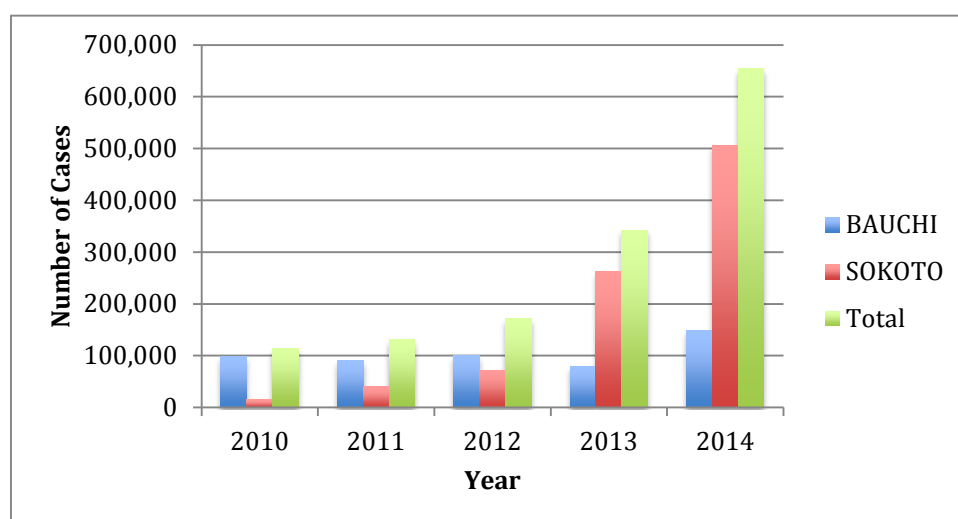


Figure 4: Number of Cases of Malaria in Children Treated with ACT

1a. Which interventions have been most (and least effective) and why?

The Evaluation Team asked government officials and TSHIP staff to list the project interventions they believed were most successful. The result was a list of more than 30 distinct interventions, the majority of which were mentioned only once. Patterns did emerge and a selection of interventions stands out as being more effective. However, Table 7 below highlights the status of some key indicators from TSHIP's LQAS surveys. Treatment of malaria with ACTs appeared to be the most effective intervention in Bauchi state. This was followed by delivery at recommended health facility, and then immunization services. In Sokoto state, delivery at recommended health facility appeared to be the most effective intervention, followed by family planning, and then malaria treatment with ACTs. Treatment of childhood diarrhea appeared to be the least effective intervention in both states.

State	Immunization (DPT3 coverage)	Delivery at a recommended health facility	Women 15-49 using a modern method of Family Planning	Children 0-59 months diarrhea who received ORS	Malaria (Children 0-59 months treated)
Bauchi (2014)	12.0%	14.9%	4.7%	1.8%	16.4%
Sokoto (2013)	2.2%	9.6%	8.0%	1.3%	3.5%

Source: TSHIP LQAS 2013 and 2014. A set of tables comparing the indicators can be found in Annex VII (a).

Service providers and clients were asked what services they perceived as being the most and least utilized. **Figure 5** displays a representation of their responses. Note that in **Figure 5**, twice as many clients were interviewed as service providers. The two groups show remarkable agreement on their perceptions of the most utilized interventions. This was true in both states—until respondents were asked about FP. Service providers were twice as likely to respond that FP was utilized. By this measure, the most utilized facility-based interventions are malaria case management, ANC, RI, and diarrheal disease treatment.

Interventions that took place outside of health facilities played a big role in the TSHIP

"If TSHIP goes, and the LGA does not sustain the activities, there is going to be a catastrophe, especially involvement of the community-based health volunteers."

approach. The most frequently mentioned by far is the community-based distribution of the drug misoprostol and the antiseptic chlorhexidine. The CBHVs were a major part of that distribution and were mentioned as often or concurrently with the drug distribution.

These two interventions were perceived by all respondents along the continuum, from clients to high-level ministry officials, as being effective. In both states, there were several state officials who criticized the CBHV program for being unsustainable and TSHIP for implementing the program in a non-collaborative manner (see Annex VII(c)).

The CBHVs should be seen in the context of TSHIP's larger community engagement/community participation activities. The most frequently mentioned of these would be the revitalization of WDCs, the 100 Women Groups, and the capacity building of LGAs.

TSHIP worked closely with WDCs in both states. In the first year of the project, only 9% of Bauchi's and 16% of Sokoto's WDCs were active (per project reports). By year three, active WDCs totaled 72% in Bauchi and 92% in Sokoto. By the end of the project, 100% of WDCs were active in both states. In year three alone, TSHIP formed or reactivated 300 WDCs. Active WDCs were important collaborators and drivers of change for health facility improvement, CBHVs, health services outreach, HMIS and other project interventions, and they reviewed health facility performance. TSHIP provided extensive training to WDCs and gave fixed obligation grants (FOGs) to some. WDCs contributed to community organization, promoted health activities (especially RI and emergency transport), and provided oversight. Active and improved WDCs are an important outcome of TSHIP. In collaboration with LEAD, TSHIP worked to build the capacity of LGAs to better plan, budget, and implement health programs and to provide oversight to health facilities.

The 100 Women Groups are a multi-sectoral women's empowerment platform representing all wards in the two states. TSHIP helped activate and train these groups, and helped them become registered with the states, open bank accounts, and apply for loans.¹⁵

¹⁵ Sources: Interviews with 100 Women Group members and WDC members, and *The 100 Women Group Movement*,

Sub-grantees were also mentioned as important contributors to community participation and other aspects of the TSHIP program. However, this activity did not achieve all it could have due to a late start and the bureaucratic hurdles that constituted barriers to entry into the program by the grantee organizations (see Annex VII (d), Sub-grantee focus group discussions).

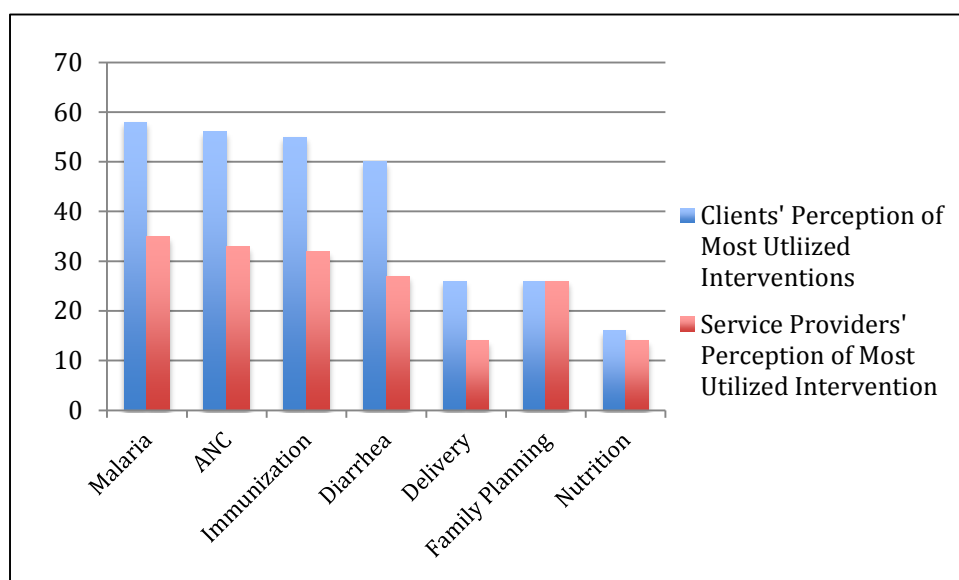


Figure 5: Clients' and Service Providers' Perception of Most Utilized Interventions

While CBHVs are seen mainly in the context of misoprostol and chlorhexidine distribution, they did more than that, including home management of diarrhea and vomiting, FP promotion, ANC and attended-delivery promotion, and more. One difference between the states was observed in the CBHV program. Volunteers in Sokoto were said to be older, more experienced, and often trained as midwives/birth attendants. Volunteers in Bauchi tended to be younger and less experienced.

1a. Part 2: Why are some interventions most effective and some least effective?

Malaria, ANC, RI, and treatment of diarrhea were ranked as 'most utilized' interventions by clients because those are the services that clients want and, over the life of TSHIP, became more reliably available (Annex VII (a)). As discussed above, the objective of TSHIP was to integrate those services with a larger package of high-impact interventions. When this worked, the integration was effective. Circumstances such as staffing and stock-outs, however, undercut the effectiveness.

CBHVs and their activities were deemed the most effective intervention because they connect clients, mainly mothers and children, to services both in and out of health facilities. The success of the community distribution of misoprostol and chlorhexidine and the use of CBHVs raise questions about how these fit within service integration. Does the program constitute an "end run" around the system? CBHVs are certainly allied with, and are a peripheral part of, the health facility system. CBHVs often work

with community health extension workers (CHEWs), particularly in outreach activities outside the facilities. They advocate and promote use of facility-based services, especially FP, RI, and focused antenatal care (FANC). Fundamentally, the volunteers are in, and of, the communities. They provide misoprostol and chlorhexidine for home use. They teach home-based disease management (diarrhea and vomiting, and malaria). They encourage community members to participate in facility-based services, while simultaneously strengthening their ability to deal with health issues at home, outside of the facilities. In the context of the two states, this seems to be a rational approach, though slightly at odds with the service integration approach of the TSHIP project.

Family planning as a facility-based intervention still struggles in the project states, especially in Sokoto. One commonly mentioned reason for this is the social and cultural pressure on women not to practice it. Even if both husband and wife approve, there is a strong perception that others do not. For this reason, there is a reluctance to go to a public health facility for these services. TSHIP worked on this problem from multiple angles: encouraging male support; getting traditional and religious leaders to encourage child spacing; improving facilities to make them more women friendly, confidential, and respectful; and working to make sure that commodities are available. While these are necessary and excellent steps, women (primarily) must still leave the home and risk censure to obtain contraceptives at a health facility, which undercuts the effectiveness of FP as an intervention.

Evaluation Question 2

How did TSHIP impact Bauchi and Sokoto states' health systems?

In answering this question address the effectiveness of USAID's Focus States Strategy

TSHIP was primarily a health systems strengthening project, with many other activities, components, and sectors contributing. TSHIP project reports include among the anticipated results:

- Improved health systems, including health information systems; use of data for decision-making; use of standards-based health management; improved health facilities and logistics systems; and improved overall capacity to plan, manage, and evaluate primary healthcare programs.
- Strengthened policy environment at the state and LGA levels; improved allocation of resources for primary healthcare; and more efficient and effective utilization of resources.¹⁶

The underlying concept of the TSHIP project design was that if TSHIP accomplished the systems strengthening and other supporting activities according to plan, and if the critical assumptions held, then health outcomes in the two states would improve. As

¹⁶ Included in quarterly and annual reports from Project Year 5.

noted at the beginning of this report, the critical assumptions were not fully realized and health outcomes remained mostly static or improved only slightly. However, the Evaluation Team found that some components of the systems TSHIP worked on over the life of the project did improve and strengthen, such as community-based distribution of some health commodities and oversight by the WDCs.

2a. Which health system strengthening interventions have been most (and least effective) and why?

The Evaluation Team asked a range of respondents in interviews and focus groups to comment on what they perceived to be the most and least effective TSHIP system strengthening activities (see Annex VII(c and d)).

Most Effective:

- Empowering Communities
- HMIS
- Enabling Environment/Policies
- Trainings/Capacity Building
- Evidence-Based Budgeting and Planning
- Integrated Supportive Supervision

Least Effective:

- Health Systems Financing
- Human Resources for Health

Other systems were mentioned as well. Some stood out at higher levels and some were more apparent at the LGA and ward levels. State officials were more likely to talk about State Strategic Health Development Plans or the Minimum Health Care Package or improvements in drug procurement. Community members were more likely to mention the community provision of misoprostol and chlorhexidine by CBHVs or improvements in health facilities' physical condition and services.

Empowering Communities

While not a state health system, TSHIP's community engagement (participation, mobilization, and empowerment) is the larger context surrounding the health facilities, referral systems, immunization programs, emergency transport systems, and more. Engaging WDCs directly influences the running of health facilities, and the facilities themselves benefit from empowered communities.

This is not a single system but a group of complementary systems and activities that may be the single biggest legacy of TSHIP. It includes, but is not limited to:

- Revitalization and training of WDCs

- Use of CSOs, 100 Women Groups, sub-grantees, and other community groups to advocate and promote health
- Establishment of the CBHV program

TSHIP's work with WDCs, which was performed with LEAD in some LGAs, created a framework for the introduction and strengthening of community-based health service delivery and increased the community members' awareness of, and participation in, their own health. The Evaluation Team observed that WDCs in Sokoto tended to be more organized, more capable, and less politicized than in Bauchi, yet both states benefitted from stronger, more involved WDCs. WDCs became more actively involved with the operations of their communities' health facilities. With TSHIP's training, they became more capable of focusing their efforts productively. The addition of CBHVs, who became the outreach extension of both the health facilities and the WDCs, further strengthened this community platform and brought it to the household level. Community members became more engaged and attendance at health facilities increased. Refurbished health facilities with more responsive staff encouraged continued attendance. A cohort analysis however, was not part of this evaluation, so from the data on-hand the team cannot attest to whether these factors improved health outcomes for patients. The transcribed comments of stakeholders in Annex VII(c) provide a fascinating insight into this process. It should be noted that not every facility and community experienced the same levels of improvement. There are still health facilities without water or adequate toilets. Most are understaffed. The 40 health facilities in 20 LGAs visited did show a pattern of improvement, however, with community participation being one of the most prominent features.

HMIS/DHIS

One of the critical assumptions of the project was that "NHMIS is functioning and is a reliable source of data for TSHIP." This was not the case at the beginning of the project, but, as a result of TSHIP's efforts, became truer over time. This is not a completed process. Reporting has improved and completeness and timeliness are much better than when the project began. Use of data for planning and budgeting is more common. However, as reported in MEMS II's DQA reports, the accuracy and reliability of the produced data need significant improvement before they can be called adequate. Data quality is an issue. Some of the factors responsible included multiple data collection registers at the health facilities (which TSHIP, in collaboration with other projects, was able to address) and a shortage of staff who will adequately keep records while also trying to cope with client service provision. TSHIP ending before the process of data quality assurance can be completed is a major setback.

The project tracked the "percentage of HMIS indicators reported in a timely manner" and reported this as an indicator. In project year one, TSHIP had a difficult time gathering the data on HMIS reporting. By year two, they had a much better grasp on the situation and reported that 66% of health facilities in 92% of LGAs in Bauchi, and

63% of health facilities in 96% of LGAs in Sokoto were reporting on time. By project year five, 100% of LGAs in both states, 87% of health facilities in Bauchi and 97.2% in Sokoto, were reporting on time. To achieve these gains, TSHIP trained staff, provided computers in each LGA, provided data collection forms, and generally provided large-scale assistance and guidance. The sustainability of the system without this support is questionable, and many of the people involved in HMIS in both states who were interviewed expressed concern about this. The biggest issue was funding the supervision and support necessary to maintain and improve the HMIS system.

Comments on HMIS were heard at all levels. State Ministry of Health (SMOH), Ministry for Local Government (MLG), Ministry of Budget and Economic Planning (MBEP), and LGA staff talked about how much improvement they have seen. People mentioned “evidence-based budgeting.” (Key informant interviews with SMOH/MLG officials in both states and MBEP in Bauchi.) LGA and WDC members referred to using data for decision-making. The Evaluation Team is also aware that many of the numbers reported do not appear to be grounded in reality, with unrealistic rates for RI and contraceptive prevalence being reported. (See Question 1.)

Enabling Environment and Policy

Some of the policy work that TSHIP has done directly impacted other work of the project. Support for state Health Development Plans in both states, helping to establish the Drugs and Medical Consumables Management Agency (DMMA) in Bauchi, and assisting the development of the Bauchi State Gender Policy and Plan are but a few of the many policies on which TSHIP has assisted the states. The list of policies from project reports is eight pages long.¹⁷ The body of work that TSHIP has accomplished in this area is impressive. This raises the question of what impact these policies have had. A striking example would be the establishment of the DMMA in Bauchi. This agency was created with support from TSHIP and DELIVER to fulfill a need. It was described as an effort to move from “drug shopping” to managed procurement. The agency was created by an Act of the Legislative Assembly, staffed, and made operational. When the Evaluation Team visited DMMA in Bauchi, the Director said that DMMA had an approved budget of one million Naira, but had received nothing. Once again, weak governance undercut systems strengthening.

The absence of budget releases was a complaint heard frequently by the Evaluation Team in Bauchi. The problem was also mentioned in Sokoto, but to a lesser extent. Several ministries mentioned that their personnel had not been paid in months—usually two or three months, but in one instance, it had been eight. Some said that the problem stemmed from the period leading up to the elections held in March 2015.

Training and Capacity Building

TSHIP put maximum effort into training and capacity building. The scale of these efforts is impressive. Training CBHVs meant training ten CBHVs per ward across 323

¹⁷ TSHIP Annual Report: Project Year Five, 59-66.

wards, or 3,230 people. **Table 7** shows reported training totals for five selected indicators—a small representation of TSHIP’s trainings. In the area of capacity building, TSHIP also created job aids, developed standard operating procedures (SOPs), conducted extensive pre-service training, trained and implemented Standards-Based Management and Recognition (SBMR), and provided on-the-job training, cross-visits, and workshops.

Table 7: People Trained in Selected Areas					
State	Indicator 10: Number of people trained in maternal/ newborn health through USG- assisted programs	Indicator 11: IIP3.1.3.4-1 Number of health workers trained in intermittent preventive treatment in pregnancy (IPTP) with USG funds	Indicator 14: Number of people trained in FP/RH with USG funds (male and female)	Indicator 22: Number of health workers trained in case management with artemisin-based combination therapy (ACTs) with USG funds	Indicator 23: IIP3.1.2.1-5 number of health workers trained in malaria laboratory diagnostics [rapid diagnostic tests (RDTs) or microscopy] with USG funds
Bauchi Year 1	244	0	311	0	0
Bauchi Year 2	269	0	625	0	0
Bauchi Year 3	654	601	624	1,070	842
Bauchi Year 4	1,669	207	348	415	479
Bauchi Year 5	3,542	0	97	298	298
Sokoto Year 1	205	0	219	0	0
Sokoto Year 2	432	0	1256	0	0
Sokoto Year 3	1,182	1,282	1,344	1,282	1,207
Sokoto Year 4	2,079	214	1790	651	879
Sokoto Year 5	118	0	77	0	298
Total	10,394	2,304	6,691	3,716	4,003

The TSHIP Midterm Evaluation noted the project had trained large numbers of people and recommended that more effort be exerted toward ensuring that training was being used, was used correctly, and was accomplishing its intended purpose. Interviews with TSHIP staff, LGA officials, and WDC members showed that TSHIP became more focused in their training efforts in the latter half of the project (see Table 8). Lack of staff and staff turnover in health facilities lessened the impact of trainings. Interviews with service providers and state officials indicated that where staff were trained and supported after training, performance improved. “Support” could take the form of integrated supportive supervision, enhanced coordination with WDC/LGA and with communities, and better equipment and/or reliable supplies. In interviews and

FGDs, people who had been trained were enthusiastically appreciative for their training.

Integrated Supportive Supervision

It was not possible to quantifiably measure the impact of supportive supervision, but its popularity was impossible to miss. One state official in Sokoto said that if he had two vehicles, a few staff, and the budget to send them to the field for Integrated Supportive Supervision (ISS) visits, he could maintain all the gains that TSHIP and the Ministry had made in HMIS. He added that when reporting fell off in a location, it could usually be restored with one or two ISS visits.

In the first five years of TSHIP, there were 3,346 supportive supervision visits to health facilities—starting with 83 in project year one and ending with 1,147 in year five. TSHIP's efforts at sustainability included advocacy to secure government financing of the CBHV/WDC system, support to policy and legislation, and partnership with state bodies to institutionalize ISS. A broad range of people interviewed for the end-of-project evaluation, including state and LGA officials, expressed concerns about continued funding for ISS and its sustainability (Annex VII(c and d)).

Health Financing

During Key Informant Interviews with SMOH officials and TSHIP staff in both states, health financing was perceived as a "least effective" health systems strengthening intervention by many of the respondents interviewed. The reasons for this relate to larger problems: allocated funds are not released and accountability for the spending of funds is weak. These are systemic problems that eluded the systems strengthening efforts of TSHIP.

During year four of the project, LGAs increased the monthly allotment for RI in Sokoto from 50,000 to 200,000 Naira. Also in Sokoto, the budget for malaria increased from 5 million Naira in 2011 to 250 million Naira in 2012. The Evaluation Team heard from LGAs (Annex VII(c)) that TSHIP taught them evidence-based budgeting and improved their planning and use of funds. The Ministry of Budget and Economic Planning in Bauchi also lauded the project for promoting and training evidence-based planning.

TSHIP helped establish Health Research Ethics Committees (HREC) in both states that screened biomedical research trials involving human subjects. These committees established a registration fee system to cover costs and were receiving research protocols during the evaluation field visit (Annex VII(c)).

A representative of the Ministry of Women Affairs and Social Development in Bauchi expressed gratitude for the help that they had received from TSHIP and LEAD in the development and later adoption of the State Gender Policy. When asked how the Ministry would move forward with the policy, the answer began, "We have no funds at present."

Human Resources for Health

This was the second most frequently referenced “least-effective” systems strengthening intervention. This is not surprising since this was one of the TSHIP critical assumptions. TSHIP’s efforts in this area were overwhelmed by the institutional inertia of the systems themselves. The TSHIP Midterm Evaluation discussed at some length what TSHIP should do to improve HR management of the health system, especially at the health facility level. There are limits to what any outside project, especially one that is funded by another government, can do to regulate and enforce policies and behaviors in a state-run health system. TSHIP did good work where it could, in areas such as ISS, capacity building, task shifting, and efforts to introduce more accountability and community oversight. One laudable effort was the *Bauchi State Human Resource for Health Strategy and Plan* and the *State Human Resource for Health Policy* in Sokoto. These were both stalled by procedural hurdles when the Evaluation Team visited the states.

2b. How (if at all) did collaboration with other USAID projects and partners in the states impact the health systems. If not, why?

Collaboration with the **states** was both lauded and decried. It is helpful in this instance to discuss differences between the two states. Sokoto entered into its relationship with TSHIP more reluctantly than Bauchi. Officials in Sokoto were more likely to express, sometimes strongly, that TSHIP was not an idea that they had come up with. They appreciated the inputs and assistance and often praised the project’s work. State officials in Bauchi were more likely to speak of a partnership of equals, collaborating fully. TSHIP staff were, by contrast, more likely to describe Sokoto as a state where the SMOH and MLG followed through on promises and were reliable and candid. They described Bauchi as a place where much was promised but not always delivered. The Evaluation Team found these differences to be clear and distinct and to have little impact on project work or outputs. One reason for this was the stronger feelings tended to be at the top of the chain of authority. The further one got from the center, the more collaborative relationships were. At the LGA level and below, these differences between the two states tended to fade. A common refrain in interviews in the two states was that TSHIP needed to collaborate with the states “before the beginning.” States want to be included in the design/planning process more than they felt they were under TSHIP. People said this would increase ownership and sustainability.

Collaboration with **development partners** had mixed results. WHO, UNICEF, and the Emergency Operations Center (EOC) all expressed gratitude for TSHIP’s contributions and cooperation, but were the most critical of TSHIP among all the stakeholders. They expressed a desire for TSHIP to operate differently, by working under their direction and that of the states. TSHIP met with the EOC weekly at the least, often more frequently during polio eradication activities, yet EOC criticized TSHIP for lack of communication. TSHIP was co-located with the State Primary Health Care and Development Agency (SPHCDA) in Sokoto and the staff held regular meetings that

included development partners. USAID also had MOUs in place with both States.

Focus State Strategy (FSS)

This section responds to FSS questions for both Question 1 and 2.

The Evaluation Team found that FSS is effective. It has a significant impact on efficiency, both for the projects involved and for the other stakeholders and clients who work with them. In this instance “efficiency” refers to saving time and effort. FSS partners smooth the way for each other. They have contacts and knowledge that become a shared resource. As the LEAD COP described, LEAD gave TSHIP access; TSHIP gave LEAD health expertise.

The Evaluation Team sampled LGAs/WDCs that were LEAD-supported along with a larger group of others that were not. Six (60%) of the 10 LGAs visited in Sokoto, and four (40%) of the 10 LGAs visited in Bauchi had both LEAD and TSHIP presence. This was a small sample but did serve to illuminate differences. An analysis of the responses from FGDs with WDCs in both Sokoto and Bauchi states revealed some noticeable differences in terms of participation/contribution of WDCs in LGAs where TSHIP and LEAD projects work and those where TSHIP works alone. This was evident in the nature and magnitude of support provided by the WDCs in the two categories of LGAs. In Sokoto for example, most WDCs in LEAD-supported LGAs are able to fuel and maintain the ambulances distributed by the state government, while only a few in non-LEAD LGAs could. Also, LEAD-supported LGAs/WDCs appear to be able to undertake larger projects to construct, renovate, or repair health facilities’ infrastructure, partly due to their ability to mobilize resources, including internal resources.

In both states, LEAD LGAs’ WDCs appear to be more engaged in monitoring and supervision of health facilities than their non-LEAD counterparts. In collaboration with the health workers, they organize public lectures/outreach services to sensitize the community to the importance and availability of healthcare services. There was no visible difference between the two categories in terms of collaboration with other organizations/CBOs; they both collaborate with other groups that are working on maternal and child health within their locality.

Overall, sustainability of most of the community interventions is not guaranteed in either of the two categories, as all the WDCs expressed the need for the local government authority to continue with the CBHV program (implying that they cannot sustain it).

Evaluation Question 3

What best practices, if any, can be learned from TSHIP to inform the design of new activities?

The Evaluation Team collated responses concerning best practices from the 524 people interviewed in the course of the evaluation. The most frequently cited were:

- Community Mobilization/Participation
 - o CBHVs, WDCs, 100 Women Group, Sub-Grantees,
 - o Traditional and Religious Leaders
 - o Community-Based Distribution of Misoprostol and Chlorhexidine
- Capacity Building, HMIS, ISS
- ORT Corners
- EMAPs/Male Involvement in FP/ANC/Women's Health
- Collaboration with the states, development partners, and other donors
- Enabling environment (Policy)
- Service Integration

Community Mobilization/Participation

"I have been working on mobilizing people but never seen a better approach than that of TSHIP, it covers not only health but other socioeconomic issues."

The most frequently mentioned best practice of TSHIP was clearly community mobilization/participation. This is not a single best practice but a group of complementary systems and activities that includes the revitalized WDCs, community-based/civil

society organizations, 100 Women Groups, sub-grantees, religious and traditional leaders, and CBHVs. These groups and individuals worked together and worked with the health facilities, the LGAs, and with other implementing partners and organizations. The plan was to get people into the facilities for health services and to get the services out to the people (outreach). Community participation created more aware clients and more responsive providers.

Focus groups with **WDC** members (Annex VII(c)) highlight much of the community participation process and the engagement with health facilities. TSHIP promoted monthly meetings between facilities and WDCs, which led to a stronger relationship and more involvement of WDCs in the running of health facilities. WDC members said that they:

- Contributed to repairs of health facility structures
- Contributed in maintaining or providing infrastructure in many health centers
- Contributed in community enlightenment and sensitization which increased health facility patronage
- Made appeals for funds to assist the healthcare providers
- Built toilets, repaired access roads
- Encouraged husbands not only to support their wives, but also to accompany

them to the health facility

- Helped keep the health facility environment clean
- Contributed to fueling and maintenance of the ambulance
- Contributed money to buy drugs (establish and maintain drug revolving funds)

Sub-grantees were an important part of community participation and extended the reach of TSHIP at the community level. As noted earlier, FGDs with representatives of the sub-grantees revealed dissatisfaction with the bureaucratic hurdles they had to cross to get started (see Annex VII (d)). They gave high marks to TSHIP for its support to them once they got their grants and work was underway. This appreciation extended well beyond funds. One respondent said about the departure of TSHIP, “I do not worry about the money. I worry about losing the level of access that TSHIP provided. TSHIP broke hard ground.” (Annex VII(c)) A major part of TSHIP’s community-level best practices was getting groups to work together collaboratively.

Sub-grantees are part of the communities where they work, and as such, offer opportunities for sustainability beyond the life of a project. In project year three, TSHIP awarded seven non-competitive grants to the following organizations to implement MNCH and FP community outreach activities:

- Life Helpers Initiative (LHI)
- Partners for Development (PFD)
- Federation of Muslim Women Association of Nigeria (FOMWAN)
- Rahama Women Development Program (RAHAMA)
- Planned Parenthood Federation of Nigeria (PPFN-Bauchi and Sokoto)
- Marie Stopes International-Nigeria (MSIN) (Bauchi and Sokoto)

In project year four, twelve competitive grants and ten WDC grants were awarded in addition to the seven non-competitive grants in year three. By project year five, grants were ending.

Religious and Traditional Leaders and organizations such as Jama’atu Nasril Islam (JNI) in Sokoto and FOMWAN fostered community acceptance and created an environment where project interventions could move forward. Religious and traditional leaders were mentioned frequently during the evaluation interviews and FGDs, but their exact role in the project was somewhat vague. Some said the engagement of these leaders was not so much to get them to promote project objectives, i.e., act as agents of social change, as it was to prevent them from impeding these objectives. The Evaluation Team heard of instances where the leaders engaged in conflict resolution over FP promotion or use.

“Involvement of CBHVs has made TSHIP outstanding among other health projects/interventions. Some mothers give their children to the CBHVs to take them for immunization.” [WDC member, Sokoto North LGA, Sokoto state]

CBHVs: Some of the highest praise for TSHIP in both states was directed at the CBHV program. Interestingly, some of the harshest criticism of TSHIP was directed at the CBHV programs as well. CBHVs extended TSHIP's reach down to the household level. For example, the *Project Year 5 Annual Report* noted:

In Sokoto, 2,440 CBHVs conducted 388,347 household visits in 244 wards, reaching 211,839 pregnant women and their families with messages on the benefits of ANC attendance (248,664 women reached), danger signs in pregnancy (186,691), malaria in pregnancy (257,149), child spacing (190,981), home management of malaria (166,371), and childhood diarrhea treatment (159,018).¹⁸

Without the CBHVs it is difficult to imagine how TSHIP could have reached the numbers of people it did. It takes thousands of volunteers to reach hundreds of thousands of women and engage them in ANC, FP, and other interventions. With the chronic shortage of staff in health facilities, the use of community-based volunteers becomes even more compelling. The Evaluation Team found that the CBHV program is very well liked across the spectrum of people interviewed. However, the CBHV program had critics as well. State officials in both Sokoto and Bauchi criticized the cost of the program, saying that the money should have gone toward training CHEWs (TSHIP paid a monthly stipend of two thousand naira (N2,000) to each CBHV as transport fare.) Some said that it was implemented in a non-collaborative manner, "behind our backs." The most frequent criticism—and one of the most frequent concerns among CBHV supporters as well—is that it is not sustainable.

Community-Based Distribution of Misoprostol and Chlorhexidine

Sokoto and Bauchi States began procuring misoprostol and chlorhexidine in 2013 for use in preventing postpartum hemorrhage and newborn infections. The use of these two drugs is best categorized as an intervention—but the means of distribution used by TSHIP qualifies as a best practice. In Sokoto, where 95% of deliveries take place at home, provision of these two drugs at facilities would have probably reached only one in 20 births. The TSHIP program used CBHVs to deliver the drugs along with health messages and support. The program has been quite successful and has garnered praise and support. It is being replicated in other states in Nigeria, starting with Plateau, Gombe, and Kano. Twenty-three other states are in the process of procuring misoprostol and chlorhexidine or are considering it.¹⁹

Respondents often cited **Capacity Building**, **ISS**, and **HMIS** as best practices. They are more a part of systems strengthening and have been discussed under Evaluation Questions 1 and 2. They are interrelated, as the tools TSHIP used to improve HMIS, among others, were capacity building and ISS. People who participated in project activities appreciated TSHIP's trainings, recognition, and other support. This was especially true of health facility staff, WDCs and community organizations.

¹⁸Targeted States High Impact Project (TSHIP), *Advancing Health in Bauchi and Sokoto States Annual Report PY5, 2014*, 18.

¹⁹TSHIP, *Transforming Nigeria's Maternal and Newborn Health Landscape*.

ORT corners were mentioned in field interviews as an intervention, and as a best practice. In and of themselves, ORT corners are an intervention. (See Evaluation Question 1 for a description of ORT corners.) The heightened emphasis that TSHIP placed on diarrheal disease management, both in health facilities and in homes, coupled with the extensive training and resources they dedicated to it, qualifies as a best practice. They pursued this activity at multiple levels and integrated it into different systems. This was a response to the context of the two states, which had very high disease rates and limited utilization of services.

Expanded Males as Partners was frequently cited as a best practice. It is covered in Evaluation Question 4 (Gender) below.

Collaboration: TSHIP was a collaborative project, and this contributed to achieving the project's goals and objectives. Collaboration is covered under Evaluation Question 2b.

As addressed above under health systems strengthening, Evaluation Question 2a, and elsewhere, an **Enabling Environment and Policy** contributed to the larger objectives of TSHIP. The project worked on a wide range of policies, including major policy initiatives, such as the *Strategic Plans for Health*, acts of legislation, and simple changes in protocols and procedures, all intended to create an environment where health outcomes in the two states will improve.

It is fair to say that the FSS is a best practice. It is also fair to say that FSS is, first and foremost, a USAID best practice. The Implementing Partners made FSS work and benefitted from the efficiencies and improved effectiveness that followed, though not always at a strategic level.

Evaluation Question 4

How well has TSHIP integrated gender into its implementation?

Gender integration was an important consideration in all programmatic areas of TSHIP and received extra emphasis at the community level. The history, culture, and social norms of northern Nigeria preclude any other approach. It would be impossible to implement a project like TSHIP without designing gender considerations into it. TSHIP did this, incorporating inclusiveness as a principle in community participation activities, work with WDCs and LGAs, and programming for males as partners.

TSHIP addressed gender at multiple levels. At the state level, the project collaborated with LEAD and NEI to facilitate a gender gap assessment and analysis and worked with the State Gender Technical Working Group in Bauchi to move the Bauchi State Gender Policy forward.²⁰ Similarly, TSHIP worked to advance the Sokoto State Gender Policy as well. Sub-grantees were important partners in TSHIP's gender approach. The project used sub-grantees to promote MNCH and FP outreach. The project trained Expanded

²⁰TSHIP Project Year Two Annual Report, 39.

Men as Partners (EMAPs) and Male Community Champions (MCCs). TSHIP engaged organizations such as FOMWAN and the Nigerian Aid Group of Jama'atu Nasril Islam (NAG-JNI) to leverage these groups' access across gender and cultural barriers.

4a. Which approaches have been the most effective at integrating gender (and least effective) and why?

The Evaluation Team included questions about gender programming in almost all of the survey instruments used in the evaluation. Collated responses show that some of the approaches used by TSHIP were more effective than others.

Most Effective:

- Extended Males as Partners (EMAPs-Male Champions), and male inclusion
- 100-Women Groups
- Use of Traditional and Religious Leaders to Promote Birth Spacing
- Proactive Recruitment and Inclusion of Women in Project Activities
- CBHVs

Least Effective:

- WDC Gender Composition
- LGA Gender Composition

The **Expanded Males as Partners (EMAP)** initiative built upon the prior Men as Partners program in Nigeria, which was designed to engage men to constructively participate in women's health issues and FP. EMAP takes this further, in an effort to engage men as active advocates for women's health and child spacing. As part of this, TSHIP trained Male Community Champions (MCCs) to motivate other men. This is just one of a group of practices TSHIP used to promote both RH/FP and gender inclusion, but stands out among respondents. An LGA official in Bauchi said, "TSHIP should have started the EMAP activities earlier at the beginning of the project to be able to achieve more in the area of men supporting their wives to access services in the HFs." Another said, "...if CBHVs are not allowed in a household where their services are needed, they report such issues to the WDCs. EMAP members and traditional leaders in turn talk with these men to allow the CBHVs to attend to the women." A TSHIP staff member expressed optimism about the sustainability of EMAPs. "We believe that these men will continue after the project ends, as they are doing what they do without pay and are dedicated."

The 100 Women Groups are a women's empowerment platform that works across sectors to engage women to improve their lives and livelihoods. They register with their states as an organization, raise funds, access loans, and participate in health and development activities in their communities. TSHIP worked closely with them. As members of the communities where they operate, they are well-placed to deliver strong messages. One representative explained their work on gender and health:

“Child spacing. Before no one wanted this. It is not stopping giving birth. It is giving the woman a rest. Men now understand the benefit to the mother, the father, and the child. The men, now they know. Even when the men do not know, the women find a way. We used drama to teach this. We invited men to watch. They came and watched. They saw the dangers of not allowing their wives to go for child spacing. Without child spacing there are too many children too fast. They do not go to school. What can they do? They go to beg.”²¹

There are forty-three (43) 100 Women Groups in Bauchi and Sokoto, which are fully registered as cooperative organizations with the state Ministry of Commerce and Industry. All 23 groups in Sokoto have secured loans from the Central Bank.²²

Religious and Traditional Leaders did not promote child spacing as much as they tacitly approved of others promoting child spacing. This was a valued contribution toward an enabling environment for male involvement in FP.

Gender Balance and Gender Inclusion in its Activities and in Recruiting was a TSHIP policy. This issue came up frequently in interviews and FGDs. Some sub-grantees joked about scrambling to make sure they had balanced trainings. The LGA officials mentioned that they maintain equal representative criteria (male/female) for selection of staff to be trained.

“We counsel husbands by telling them if they don’t sacrifice 500 Naira for their wives’ wellbeing during pregnancy, they may spend thousands of Naira if there is complication or if she dies.”
[CBHV member, Alkaleri LGA, Bauchi]

CBHVs are role models and tend to be viewed with respect.

The **least effective** gender activities include efforts to get WDCs, and where possible LGAs, to recruit more women and to recruit women into positions of authority. This did not bear much fruit. In FGDs, WDCs and LGA officials mentioned that women made good treasurers and as such are given the position in WDCs because they are good with money.

Why are some approaches more effective at integrating gender? There are two distinct patterns that help define the more effective approaches to gender inclusion, empowerment, and acceptability employed by TSHIP. Approaches used by TSHIP that succeeded met one or both of these criteria.

The 100 Women Groups, CBHVs, and inclusion of women in participation and leadership of community structures (WDCs, LGAs) are empowering. The establishment of CBHVs produced a profound increase in women’s representation in the health systems of Bauchi and Sokoto, providing role models as well as a new community-based resources.

²¹Key Informant Interview with 100 Women Group Member, Annex VII(c)

²² TSHIP Second Quarter 2015 Report.

When men, husbands, and leaders (EMAPs, Champions, Religious and Traditional Leaders) take an active, vocal stand on the acceptability of women's participation, child spacing, and women organizing into cooperative groups and obtaining loans to pursue economic activities outside of the household, this is a major step toward gender inclusion. Altering the power relationships of LGAs and WDCs by increasing the number of women in leadership positions does not happen easily.

TSHIP's role in this process was more enabling than causal. No person or project can dictate or demand change. TSHIP encouragement and mentoring created an enabling environment for change in gender roles and participation.

4b. What could the project have done better to improve gender integration?

TSHIP's gender activities sometimes appeared to be more opportunistic than strategic. The project should have had gender strategies and work plans integrated into project activities from the very beginning. The project would have benefitted from having a gender specialist on staff. TSHIP should have established benchmarks and indicators for gender integration and inclusion to be measured and reported over the lifespan of the project. Future projects might want to consider incorporating periodic external assessments of the project's gender activities and strategies. MEMS II can undertake these.

CONCLUSIONS

Strengthening health systems is a necessary condition for substantially improving health outcomes in the two states, but alone is not sufficient. To improve health outcomes, the strengthened health systems must be combined with health governance improvements, so that the improved systems will have an environment in which to develop. Three of the TSHIP's critical assumptions did not hold. Staffing levels were not adequate for planning, implementation, and supervision; supplies of commodities were unavailable or inconsistent in supply; and healthcare funding was not released in a timely fashion and monitored for legitimate use.

For the most part, TSHIP activities in maternal health, family planning, and child health did not show significant impact on those indicators as measured in population-based surveys (NDHS, LQAS). This, again, is due to the breakdown of the three critical assumptions of the project.

Routine immunization rates in both states, but dramatically more so in Sokoto, are stuck at unacceptably low levels. Contraceptive prevalence rates have also not improved greatly despite expanded access to services. TSHIP and other donor-funded projects put effort into turning this around. The combined efforts of many agencies, projects, donors, and governments are still not getting the job done.

Integration of MNCH, ANC, RH/FP, RI, and child health services in health facilities did improve, but with mixed results. Only one LGA visited reported that routine immunizations are available on a daily basis; however, all health facilities visited

reported that family planning and malaria services are offered daily.

TSHIP supported a wide range of policies, from simple SOPs to legislation that created new agencies, such as the DMMA. All of these were designed to strengthen and improve health systems or the context surrounding these systems. There is no assurance that the state governments will fund these policies and agencies.

TSHIP improved HMIS in both states. Its contribution is widely appreciated in both states. However, data quality remains a problem, with accuracy and reliability of data both needing much more work at the time the project is ending. Sustainability of HMIS gains is in question as many of the support functions provided by TSHIP may not be picked up by the states and LGAs.

The revitalization of the WDCs in both states (performed in collaboration with LEAD) was successful and made important contributions to the success of the project. Revitalizing the WDCs was a powerful tool that strengthened communities and peripheral health facilities, outreach services, referral systems, and emergency transport systems. The WDCs in Bauchi tend to be more politicized than in Sokoto, but this did not hinder the project. In both states, the WDCs played an active role in project interventions, taking on responsibility for them. The WDC structure holds promise for sustainability of project gains.

The community-based distribution of misoprostol and chlorhexidine using CBHV, which is a TSHIP innovation, is an effective, lifesaving intervention and is widely appreciated by communities. The distribution system not only provides lifesaving drugs to the homes, it also brings mothers into contact with CBHVs who educate and inform them. Many people interviewed expressed concern about the continued funding for the CBHV program. If not funded, it could damage the gains made in the distribution of misoprostol and chlorhexidine.

The Focus States Strategy is an effective framework for creating synergy and multiplying the outputs of investments by USAID. FSS made TSHIP more efficient, saving them time and resources. This was especially true with their work with LEAD, but also with the other FSS partners. Along with effectiveness and efficiency, FSS gave the partners credibility. They presented a united front to the states and to stakeholders. Governance is the chief problem with the health systems in the two states. LEAD's presence in the FSS partnership strengthened TSHIP. NEI, DELIVER, and WASH also contributed to TSHIP's effectiveness.

Sub-grants to WDCs, LNGOs, faith-based organizations, and others worked very well, once they were up and running. Sub-grantees show promise for sustainability, as they are indigenous to the communities and not as reliant upon state funding.

Integrated supportive supervision is a powerful tool, and it was used well by TSHIP. Its funding by the two states remains an issue.

Gender issues were and still are a barrier to improving health outcomes in the two

states. TSHIP made progress in this area. The problem is far greater than any health or development project can solve by itself. TSHIP improved gender integration and inclusiveness incrementally. The use of men to promote use and acceptance of child spacing stands out. TSHIP could have done more to integrate gender into its implementation if it had a well-articulated gender strategy and a gender specialist on staff to turn the strategy into action.

RECOMMENDATIONS

Follow-on activities should be designed in collaboration with key stakeholders (state and local governments and the civil society) in the two states. This will increase ownership and sustainability and can be used to address some of the shortfalls in the critical assumptions for TSHIP. State responsibilities need to be negotiated and should include provisions for staffing, commodities, and the timely release of funds. Negotiations should also include support for the implementation of policies; new agencies created; CBHVs; HMIS; and ISS. They should also include an MOU defining the state's roles and contributions to the project and should include a commitment, plan, and benchmarks for addressing the chronic staffing problems at state health facilities. The MOU would benchmark proposed budgets and consequences for not meeting agreed-upon resource needs and responsibilities. Every effort must be made to avoid repeating the breakdown of critical assumptions that plagued TSHIP.

Both states are developing legislation to address the issue of multiple ministries and agencies having authority over health staff (often citing Kano state's efforts in this area as an example). USAID should consider the possible impact of this and plan accordingly and ensure that any future project incorporates any structural changes and has both the flexibility and a strategy to adapt.

The Focus States Strategy should be continued as a strategic approach, not a project approach. There should be articulated objectives and more oversight from USAID on FSS implementation. Health governance is the single biggest problem in the Nigerian health system. Governance is a unifying theme of FSS, and should be a unifying theme of future projects' designs under FSS.

Future health projects should have gender strategies and work plans integrated into project design. Projects with large gender components should have a gender specialist on staff. Projects should establish benchmarks and indicators for gender integration and inclusion to be measured and reported over the lifespan of the project. It would be useful to have periodic external assessments of gender activities and strategies.

Ward Development Committees proved to be a valuable asset and a powerful tool for TSHIP and the entire HSS/development process. This should be replicated in any future projects working at the ward level, not just those focused on health.

ANNEX I: EVALUATION STATEMENT OF WORK



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[Targeted States High Impact Project(TSHIP)]

EVALUATION SCOPE OF WORK

[End-of-Project Evaluation]

Submission Date: March 03, 2014.

[Contract/Agreement] Number: [620-A-00-09-00014-00]

Activity Start Date and End Date: AUG. 12, 2009 to AUG. 11, 2015

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This document was produced for review by the United States Agency for International Development Nigeria (USAID/Nigeria).

I. BACKGROUND INFORMATION

A. Project Identification Data:

Development Objective	Project Title
Improved Health Status of Nigerians	Targeted States High Impact Project (TSHIP)
Award Number	Award Date
620-A-00-09-00014-00	12 August 2009 to 11 August 2015
Funding	Implementing Partner(s)
\$89,953,015	JSI, Research and Training Institute including: Centre for Development and Population Activities (CEDPA), Futures Group International, LLC (Futures), JHPIEGO and Management Strategies for Africa (MSA)
COR/AOR	Estimated Evaluation Budget
Gertrude Odezugo	\$150,000

B. Purpose:

The purpose of this evaluation is to appraise the Targeted States High Impact Project's (TSHIP) end of project performance. The evaluation will seek to determine TSHIP's overall attainment of its development objectives, assess the strengths and weaknesses of TSHIP's implementation strategy, and to determine best practices and lessons learned during the life of the project. The evaluation's findings will be used to inform the design and implementation of future USAID supported Maternal Newborn Child Health/Reproductive Health/Family Planning (MNCH/RH/FP) activities.

C. Development Context:

Nigeria accounts for only two percent of the world's population, but contributes about 10 percent of global infant, child and maternal mortality. Every year, about one million under-five children die, and some 33,000 women die of pregnancy-related conditions most of which are preventable deaths. Nigeria has been grouped among the 68 countries that are unlikely to attain the Millennium Development Goals (MDG) four and five on child and maternal survival by 2015. In nearly every area of primary health care, there is low coverage of high impact interventions. Coverage tends to be substantially lower in the North East and North West zones of the country where the TSHIP project is located.

TSHIP supports integrated primary health care to deliver MNCH interventions and strengthen the health systems in Bauchi and Sokoto States. These two states, also home to USAID-funded Education, and Peace Democracy & Governance activities, are part of USAID's focus states strategy. The focus state strategy is premised on the idea that concentrating activities from different sectors will lead to sectoral synergies and a greater development impact. TSHIP was designed in 2008, in compliance with a Country Partnership Strategy agreement between DFID, the African Development Bank, the World Bank, and USAID. The Country Partnership Strategy called for a division of northern Nigeria by donors into in different "focus states," with the goal of reducing overlap and duplication.

TSHIP was designed, in part, based on lessons learned from three preceding USAID-funded projects (COMPASS, ACCESS and Immunization Basics). The key lessons learned from these projects is that an integrated approach to addressing primary-health care and strengthen the overall health system leads to better health outcomes than does a more vertical approach focusing on selected interventions.

D. Results:

- **Intended Results.**

It is expected that at the end of TSHIP that strong and durable bonds between community institutions and the health care delivery system will exist in every ward of Bauchi and Sokoto, with measurably improved household practices and increased use of services. Bauchi and Sokoto will have improved health systems and higher quality service delivery for family planning, Antenatal Care (ANC), complicated pregnancy, EmONC, RI, Vitamin A, and child health.

Taken as a whole, TSHIP's inputs will form an integrated package assisting state and local governments to improve Primary Health Care (PHC) services by filling in capacity gaps, building on institutional strengths, and improving a household's ability to

protect and promote their own health.

See Implementation Approach below for TSHIP Strategic Framework.

E. Approach and Implementation:

Implementation Approach

Five over-arching strategies were identified in the project proposal to guide and shape all aspects of TSHIP implementation:

1. Applying Standards-Based Management to Improve Quality and Performance;
2. Forging Partnerships in all aspects of TSHIP implementation;
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.

Program activities for TSHIP are organized under four Sub-Objectives that were specified in USAID’s Request for Application (RFA) and in the original Program/Technical Description, which was the basis of JSI’s proposal in response to the RFA and for the eventual approval of the award by USAID, leading to a Cooperative Agreement (CA) with JSI in 2009. Since then, TSHIP has organized project work and staff according to these sub-objectives. The activities bulleted below reflect how TSHIP has arranged the sub-objective work in its Project Year Three Work Plan (covering October 2011 through September 2012). TSHIP also identified project support activities and a cross cutting activity in the same work plan, which are listed below. Plans for specific project interventions were also detailed in the original proposal, as incorporated into the Cooperative Agreement and can be reviewed in that document. TSHIP’s project description goes from five strategies to the Overall Objective and four sub-objectives.

TSHIP Strategic 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 manner 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.			

Overall Objectives: Increase the use of high impact integrated maternal, newborn and child health and family planning/reproductive health interventions in Bauchi and Sokoto.

Sub-Objective 1: Strengthen state and local government capacity to deliver and promote use of high-impact FP/RH/MCH interventions.

Strengthen the capacity of the health systems of the states and the local government areas (20 in Bauchi and 23 in Sokoto) and mechanisms to deliver and promote the use of high impact quality MNCH/FP/RH interventions and selected disease prevention/promotion in response to community needs. TSHIP interventions under this objective are to enhance state government and LGA ownership and sustainability.

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

This sub-objective has been divided into two parts for coverage by two TSHIP teams.

Sub-Objective 2A: This includes the following child health programs:

- a. Malaria. Includes promotion of long lasting insecticidal nets, improved diagnostics and treatment of malaria, and intermittent preventive therapy for malaria in pregnancy;
- b. Nutrition (previously IMCI). Includes improved management of childhood diarrhea with ORT under the nutrition heading in its Project Year Three plan. Nutrition specific interventions include promotion of exclusive sustained breastfeeding, improved infant and young child feeding, and vitamin A supplement distribution;
- c. Routine immunization;
- d. Polio eradication.

Sub-Objective 2B: This includes the following family planning and maternal health programs:

- a. Capacity building;
- b. Maternal and newborn care (antenatal care, malaria in pregnancy, skilled birth attendance, emergency obstetric care and management of newborns);
- c. Family planning;
- d. Adolescent reproductive health;
- e. Male involvement;
- f. Gender and female participation;
- g. Integration of sexual reproductive health and HIV/AIDS.

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

Building on the national primary health care and integrated MNCH/RH/FP and disease prevention/treatment guidelines and strategies, TSHIP strengthens community structures by providing technical and managerial support to Ward Development Committees (WDCs).

Sub-Objective 4: Improved policies, programming and resource allocation

TSHIP continues to support Bauchi and Sokoto to develop, disseminate and implement policies, plans, guidelines, laws and regulations. Policies developed nationally and adopted by the two states will be "stepped down" and disseminated to all stakeholders.

Project Support Activities

In addition to the four Sub-Objectives, project support includes the following:

- a. A grants program;
- b. Knowledge management and communication;
- c. Operations research;
- d. Monitoring and evaluation (both within the state health system and in the project).

Cross Cutting Activity: Coordination and Collaboration

As previously mentioned, the two TSHIP states, Bauchi and Sokoto, were chosen by the USAID/Nigeria as “focus states” in which USAID resources in several sectors (e.g. education, governance, water, health) would be concentrated. In order to benefit from this co-location, TSHIP is expected to actively collaborate with other USAID projects, especially LEAD, NEI, FHI/GHAIN (and its follow-on, SIDHAS) to develop and implement specific collaborative activities. TSHIP should also collaborate with other donor programs in its target states (e.g. activities supported by UNICEF, UNFPA or the World Bank Booster Program) and should share information and learn lessons from related projects in other northern states (e.g. PRINN-MNCH and PATHS2, both funded by DFID).

Examples of specific TSHIP coordination with other USAID projects are: school-based health services, with the NEI project: reproductive health commodity supply chain management, with the DELIVER project; incorporating lessons learned from the Maternal and Child Health Improvement Project (MCHIP); and the USAID/DFID-funded social marketing activities in each state (IRHIN and ESMPIN).

E. Project Modifications

The findings from TSHIP’s midterm evaluation¹ conducted in 2012 revealed that TSHIP was not on track in achieving its planned goals and objectives. A number of key sustainability focus activities were yet to be implemented and key milestones were far from being reached. TSHIP’s start-up and expenditures were also delayed and possibility contributed to some of its poor performance. Despite these findings, a number of their interventions did demonstrate to be promising, with prospects for future capacity to achieve notable success were the project extended. Some of these include the introduction of Cchlorhexidine and misoprostol instrumental in reducing maternal and child mortalities was gaining much acceptance, strong community structures on which the SPHCDA and LGAs must build on and sustain, WDC which had been significantly strengthened to create demand for services was likely to increase if supported a bit more improving acceptance of family planning services in the 2 TSHIP

¹ Target States High-Impact Project (TSHIP) Mid-Term Evaluation, conducted by The Mitchell Group, Inc. (TMG)/Monitoring and Evaluation Management Services (MEMS) II - November 2012.

focus states.

There are other areas that have shown either modest or little progress, but which have promise for greater accomplishment given more time. These include:

- Routine immunization;
- Coverage of facility based antenatal and maternal care;
- Vitamin A distribution;
- The routine health information;
- Management of childhood illness,
- Essential commodities and logistics.

On these notes stated above, it was agreed that in order to achieve its objectives and build on the promising interventions, TSHIP extension should be approved to bringing the project a close by August 2015, at an extra cost of \$4.5m.

F. Existing Data:

Documents available for use in this evaluation include:

1. TSHIP mid-term evaluation report;
2. Focus States Strategy Assessment Report;
3. Project's survey reports, like the LQAS;
4. National Survey reports – NDHS 2013, NDHS 2008, NDHS 2003, and Multiple Indicator; Cluster Survey 2011;
5. UNICEF-conducted SMART Surveys;
6. Project reports – Quarterly Reports, Annual Reports, Work Plans, Trip Reports;
7. The Cooperative Agreement Award Document, including the Program Description;
8. Peer reviewed literature – some by TSHIP, others by other partners;
9. Report of mid-term evaluation; and
10. RMNCH-related policies and guidelines.

These documents will be provided to the team upon arrival.

II. EVALUATION RATIONALE

A. Audience and Intended Users:

The findings of the evaluation will primarily benefit USAID HPN office to make better decisions while planning for the design and implementation of a new USAID-funded MNCH program in Sokoto & Bauchi. The findings will be disseminated and significantly

benefit the Sokoto and Bauchi state governments, donors, and civil society organizations that have interest and investments in these states.

Secondary users include:

1. USAID Washington – which will support the Nigeria Mission during the design of the new program;
2. The Government of Nigeria (Federal Ministry of Health) – which will better understand the needs of the two states and how programming can be improved in these states;
3. Bauchi State Government – which will have more information on best practices and lessons learnt and what will work best in their local context; and how best to use and leverage existing resources;
4. Sokoto State Government – same as for Bauchi state;
5. Other donors and partners working in Sokoto and Bauchi states – who will better understand the context within which they work; and this may inform re-programming and possibly, change in their project(s) focus;
6. TSHIP.

B. Evidence of Participatory Approach:

It is expected that the evaluation team will reach out to all relevant direct and indirect beneficiaries of the project. This will ensure full participation, objectivity and representation of all interested parties in the evaluation process thus creating a platform that will encourage ownership and use of the evaluation findings.

Evaluation Questions:

1. To what extent has TSHIP's integrated services approach led to improved health outcomes in Bauchi and Sokoto states?

1a. Which interventions have been most (and least effective) and why?

In answering this question address the effectiveness of USAID's Focus States Strategy (FSS).²

2. How did TSHIP impact Bauchi and Sokoto states' health systems?

²The objective of the FSS is to create a governance model to demonstrate and achieve effectiveness, efficiency and synergy in programming by concentrating USAID resources on two Focus States where the Mission believes resources can be effectively utilized. Three have been regional projects valued at \$169 million incorporated into the FSS in 2010: Targeted States High Impact Project (TSHIP); Northern Education Initiative (NEI); and Leadership, Empowerment, Advocacy and Development (LEAD). In addition, three national level projects, already operational in Bauchi and Sokoto, were incorporated into the FSS: Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS); Water Sanitation and Hygiene (WASH); and Fistula Care. [Focus States Assessment (FSS) USAID conducted by The Mitchell Group, Inc. (TMG)/Monitoring and Evaluation Management Services (MEMS) II –March 2013]

2a. Which health system strengthening interventions have been most (and least effective) and why?

2b. How (if at all) did collaboration with other USAID projects and partners in the states impact the health systems. If not, why?

In answering this question address the effectiveness of USAID's Focus States Strategy

3. What best practices, if any, can be learned from TSHIP to inform the design of new activities?

4. How well has TSHIP integrated gender into its implementation?

4a. Which approaches have been the most effective at integrating gender (and least effective) and why?

4b. What could the project have done better to improve gender integration?

III. EVALUATION DESIGN AND METHODOLOGY

A. Evaluation Design:

The evaluation team will use the Before-and-After approaches to answer the evaluation questions. In doing this, the team will review available data and reports and identify and conduct key informant interviews (KIIs) and in-depth interviews with various stakeholders under the project.

The team will also review performance records available through routine health reporting, project records, past evaluations and USAID/Nigeria performance records for quantitative information and other relevant sources. Interviews and data gathering will be conducted through meetings and conference calls in Abuja, as well as field trips to Bauchi and Sokoto states, as much as the security situation permits.

B. Data Collection Methods:

The focus of this performance evaluation is to use existing data to address the objectives listed above. Between 2003 and 2013, there have been at least six

population-based household surveys, a variety of reports and technical documents,³ and peer-reviewed literature about MNCH/RH/FP in Bauchi and Sokoto states. To augment these, the evaluation team will conduct key informant interviews with key stakeholders, such as USAID Nigeria, TSHIP key staff, local and international partners, other project staff, local, state and national government stakeholders.

Evaluation Question	Type of answer needed	Data Collection Method(s)	Data Source(s)	Sampling or Selection Criteria	Data Analysis Method(s)
1) To what extent has TSHIP's integrated services approach led to improved health outcomes in Bauchi and Sokoto states?	Descriptive	Document review Key informant interviews Data Review	Survey reports, program documents, health systems data, peer-reviewed literature, qualitative studies and reports.	TBD at TPM	Trend analysis, using descriptive statistics
2) How did TSHIP impact Bauchi and Sokoto states' health systems?	Normative	Document review Key informant interviews Data review	Survey reports, program documents , health systems data, peer-reviewed literature, qualitative studies and Reports.	Same as above	Quantitative and qualitative, including trend analysis.
3) What best practices, if any, can be learned from TSHIP to inform the design of new activities?	Descriptive	Document review Key informant interviews Data Review	Survey reports, program documents, health systems data, peer-reviewed literature, qualitative studies and	Same as above	Quantitative and Qualitative

¹Background Documents Review: Prior to conducting field work, the evaluation team will review background materials such as TSHIP Program Description, annual work plans, technical and training materials, past program evaluations reports and other documents related to the project. The Mission will provide these to the team as soon as possible and if possible, prior to the team's arrival to Abuja.

Evaluation Question	Type of answer needed	Data Collection Method(s)	Data Source(s)	Sampling or Selection Criteria	Data Analysis Method(s)
4) How well has TSHIP integrated gender into its implementation?	Normative	Document review Key informant interview Review of data.	reports Survey reports, program documents, health systems data, peer-reviewed literature, qualitative studies and reports.	Same as above	Quantitative and qualitative

The evaluation team will use a variety of approaches to appraise the impact of TSHIP on MNCH/RH/FP situation in Bauchi and Sokoto States. The team will also review performance records available through routine health reporting, project records, past evaluations, and USAID/Nigeria performance records for quantitative information and other relevant sources. Interviews and data gathering will be conducted through meetings and conference calls in Abuja, as well as field trips to Bauchi and Sokoto states, as much as the security situation permits.

Background Materials Review: Prior to conducting field work, the evaluation team will review background materials such as TSHIP's Program Description, annual work plans, Performance Monitoring Plans (PMP), technical and training materials, past program evaluations reports, and other documents related to the project. The Mission will provide these to the team as soon as possible and if possible, prior to the team's arrival to Abuja.

1. **Team Planning Meeting:** The team will conduct a two-day team planning meeting (TPM) upon arrival in Abuja and before starting the interviews and field site visits. The TPM will review and clarify any questions on the evaluation SOW, clarify and agree on team member roles and responsibilities, clarify USAID's expectations of the evaluation and evaluation team, decide on the details of methodology, draft an initial work plan, develop a data collection plan, develop tools/interview guides that will be used by the team for key informant interviews and for synthesis of data, finalize the evaluation questions, develop the evaluation report table of contents, and assign drafting responsibilities for the Evaluation report. During the TPM, the evaluation team can discuss the methodology and make suggested revisions to respond to the objectives. The TPM outcomes will be shared with USAID/Nigeria, which will participate in sections of the TPM.
2. **Review existing documents and materials.** USAID/Nigeria will compile existing reports, documents, and materials from Bauchi and Sokoto state for the evaluation team prior to them coming to Nigeria. The team will review the materials and synthesize findings using a standard analysis template to be developed after the TPM.
3. **Interviews/Consultations in Abuja:** Conduct interviews with key informants from other selected USAID Implementing Partners TSHIP staff, USAID/Nigeria, SMOHs, LGA

authorities and other relevant stakeholders identified in project documentation and interviews.

4. **Field Visits:** Conduct field visits to selected sites in Bauchi and Sokoto states, as much as the security situation permits. If travel is not feasible, key stakeholders from Bauchi and Sokoto will be invited to travel to Abuja to meet with the evaluation team.
5. **Debrief:** Prepare a presentation and debrief for USAID/Nigeria with main findings and recommendations.
6. **Draft Report:** Prepare a draft report for USAID/Nigeria to be submitted within two weeks after departing Abuja.
7. **Final Report:** Prepare a final report with an executive summary that includes main findings, conclusions, and recommendations for program improvements, incorporating feedbacks provided by USAID for the draft report.

C. Data Analysis Methods:

The Evaluation Team will develop an analysis plan and review with USAID/Nigeria for input. The plan should detail the types of analyses and analytical software to be used. For each question the Evaluation Team will explain how evaluation data will be analyzed. Data tables, as agreed upon in the analysis plan, will be generated and analyzed. The team should also note that all raw data from the evaluation would also be made available to the mission.

D. Methodological Strengths and Limitations:

TSHIP's baseline assessment report and the mid-term evaluation report will serve as the baseline against which progress will be measured, and how lessons learned have or have not evolved over time. Limitations to this evaluation may include:

- The quality of data available
- Recall bias among stakeholders
- Limited institutional knowledge among USAID staff, TSHIP staff, GoN staff, due to staff turnover
- Inaccessibility of implementation sites due to insecurity.

IV. EVALUATION PRODUCTS

A. Deliverables

The following deliverables will be submitted to USAID/Nigeria. The timeline for submission of deliverables will be finalized and agreed upon during the Team Planning Meeting (TPM):

1. An evaluation work plan and timeline - prepared during the TPM.
2. A detailed report outline - prepared during the TPM.

3. Questionnaire/guideline for conducting key informant interview and stakeholder consultations and interviews - prepared during the TPM, submitted to USAID/HPN for review and approval prior to initiating consultations, key informant interviews, and site visits.
4. Raw data: Both qualitative and quantitative.
5. Analysis template – prepared during TPM, submitted to USAID/HPN for review and approval prior to review and synthesis of data.
6. Debriefings - the two-member team will debrief USAID/Nigeria on findings, conclusions and recommendations before leaving Nigeria. Up to two PowerPoint presentations for debriefing and summarizing findings, conclusions and recommendations will be prepared and distributed at intervals. USAID/Nigeria will provide feedback during the briefing meeting and debriefing(s).
7. Draft Evaluation Report - a synthesized draft report will include, at a minimum, the following: scope of work and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); recommendations (proposed actions for USAID/Nigeria based on the conclusions); lessons learned (documented and highlighted); and future directions (implications for future designs and for others to incorporate into similar programs). The evaluation team will provide USAID/Nigeria with a draft report that includes all the components of the final evaluation report within two weeks after their departure from Nigeria. USAID/Nigeria will provide written comments on the draft report to the Evaluation team within 10 working days of receiving the draft report.
8. Final Evaluation Report - the final report will address the comments provided by USAID/Nigeria on the draft report. The Team Leader will revise the draft report and deliver an electronic copy of the final revised version USAID/Nigeria within three weeks of receiving USAID feedback. This report will be a public document. Any procurement sensitive pieces, comments and recommendations that need to be treated as confidential in the judgment of the Team Leader, will be separated by the Team Leader from the final report and included in an internal memorandum to USAID/Nigeria. The memorandum will be internal to USAID/Nigeria.

Discussions and recommendations related to SOW can be made publicly available.

9. MEMS II will provide the edited and formatted final document approximately 30 days after USAID/Nigeria provides final approval of the report. The report will not be longer than 40 pages total, excluding annexes. MEMS II will provide 10 printed copies and an electronic file. MEMS II will make the results of the evaluations

public on the USAID Development Experience Clearinghouse and on its project website.

Reporting Guidelines

- USAID's evaluation policy requires that all evaluation SOWs include USAID's *Criteria to Ensure the Quality of the Evaluation Report* (see USAID Evaluation Policy Appendix I).
- Follow the Evaluation Report Requirements (see below).
 - o The format for the evaluation report is as follows:
 1. Executive Summary (2 pp.)
 2. Table of Contents (1 pp.)
 3. Introduction (1 pp.)
 4. Background (2-3 pp.)
 5. Methodology (1 pp.)
 6. Findings/Conclusions/Prioritized Recommendations (17- 20 pp.)
 7. Issues (1-2 pp.)
 8. Future Directions (2-3 pp.)
 9. References
 10. Annexes:
 - ✓ Evaluation Scope of Work
 - ✓ Annotated List of Documents Collated and Reviewed
 - ✓ Persons Contacted
 - ✓ Tables and Graphs, as applicable.

The report should be written in English language and submitted electronically and in hard copies, to the USAID Nigeria Mission.

V. TEAM COMPOSITION

The evaluation team will consist of 3 members including a Team Leader (international). The team members should represent a balance of technical expertise related to monitoring and evaluation, statistical data analysis, understanding of MNCH/RH/FP service delivery at the PHC level in Nigeria (local team member), and health systems strengthening, with expertise in human resources and logistics management.

The evaluation team members must have significant national/international health program experience. They should have some Nigeria country or African regional experience, along with comparative experience in MNCH/RH/FP service delivery in developing countries. Substantial experience in conducting evaluations, reviews or assessments is expected of the members, and experience in developing MNCH/RH/FP strategies would be useful. All team members must be computer literate and have fluent professional-level English speaking, writing and presentation skills with at least one of the in-country evaluators being capable of speaking Hausa.

An Illustrative Table of Level of Effort (LOE)

Level of Effort (LOE)	Desk Review	Travel to Abuja, Nigeria	USAID In-Brief/Team Planning Meeting/Instruments development	Internal Travel	Field Work		Data Analysis/Wrap-Up	Presentation of Preliminary Findings & Conclusions to USAID	Draft report and submit to USAID for review	Travel to base	Finalize report in response to USAID comments	Total
					Bauchi	Sokoto						
Team Leader	3	2	6	4	5	5	6	1	4	2	3	41
Local Consultant 1	2		6	4	5	5	6	1				29
Local Consultant 2	2		6	4	5	5	6	1				29
Data Collector 1					5							5
Data Collector 2						5						5

VI. EVALUATION MANAGEMENT

A. Logistics

The Evaluation team will work under the technical direction of USAID/Nigeria. A six-day work week is authorized for the evaluation team while in Nigeria. USAID/Nigeria will provide overall direction to the team, provide key documents, background materials, and help arrange the TPM and debriefing. Logistical support will be provided by MEMS II.

USAID/Nigeria will:

- Provide names and contact information for possible evaluation team members;
- Approve final team composition and members;
- Approve final evaluation statement of work and final evaluation report;
- Approve country clearances for the Evaluation Team members and approve all subsequent internal travel by road and air by team members;
- Provide the evaluation team with USAID essential contact information, and facilitate initial and subsequent communications and letters of introductions;
- Provide the evaluation team with background documents and project documentation

B. Scheduling/Timeline:

Date	Activity	Days	Location
April 28-30	Desk Review (Team Leader)	3	Base
May 2-3	Arrival of Team Leader	2	Abuja
May 4-9	In-brief at USAID/Team Planning Meeting/Instrument Development	6	Abuja
May 10-23	Field Work in Bauchi and Sokoto states (plus travel days)	14	Bauchi and Sokoto
May 25-30	Data Analysis/Wrap-up	6	Abuja
June 1	USAID De-brief	1	Abuja
June 2-3	Departure of team leader	2	Base
June 4-8	Submit draft report to USAID for review	4	Base
June 26*	Review and submit final report to USAID	3	

*Assuming USAID will review the draft report within 2 weeks

Scheduling detail:

May 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		April 28 Desk Review (TL)	April 29 Desk Review (TL & team members)	April 30 Desk Review (TL & team members)	1	2 TL travels to Abuja, Nigeria
3 Arrival of TL and team members	4 Team Planning Meeting begins	5 In-brief USAID	6	7	8 In-brief by TSHIP	9
10 Travel to field (Bauchi or Sokoto)	11 Field work begins	12	13	14	15	16 Travel back to Abuja
17 Travel to Sokoto or Bauchi	18	19	20	21	22 Field work ends	23 Travel back to Abuja
24	25 Data Analysis and Wrap up	26	27	28	29 Debrief TSHIP	30 Data Analysis ends
31						

June 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 Presentation to USAID	2 Team Leader departs Abuja	3 Team Leader arrives base	4 Draft Report writing	5	6
7	8	9 Draft report submitted	10	11	12	13
14	15	16	17	18	19	20
21	22	23 Finalize draft report	24	25	26 Submit Final Report	27
28	29	30				
Desk Review	TPM	Field Work	Data Analysis and Wrap up	Draft Report writing	Final Report	

C. Budget

The end-of-project evaluation will be funded by USAID/Nigeria. The estimated budget is US\$150,000.00 (One hundred and fifty thousand US Dollars).

CONTACT INFORMATION

Dr. Gertrude Odezugo (TSHIP AOR), email: godezugo@usaid.gov, and Mr. Uche Ikenyei (USAID Nigeria M&E Specialist), email: uikenyei@usaid.gov, will be the USAID Nigeria points of contact for this evaluation.

ANNEX II: EVALUATION METHODS AND LIMITATIONS

Methodology

The Evaluation Team used a mixed (qualitative/quantitative) approach to gain insight into the Evaluation Questions and to determine TSHIP's accomplishment of the objective, intermediate results and indicators in the project's Results Framework. The methodology consisted of interviews and focus group discussions with TSHIP staff members, key government officials at the state, local and community levels, members of civil society organizations, community members, other donor organizations, and USAID. The Evaluation Team developed twelve data collection tools/guides for use in the field. These were comprised of both structured and semi-structured discussion guides for: client exit interviews, service provider interviews, health facility assessments, Focus Group Discussions (FGD), and Key Informant Interviews (KIIs). (See Annex III for these instruments.) The Evaluation Team conducted a thorough desk study of relevant documentation and analysis of performance indicators. The Team interviewed a total of 524 people (254 in Sokoto and 253 in Bauchi, in addition to 17 USAID officials); and reviewed 68 documents (see Annex IV(a) List of Persons Interviewed, and IV(b) Bibliography of Documents Reviewed). The Team conducted 21 focus group discussions, Sokoto (11) and Bauchi (10). (A detailed methodology matrix is provided in Annex III.) The key approaches that were used to collect and analyze data for the evaluation are as follows:

Review of Background Materials and other Relevant Documentation: Project documents relevant to the evaluation were collected for review and analysis, including project design, scope of work, annual and quarterly reports, annual work plans, technical and training materials, TSHIP gender and social inclusion materials, and technical and statistical documents relevant to the evaluation.

Interviews and Field Visits: In collaboration with USAID/Nigeria and the TSHIP team, the Evaluation Team selected twenty LGAs (ten LGAs each in Sokoto and Bauchi state) for the field work. The Team randomly selected forty health facilities from the twenty LGAs (two health facilities in each LGA) for assessment. The selection of LGAs was done across the Senatorial Districts in each state, while taking into consideration security and accessibility (see Annex V for a full list of LGAs and Health Facilities visited by the Evaluation Team). The Evaluation Team conducted both individual interviews and focus groups. These included meetings with USAID staff in Abuja and the TSHIP project staff, State, LGA, CSO, and NGO leaders in Sokoto and Bauchi. The Team conducted fieldwork in Sokoto from June 29-July 3 and in Bauchi from July 6-10. Fieldwork included joint and individual meetings with management and relevant staff of the TSHIP project. Subsequent meetings were held with state and local government

officials and civil society organizations. The Evaluation Team organized and conducted community level focus group discussions with local government leaders, officials, ward development committee members, State government desk officers for the TSHIP project, and representatives of community based organizations as well as beneficiaries (women) attending the health facilities. Also a facility survey was conducted to review the quality of health care services provided. The Evaluation Team recruited and trained female facilitators for effective interaction with female clients at the health facilities visited. The Team visited both LEAD and TSHIP LGAs and TSHIP only LGAs to try to determine the impact of FSS. In Sokoto, LGAs visited were Bodinga, Dange-Shuni, Gwadabawa, Kware, Rabah, Sokoto North, Sokoto South, Wamakko, Wurno, and Yabo. In Bauchi the Team visited Alkaleri, Bauchi, Darazo, Dass, Giade, Misau, Ningi, Shira, Tafawa Balewa, and Warji.

A five-person Evaluation Team (including two MEMS II staff) conducted the evaluation, with the assistance of seven research associates. To ensure effective communication, two members of the team who speak the native language of Hausa conducted focus group discussions with the Ward Development Committees, while the other members interviewed local government officials, and the team leader interviewed TSHIP staff, state officials, other USAID project staff, and officials of other donor agencies (WHO, DFID, etc.).

Limitations

TSHIP covered the entire two states, and provided one form of support or another to all health facilities in each state. Therefore, the findings from a sample of forty health facilities were not sufficient to draw inferences on the entire population of health facilities, which counts in the hundreds in each of the two states.

The Evaluation Team selected the randomized sample of LGAs, Wards, and health facilities, in order that "LEAD+TSHIP" LGAs (LGAs where TSHIP and LEAD projects were both present and worked together) and "TSHIP only" LGAs (LGAs where LEAD was not present) were sampled. In addition, health facilities were chosen randomly from a list of facilities implementing a minimum of four TSHIP project interventions (ANC, Immunization, Delivery, and Family Planning). This resulted in a selection bias.

Due to difficult terrain and in some instances security concerns, the Evaluation Team had to replace some of the health facilities. However, the health facilities used as replacements were also selected from the randomized list. (See the full list of health facilities in Annex V.)

Due to time constraints, some aspects of the project were not included in the evaluation, including SBMR, pre-service training, and policies pursued or enacted under the enabling environment component.

TSHIP reported HMIS/DHIS2 data, often measuring progress against targets that were established by projecting population (denominator) figures obtained by estimating

population growth using the 2006 census as a baseline. The HMIS data has serious accuracy and reliability issues. The targets were carefully considered, but usually not objectively verifiable. Often the eligible population for an intervention (e.g., number of children 12-23 months of age) was not known and the number of that population actually reached by an intervention may not be reliably measured or reported. Measuring progress against targets over time does show change and trends, but can be misleading.

Detailed Work Plan for Activities in Abuja—Pre Field Work

(Evaluation Team: JO = Jake O’Sullivan; AM = Abdulkarim Mairiga; WA = Wale Adeogun; TO = Tayo Olugbemi; NN = Nura Nasir) DC=Data Collector (Sokoto: DC1, DC2, DC3, & DC4; Bauchi: DC1, DC2, DC3, & DC4)

Date	Activity	Detailed Task	Responsibility	Deliverable
Saturday 20 June	Arrival of Team Leader	- Jake O’Sullivan arrives Abuja, Nigeria - Airport pick up -- <i>to Valencia Hotel</i>	Sabo Mohammed	
Sunday 21 June	Arrival of Team Member	Wale Adeogun arrives Abuja -- <i>Prixair Hotel</i>		
Monday 22 June	Meeting with MEMS II Staff & evaluation team; Initial planning	- Initial discussion with MEMS II Chief of Party on field plans for the TSHIP evaluation (work plan, logistics etc.) -- <i>8:30am</i> - Introductions to MEMS II staff -- <i>10am</i> - Development of evaluation tools	MEMS II COP, MEMS II staff, Evaluation team	
Tuesday 23 June	- Team planning - Work plan development	- Abdulkarim Mairiga arrives Abuja -- <i>Prixair Hotel</i> - Development of evaluation tools cont.	Evaluation team	
Wednesday 24 June	Team planning cont.	- Finalize evaluation tools and submit to USAID for approval - Prepare PowerPoint presentation for USAID in-brief and share with TMG/MEMS II - Complete work plan, and report outline, and submit to MEMS II COP	Evaluation team	

Date	Activity	Detailed Task	Responsibility	Deliverable
Thursday 25 June	Team planning cont.	- Incorporate USAID's feedback on draft evaluation tools - Submit work plan and report outline to USAID	- Eval. team - TMG	Final: - Work plan - Evaluation tools - Report outline
Friday 26 June	USAID In-briefing	- In-brief USAID: presentation of methodology, clarification on evaluation questions, USAID expectations etc. - <i>9:00am</i> - Finalize logistics plan and travel arrangements	Evaluation team and MEMS II COP	In-brief USAID
Saturday 27 June	Travel to Sokoto for field work	Travel to Sokoto for field work -- <i>Flight Time: 11:25am; Take-off: 9:30am -- Meeting Point: MEMS II Office</i>	Evaluation team Sabo & Samson	

Detailed Plan for Field Work

Sokoto

Date	Detailed Task	Responsibility	Notes
Monday 29 June	Logistics meeting with TSHIP technical staff - - 9am Interviews with TSHIP Technical staff <u>Sokoto North LGA [Sokoto North SD; TSHIP LGA]:</u> KII with LGA officials FGD with WDCs Kofar Rini Clinic Gidan Dare Gandu Dispensary <u>Sokoto South LGA [Sokoto North SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs Sokoto Specialist Hospital Turaki Basic Health Clinic	Evaluation team JO WA NN DC1 DC2 TO AM DC3 DC4	
	Interviews with state officials	JO	

Date	Detailed Task	Responsibility	Notes
	<u>Wurno LGA [Sokoto North SD; TSHIP LGA]:</u> KII with LGA officials FGD with WDCs Sabon Garin Liman Dispensary Achida Model Primary Health Centre <u>Gwadabawa LGA [Sokoto East SD; TSHIP LGA]:</u> KII with LGA officials FGD with WDCs Kiliya Dispensary Sakamaru Dispensary	WA DC1 NN DC2 TO DC3 AM DC4	
Wednesday 1 July	Interviews with LEAD COP Interview with Other Donors <u>Dange Shuni LGA [Sokoto South SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs Wababe Dispensary Rikina Dispensary	JO JO WA NN DC1 DC2	

Date	Detailed Task	Responsibility	Notes
	<u>Rabah LGA [Sokoto East SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs Gawakuke PHC Gidan Almajir Dispensary	TO AM DC3 DC4	
Thursday 2 July	TSHIP EOP Dissemination FGD with TSHIP sub-grantees <u>Kware LGA [Sokoto North SD; TSHIP LGA]:</u> KII with LGA officials FGD with WDCs Mallamar Yari Dispensary Zamau Community Dispensary <u>Yabo LGA [Sokoto South SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs Yabo General Hospital Addam Dispensary	JO, NN JO, TO WA NN DC1 DC2 TO AM DC3 DC4	

Date	Detailed Task	Responsibility	Notes
Friday 3 July	Interviews with state officials <u>Bodinga LGA [Sokoto South SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs Darhela Upgraded Dispensary Madorawa Dispensary <u>Wamakko LGA [Sokoto North SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs Yarume Dispensary Yarlabe Dispensary	JO WA NN DC1 DC2 TO AM DC3 DC4	
Saturday 4 July	Travel back to Abuja	Evaluation team	

Bauchi

Date	Detailed Task	Responsibility	Notes
Sunday 5 July	Travel to Bauchi for field work -- <i>Flight Time: 10.00am; Take-off: 8:30am -- Meeting Point: MEMS II Office</i>	Evaluation team Sabo & Samson	
Monday 6 July	Logistics meeting with TSHIP technical staff - - 9am Interviews with state officials <u>Bauchi LGA [Bauchi South SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs Tirwun Maternal and Child Health Clinic Federal Low Cost Health Centre <u>Dass LGA [Bauchi South SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs Dabardak Maternity Town maternity	Evaluation Team JO WA DC1 NN DC2 TO DC3 AM DC4	

Date	Detailed Task	Responsibility	Notes
Tuesday 7 July	TSHIP EOP Dissemination/FGD with TSHIP sub-grantees <u>Darazo LGA [Bauchi Central SD; TSHIP LGA]:</u> KII with LGA officials FGD with WDCs Under 5 Clinic Wahu Health Centre <u>Shira LGA [Bauchi North SD; TSHIP LGA]:</u> KII with LGA officials FGD with WDCs Shira General Hospital MPHC Feggo	JO WA NN DC1 DC2 TO AM DC3 DC4	
Wednesday 8 July	Interviews with LEAD COP Interviews with Other Donors <u>Ningi LGA [Bauchi Central SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs	JO, NN JO, TO WA NN DC1	

Date	Detailed Task	Responsibility	Notes
	Ningi GH Gadar Maiwa <u>Misau LGA [Bauchi Central SD; TSHIP/LEAD LGA]:</u> KII with LGA officials FGD with WDCs Misau Town Maternity Zindi Maternity	DC2 TO AM DC3 DC4	
Thursday 9 July	Interviews with state officials <u>Warji LGA [Bauchi Central SD; TSHIP LGA]:</u> KII with LGA officials FGD with WDCs Dagu maternity Baima Maternity <u>Giade LGA [Bauchi North SD; TSHIP LGA]:</u> KII with LGA officials	JO WA NN DC1 DC2 TO AM	

Date	Detailed Task	Responsibility	Notes
	FGD with WDCs HeZabi Model PHC Giade MCH	DC3 DC4	
Friday 10 July	Interviews with state officials <u>Alkaleri LGA [Bauchi South SD; TSHIP LGA]:</u> KII with LGA officials FGD with WDCs Gar Maternity Town Maternity Alkaleri <u>Tafawa Balewa LGA [Bauchi South SD; TSHIP LGA]:</u> KII with LGA officials FGD with WDCs Bununu Maternity Zwall Maternity	JO WA NN DC1 DC2 TO AM DC3 DC4	
Saturday	Data Analysis commence	Evaluation	

Date	Detailed Task	Responsibility	Notes
11 July		team	
Sunday 12 July	Travel back to Abuja	Evaluation team	

Detailed Plan for Activities in Abuja—Post Field Work

Date	Activity	Detailed Task	Responsibility	Deliverable
Monday 13 July	Data analysis	Analyze data, consult and consolidate field notes and synthesize findings.	Evaluation team	
Tuesday 14 July	Data analysis	Analyze data, consult and consolidate field notes and synthesize findings. • Discuss preliminary findings with TSHIP	Evaluation team	
Wednesday 15 July	Data analysis	Analyze data, consult and consolidate field notes and synthesize findings.	Evaluation team	
Thursday 16 July	Data analysis	Analyze data, consult and consolidate field notes and synthesize findings.	Evaluation team	
Friday 17 July	Data analysis	Analyze data, consult and consolidate field notes and synthesize findings.	Evaluation team	Data analysis
Saturday 18 July	Data analysis	Analyze data, consult and consolidate field notes and synthesize findings.	Evaluation team	Data analysis
Monday 20 July	Finalize findings and conclusions	• Finalize findings and conclusions • Prepare PowerPoint presentation	Evaluation team	

Date	Activity	Detailed Task	Responsibility	Deliverable
Tuesday 21 July	Finalize PowerPoint Presentation	Share the PowerPoint presentation with MEMS II senior staff for review	Evaluation team, MEMS II	PowerPoint presentation review by MEMS II
Wednesday 22 July	Debrief USAID Nigeria	Present findings and conclusions to USAID through PowerPoint presentation	Evaluation Team, Ed Birgells, Zakari Zakariya	Presentation of preliminary findings and conclusions to USAID
Thursday 23 July	Draft Report Writing	Report-writing commences Analysis of data continues	JO WA	Draft Report
Friday 24 July	Draft Report Writing	Report-writing continues Analysis of data continues	JO WA	Draft Report
Saturday 25 July	Draft Report Writing	Report-writing continues Analysis of data continues Dr Mairiga returns to base	JO WA	Draft Report
Monday 27 July	Draft Report Writing	Report-writing continues Analysis of data continues	JO WA	Draft Report

Date	Activity	Detailed Task	Responsibility	Deliverable
Tuesday 28 July	Draft Report Writing Team Leader Departs	Report-writing continues Analysis of data continues Jake O' Sullivan returns to base <i>Airport Drop-off by Samson</i>	JO WA	Draft Report
Wednesday 29th July	Team Member Departs	Dr Wale returns to base	WA	
Friday 7th August	Submit Draft Report	Submit Draft Report to TMG/MEMS II for review	JO	Draft Report
	Submit Final Report*	Submit Final Report (addressing USAID comments)	JO	Final Report

*Tentative

Timeline for Evaluation Activities

Activity	June 20 - 26	June 29 - July 10	July 13 - 22	July 22 – August 7	Aug 7	Aug 21		Deliverable
• Team Leader arrives Abuja, Nigeria • Documents review, development of draft evaluation tools • Initial meetings with MEMS II COP • In-briefing with USAID • Meeting with IMC/TSHIP • Team planning & work plan development • Finalization of evaluation tools • Submission of work plan & tools to USAID	X						•	• Work plan • Evaluation tools • Detailed report outline
• Field work: interviews and discussions in Sokoto and Bauchi States		X						
• Preparation of findings and conclusions • Presentation to USAID			X					PowerPoint presentation of findings & conclusions
• Draft report preparation •				X				Draft report

Activity	June 20 - 26	June 29 - July 10	July 13 - 22	July 22 - August 7	Aug 7	Aug 21		Deliverable
• Draft report presentation to USAID					X			Draft report
• USAID review of draft report • USAID feedback to Team Leader						X*		
• Final report preparation and submission to USAID							X	Final Evaluation Report

*Tentative

ANNEX III: DATA COLLECTION INSTRUMENTS

End-of-Project Evaluation of Targeted States High Impact Project (TSHIP) June/July 2015

Focus Group Discussion Session

Users of Services at TSHIP Supported PHC Facilities

- Purpose: Assessment of client's satisfaction with and benefit from services provided 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: TBD
- Venue: TSHIP supported PHC Facility

Introduction: My name is (*Name of the interviewer*); I am working for USAID/Monitoring and Evaluation Management Services (MEMS) II, a USAID contractor on Monitoring and Evaluation. We are evaluating the USAID/TSHIP project in order to find out its impact, therefore we are interviewing individuals who directly or indirectly benefit or are involved in the project's activities.

Confidentiality and consent: I am going to ask you questions some of which may be personal, and will use an audio recorder. Your answers will be kept strictly 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 communities that are involved in the project in Sokoto and Bauchi states as well. I will greatly appreciate your help in responding to this survey. May I continue?

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 at this health facility at your last visit(s)?
What other services did you get? (**probe this for service integration**)
3. Tell us your general experiences at the health facility during your visits.
Comments (why): _____
4. Do your husbands encourage/accompany you to (ANC, FP etc.)? Please explain.
5. How do staffs treat you at this facility?
6. Is it likely that you will return to the health facility should you need health care services?
7. What are your suggestions towards improvement of services at the health facility?

Ask WHY? WHY?

Facilitator: Fill out table below in a manner that reflects the group's perceptions. If the group does not volunteer opinions on the topics in the table below—then prompt using the categories

in the table.

	Intervention	Most satisfactory	Moderately satisfactory	Not satisfactory
1.	ANC			
2	Delivery			
3.	Family Planning			
4.	Nutrition			
5.	Immunization			
6.	Malaria prevention/treatment			
7.	Treatment of childhood diarrhea			

COMMUNITY LEVEL INTERVIEW GUIDE

EOP Evaluation of Targeted States High Impact Project (TSHIP) June/July 2015

Questionnaire for Community Level

Introduction: My name is (*Name of the interviewer*); I am working for USAID/Monitoring and Evaluation Management Services (MEMS) II, a USAID contractor on Monitoring and Evaluation. We are evaluating the USAID/TSHIP project in order to find out its impact, therefore we are interviewing individuals who directly or indirectly benefit or are involved in the project's activities.

Confidentiality and consent: I am going to ask you questions some of which may be personal, and will also use an audio recorder. Your answers will be kept strictly 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 communities that are involved in the project in Sokoto and Bauchi states as well. I will greatly appreciate your help in responding to this survey. May I continue?

A. Identification

1. Questionnaire number: _____ (*Skip*)
 2. State: _____
 3. LGA: _____
 4. Name of the WDC: _____
 5. Name of Community: _____
 6. Location: Rural ----- 1, Urban-----2
 7. Name of the interviewer: _____
-
1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (**Prompt: *how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years***)
 2. Has your group been trained by TSHIP? How do you use this training?
 3. Did the use of this training change anything? What do you do differently?
 4. How does your community/group collaborate with the Health Facility?
(**Prompt: to increase public awareness and utilization of MNCH/FP/RH services**)
 5. How do you think the health facility benefit from your contributions? Please give examples.

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?
7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.
8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples
9. What has changed in the way husbands support their wives in utilizing health facilities?
10. Has the participation of women increased in your group? What's the evidence?
11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

End-of-Project Evaluation of Targeted States High Impact Project (TSHIP) June/July 2015

Development Partners Questionnaire - KII

Category Question	Prompts
What health outcomes did you see from TSHIP project?	What outcome do you think you will see after TSHIP is gone 1 yr from now? 5yrs from now? Are there any differences between the health system now compared to pre-TSHIP?
What interactions did you have with TSHIP?	• Planning • Policies • Capacity Building • Work plans/Strategic plans • Gender integration • Service Delivery
Could TSHIP's collaboration with other partners been better?	
What recommendations will you make for future programming?	Examples

End-of-Project Evaluation of Targeted States High Impact Project (TSHIP) June/July 2015

Exit Interview for Female Clients

Introduction: My name is (*Name of the interviewer*); I am working for USAID/Monitoring and Evaluation Management Services (MEMS) II, a USAID contractor on Monitoring and Evaluation. We are evaluating the USAID/TSHIP project in order to find out its impact, therefore we are interviewing individuals who directly or indirectly benefit or are involved in the project's activities.

Confidentiality and consent: I am going to ask you questions some of which may be personal, and will also use an audio recorder. Your answers will be kept strictly 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 will greatly appreciate your help in responding to this survey. May I continue?

A. Identification

1. Questionnaire number: _____ (*Skip*)
2. State: _____
LGA: _____
3. Ward: _____
Community: _____
4. Location: Rural ----- 1, Urban-----2
5. Name of the interviewer: _____

B. 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, Farming-----6
5. **Parity:** Number of children you have: _____; Age of last child (in
months): _____

C. Effects of TSHIP activities on women

1. (a) What kind of services have you been receiving in this facility? (**Circle as many as appropriate**)

MNCH-----1, FP-----2, Malaria-----3, RH -----4, Immunization-----
---5, Nutrition-----6

(b) What service(s) were offered to you today?

2. How have these services affected the wellbeing of your family members?
Give examples

3. Which intervention is the most (and least) utilized?

	Intervention	Most utilized	Less utilized	Not utilized
1.	ANC			
2	Delivery			
3.	Family Planning			
4.	Nutrition			
5.	Immunization			
6.	Malaria prevention/treatment			
7.	Treatment of childhood diarrhea			

4. What informed your judgment?

D. Clients Satisfaction

1. How would you describe the services you received in the facility?

Very satisfied----1, Satisfied-----2, Dissatisfied-----3, Very dissatisfied--
-----4

2. What are your suggestions for the improvement of services offered in this facility?

E. Gender Sensitivity

1. Has there been any change in the way you are treated as a woman in this HF (male involvement, women-friendly environment etc.)? Please explain

Thank you for your time and attention

**End-of-project Evaluation of Targeted States High Impact Project (TSHIP)
June/July 2015**

FSS Partners (LEAD, SIDHAS, PROACT) Questionnaire - KII

Category Question	Prompts
1. What interactions did you have with TSHIP?	• Planning • Policies • Capacity Building • Work plans Strategic plans etc. • Regular, scheduled or ad-hoc interactions • Gender Integration • Service Delivery
2. What activities did you implement with TSHIP?	• Advocacy • Others please mention
3. How did the process of collaboration evolve?	• What drove the process? • Formal or informal or both
4. What outcomes did you see from focus state strategy collaboration with TSHIP and others?	What outcome do you think you will see after TSHIP is gone 1 yr from now? 5yrs from now? How are government health systems stronger now?
5. Did you collaborate with TSHIP on health systems strengthening?	If yes what did you do What was the result of the collaboration?
6. How could TSHIP have collaborated better with other partners?	What could they have done differently?
7. Was there a gender aspect to your collaboration with TSHIP?	Please describe
8. What recommendations will you make for future programming?	Health Projects Joint Projects

End of Project Evaluation of Targeted States High Impact Project (TSHIP) June/July 2015 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

Service provision

	Service	Monthly	Once a week	Twice a week	Daily
1.	ANC				
2	Delivery				
3.	Family Planning				
4.	Nutrition				
5.	Immunization				
6.	Malaria prevention/treatment				

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

Yes 1 (Go to Question 8)

No 2 (Skip to Question 11)

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

Yes 1

No 2

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

Yes 1

No 2

Comment _____

10. **Is the house adequate?**

Yes 1

No 2

11. **Can you tell me when this health centre was renovated? Did TSHIP renovate this health centre?**

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

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

Yes 1

No 2

Comment

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

Yes

No

Comment

15. **Is there an ORT Corner in this facility:**

Yes 1

No 2

[Interviewer should observe if ORT corner is there, and available/equipped for use.]

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

Yes 1

No 2

Comment _____

17. **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 _____

18. **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_____

19. **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

c) Do patients use the toilets?

Comment_____

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

a. National Electricity grid (NEPA, PHCN).....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

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

Yes 1

No 2 (skip to 23)

Comment _____

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 _____

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

(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 _____

23. Is there a separate room /area for examinations?

Yes 1 (Skip to Question 25)

No 2 (Go to Question 24)

Comment _____

24. (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 _____

25. **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 _____

26. **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 _____

27. **(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)

28. **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.)

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

In a locked cabinet/cupboard 1

In an unlocked shelf 2

Other 3 (Please specify) _____

Note to interviewer: Take a photo if possible.

30. **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. BP Apparatus			
2. Air Ways Infant			
3. Airway Resuscitation			
4. Urine testing stick			
5. Ambubag (resuscitation bag)			
6. Extractor Vacuum Obstetric/forceps			
7. Foley catheter (urine collection)			
8. Is there a refrigerator?			
9. Gloves Surgeon (Different Size)			
10. Hurricane Lamp – Kerosene Operated or rechargeable			
11. Intravenous Administration Set			
12. A. Microscope/ 13. B. RDTs			
14. Oxygen BP 3,800 L (full)			
15. Weighing machine			
16. Autoclave or other sterilization method			
17. Cold Chain Equipment for vaccines & drugs e.g. a. Thermometers / Temperature indicators b. Temperature registers	Yes 1 No 2 Don't know ..3		
18. Vaccine cold boxes			
19. Vaccine ice packs			
20. Vaccine carrier			

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)
21. Delivery (Mama) kits	Yes 1 No 2 Don't know .3		
22. Long lasting Insecticidal Nets (LLINs)	Yes 1 No 2 Don't know .3		

31. 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
IUCDs	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2 Don't know 3
Implant (contraceptive)	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 (or other ACT)	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2 Don't know 3

Drug	Available (a)	Expired (b)	Was there a stock out in the last six months?(no/yes/ don't know/not applicable)(c)
Diazepam injection – for ivi, rectal use	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2 Don't know 3
Ergometrine	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2 Don't know 3
Ferrous sulphate/iron/folic acid	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
MgSO ₄	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	Yes 1	Yes 1

Drug	Available (a)	Expired (b)	Was there a stock out in the last six months?(no/yes/ don't know/not applicable)(c)
	No 2	No 2	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 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
Vitamin A	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2 Don't know 3
Zinc tablets	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2 Don't know 3

32. **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

33. **(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 _____

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

Every week 1

2

Every quarter 3

Cannot recall last time received 4

Don't know 5

35. **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

36. **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

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

Yes 1

No 2

Comment _____

Interviewer should ask to see medicine tracking registers.

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

Yes 1

No 2

Comment _____

39. **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

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

Yes 1

No 2

Comment _____

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

Yes 1

No 2

Comment _____

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

Yes 1

No 2

Comment _____

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

Yes 1

No 2

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

Yes 1
No 2
How many?.....
Comment _____

45. **Are "health talks" (group lectures or discussions with clients) held regularly?**

Yes 1
No 2 (Skip to question 57)

Comment _____

46. **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 _____

47. **Is this record updated?**

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

Comment _____

48. **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 _____

Are there any of the following?

- a. Medical Records Yes 1
 No 2
- b. Immunization record Yes 1
 No 2
- c. ANC Register Yes 1
 No 2
- d. Delivery Register Yes 1
 No 2
- e. Child (U5)register Yes 1
 No 2
- f. Rx Dispensing report Yes 1
 No 2

48. **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 _____

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

All health staff	1	
One person	2	(specify position) _____
Don't know	9	

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

Yes, always	1
Yes, sometimes	2
No	3

Comment _____

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

Yes	1
No	2

Comment _____

52. **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

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.

End-of-Project Evaluation of Targeted States High Impact Project (TSHIP)
June/July 2015

Questionnaire for Healthcare Providers

Introduction: My name is (*Name of the interviewer*); I am working for USAID/Monitoring and Evaluation Management Services (MEMS) II, a USAID contractor on Monitoring and Evaluation. We are evaluating the USAID/TSHIP project in order to find out its impact, therefore we are interviewing individuals who directly or indirectly benefit or are involved in the project's activities.

Confidentiality and consent: I am going to ask you questions some of which may be very personal, and will use an audio recorder. Your answers will be kept strictly 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 will greatly appreciate your help in responding to this survey, may I continue?

A. Identification

1. Questionnaire number: _____ (*Skip this question*)

2. State: _____

LGA: _____

3. Name of the

facility: _____

Community/Village: _____

4. Location: Rural ----- 1, Urban-----2

5. Name of the interviewer: _____

B. Background characteristics

6. **Sex:** Male-----1, Female-----2.

7. **Age** as at last birthday: _____

Marital status: Single: -----1, Married: -----2, Separated: -----3,

Divorced: -----4, Widowed: -----5

8. **Category of health provider:**

Doctor-----1, Nurse/Midwife-----2, Nurse-----3, Midwife-----4,

CHEW-----5 Others (Specify) _____6

9. Year of graduation: _____

10. How long have you been working in this facility? _____

C. Participation in TSHIP Program

11. Are you aware of any TSHIP activities in this facility? Yes-----1, No---
-----2

12. If yes, give the activities you know (**Circle all responses**)

- a. ANC-----1
- b. Labor and Delivery-----2
- c. Post-natal care-----3
- d. Newborn care-----4
- e. Nutrition-----5
- f. Treatment of childhood diseases (malaria, pneumonia, diarrhea)--6
- g. Family Planning-----7
- h. Immunization-----8
- i. Reproductive Health-----9

13. Which intervention is the most (and least) utilized?

	Intervention	Most utilized	Less utilized	Not utilized
1	ANC			
2	Delivery			
3	Family Planning			
4	Nutrition			
5	Immunization			
6	Malaria prevention/treatment			
7	Treatment of childhood diarrhea			

14. What informed your judgment:_____

15. Do you have a job description? Yes-----1, No-----2 (**View the document**)

16. Do you have Standard Operating Procedures (SOP manuals) to guide you?

Did TSHIP train you in their use? How do you use them?

17. When was the last supervisory visit by TSHIP/state/LGA officials to this HF?
How often do they happen? What effect did they have on service delivery?

18. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

19. Have you (or any of your staff) participated in any training in the past 4 years?

Yes-----1, No.....2

20. If yes, mention the training (*use the back of the questionnaire if more than 2 trainings*):

Type of Training

By whom?

21. What do you (or your staff) do differently as a result of the training you received?

22. Mention any significant changes (if any) in the HF in the last 2 two years?
(Prompt for quality of service delivery, and uptake of services)

23. What are the 3 biggest challenges experienced in this HF for the last 2 years, how have they affected service delivery?

24. How have you been able to address gender-related issues (male involvement...) in service delivery?

25. What are the 3 major changes in the relationship between your HF and the community(ies) you serve?

26. List all the donors or projects supporting this facility (*if more than 2, use the back of the questionnaire*):

Project

Period

Type of support

27. What are your recommendations for improving primary health care delivery in your community?

Thank you for your time and attention

**End-of-project Evaluation of Targeted States High Impact Project (TSHIP)
June/July 2015**

LGA Officials Questionnaire - KII

Category Question	Prompts
1. What is your experience with how TSHIP engaged the LGA in its project implementation?	Do you feel the LGA is full equal partner in the implementation? Why
2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain	• Management • Capacity Building – Training, Supportive supervision • Integrated Services • Applying standards to improve quality • Collaboration/partnership • Harmonizing community approaches • Gender mainstreaming • Monitoring and Evaluation • Staffing of health facilities • Policy
3. What Policies did you initiate/change as a result of working with TSHIP?	Did changing the policies change the practices?
4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals)	Examples
5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain	What did you do for TSHIP? Cash or Kind How much did it cost?
6. How have the HFs changed during TSHIP implementation?	Status before and after implementation? Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral
7. Have you been trained by TSHIP?	What training do you wish you had
8. What did they train you on?	

Category Question

9. How did you use this training?
10. What do you do differently now?
11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?
12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?
13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?
14. Did TSHIP support you to develop a Costed Health Development Plan?
15. Did LEAD work with you to produce a Community Based Development Plan?
16. How would you describe the linkage between the facility and community?
17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviors?

Prompts

that you did not receive?

Do you think this is a good approach?

What is the level of implementation, and how has it improved health care delivery system?

How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

Would you say that approaches used were appropriate?

What could they have done differently?

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

Are husbands more supportive of their wives going to the health facilities? Explain?

Are more women being placed in

Category Question

Prompts

	leadership positions? Give examples?
	What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community?
18. How has TSHIP collaborated with other organizations and projects in your LGA?	LEAD NEI SIDHAS PROACT DELIVER WHO, UNICEF etc.
19. What is the most significant health change you observed in your LGA due to TSHIP intervention? explain	Others?
19. What are the things TSHIP did in your LGA which you will like to continue doing?	What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?
20. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service?	Examples

**End-of-Project Evaluation of Targeted States High Impact Project (TSHIP) June/July
2015**

TSHIP EOP Evaluation Interview Form: Sokoto ☐ Bauchi ☐

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

SMOH/SPHCDA/BACATMA/HMB

1. What is the most significant change in the health care system in the state due to contribution of TSHIP (addressing weaknesses, building on strengths, and leveraging on opportunities)?
2. How has TSHIP intervention contributed to MDGs Goals 4 and 5 in the state?
3. What do you know about the effectiveness of TSHIP in improving the quality of the services in the state in terms of supporting coordination, monitoring and supervision, policy development/implementation? What could TSHIP have done better?
4. Did TSHIP collaborate with SMOH on the development of Standard Operating Procedures (SOPs) for health staff? When? Are these SOPs in use?
5. How has TSHIP collaborated with other organizations and projects in the state?
6. What is the evidence of ownership of the interventions supported by TSHIP? Give specific examples, did this change over time?
7. What recommendations would you give to sustain what TSHIP has done on MNCH/FP/RH service in the state?

MLG

1. What is the most significant change in the health care system in the state due to contribution of TSHIP (addressing weaknesses, building on strengths, and leveraging on opportunities)?
2. How has TSHIP intervention contributed to MDGs Goals 4 and 5 in the state?
3. What do you know about the effectiveness of TSHIP in improving the quality of the services in the state in terms of supporting coordination, monitoring and supervision, policy development/implementation? What could TSHIP have done better?
4. How has TSHIP collaborated with other organizations and projects in the state?

5. How has MLG collaborated with TSHIP to enhance the quantity and quality of HR at PHCs?
6. Evidence of ownership of TSHIP interventions, give specific examples.
7. What recommendations would you give to sustain what TSHIP has done on MNCH/FP/RH service in the state?

MOF/MBEP

1. How has budgetary allocation and disbursement for the MOH changed over the last 4 years? What do you think led to the change? (Ask for data source)
2. What other sources of health financing exist in the state?

End-of-Project Evaluation of Targeted States High Impact Project (TSHIP) June/July 2015

Sub grantees Questionnaire - FGD

Category Question	Prompts
How did you use your grant to improve the health care delivery of your community?	Give examples, what is the most significant health outcome you achieved?
Overall, how has your organization benefitted from the TSHIP Project? Please explain	• Management • Capacity Building – Training, • Human Resources • Policies • Finance • M&E - reports
What do you do differently now as a result of TSHIP intervention?	[Guide participants to talk about programmatic changes]
What approach (if any) have you used to integrated gender into your programming?	How many women do you have in leadership position?
How accountable is TSHIP to stakeholders?	Explain and give example
How easy and transparent was the grant process?	Examples
Do you have suggestions on how to improve the grant management process?	
Will you continue your activities after TSHIP?	Where will you seek funds?

End-of-Project Evaluation of Targeted States High Impact Project (TSHIP) June/July 2015

TSHIP program staff KII

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

1. What will project beneficiaries in this state be doing differently five years from now as a result of the TSHIP project?
2. What worked and what did not? What are your five best practices? What factors contributed to success/best practice.
3. How did the Focus State Strategy contribute to TSHIP's success?
4. If you were writing the follow-on solicitation for this project—what would you change?
5. What were the project's most successful interventions? Why? [rank in order if possible]
6. What were the hardest interventions to get the HF/LGA/WDC/SMOH to take ownership of? What were the easiest?
7. What were the three biggest challenges?
8. How do you show gender sensitivity in your program area?
9. What health systems changed under the project? How? Which systems resisted change?

Targeted States High Impact Project (TSHIP) End-of-Project Evaluation

June/July 2015

Key Informant Interviews with 100 Women Group Member

Question

1. How was your group formed? What is/are the objective(s) of the group (Probe: Who helped you to organize your group?)
2. What is your linkage with TSHIP Project?
3. Have you been trained by TSHIP? What did they train you on? *See above*

How have you or your members used the training?

4. How can you describe the financial status of your members before (the group did not exist before TSHIP) TSHIP and with TSHIP intervention?
5. Have your group been able to secure loan from any source? Name the Source. How have you used the loan?
6. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how have these roles affect health-seeking behavior in your community?
7. What is the most significant health change you observed in your community due to TSHIP intervention? Explain.
8. What are the things you feel TSHIP could have done better for your group?
9. Other comments:

ANNEX IV: SOURCES OF INFORMATION

a) List of People Interviewed

USAID:

Name	Sex	Organization	Designation	Email	Phone Number
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SOKOTO STATE:

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Bello A. Kilgori	M	TSHIP			07063723460

State officials:

Name	Sex	Organization	Designation	Email	Phone Number
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Cecilia M. Esemé	F	Centre for Peoples Health Peace	Ex Coordinator		08039618899

Name	Sex	Organization & Progress (3PS)	Designation	Email	Phone Number
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USAID/Implementing Partners:

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Other Donors:

Name	Sex	Organization	Designation	Email	Phone Number
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TSHIP Sub-Grantees:

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Cecilia M. Esemé	F	Centre for Peoples Health Peace & Progress	Ex Coordinator		08039618899
Hafsatu Halilu	F	Planned Parenthood Federation of Nigeria	Project Coordinator		08032902002

LGAs:

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Nasiru Shehu	M	Primary Health Care Dept. Gwadabawa LGA	Monitoring and Evaluation officer, Director Primary Health Care, Gwadabawa LGA	081-3120-5292
Sanusi A Wari	M	Primary Health Care Dept. Gwadabawa LGA	Roll Back Malaria (RBM) Officer, Gwadabawa LGA	070-6431-9761
Isa Ibrahim Rangonda	M	Primary Health Care Dept. Gwadabawa LGA	Health Educator, Gwadabawa LGA	080-9804-8279
Aishatu Umar	F	Primary Health Care Dept. Gwadabawa LGA	Maternal and Child Health Coordinator, Gwadabawa LGA	080-6328-9673
Nasiru Umar	M	Primary Health Care Dept. Gwadabawa LGA	Local Immunization Officer (L.I.O), Gwadabawa LGA	080-8828-6773

Rabah LGA

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Name	Sex	Organization	Designation	Phone Number/E-mail
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Nasiru Majikira	M	Primary Health Care Dept. Rabah LGA	L.I.O Rabah LGA	070-6574-8117

Sokoto South LGA

Name	Sex	Organization	Designation	Phone Number
Ahmed Ladan	M	Primary Health Care Dept. Sokoto South LGA	Director Primary Health Care (DPHC), Sokoto South LGA	080-3358-9666
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Isah Hassan	M	Primary Health Care Dept Yabo LGA	Roll Back Malaria Officer	080-3533-7075

Dange-Shuni LGA

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Kware LGA

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Sokoto North LGA

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Bodinga LGA

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Uwaisu Harande	M	Bodinga LGA	LIO		08033132394
Aliyu Isa	M	Bodinga LGA	H/E		080329498
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Chairman D/Darhela	M	WDC	Chairman		08067217728	Bodinga
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Magajin Badau	M	WDC	Secretary		08122379110	Bodinga
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Babuga Ibrahim	M	WDC	Chairman		08066267370	Bodinga
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Hajiya Abu	F	WDC	member		08068663730	Bodinga
Hajiya Ai D/Galadima	F	WDC	member		07032632030	Bodinga
Adi Musa Bagarau	F	WDC	member		08147867636	Bodinga
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Dangaladima Achida	M	Achida	Chairman		07061305541	Wurno
Sarkin Yakin	M	Dinawa	Chairman		08036510561	Wurno
Altine Alfa	M	Magarya	Chairman			Wurno
Hamisu Budah	M	Achida	Secretary		08034635798	Wurno
Auwalu Abubakar	M	Dinawa	Secretary		07036197284	Wurno
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Abubakar Umar	M	S/Musul mi B	Secretary		08163534996	Sokoto North
Mamman Lulu	M	S/Musul mi B	Chairman		08034463299	Sokoto North
Bello Kuluta	M	S/Musul mi B			08067786606	Sokoto North
Balkisu Muhd. T.	F	Helele Magajin Gari A	Secretary		08156565329	Sokoto North
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Dangaladima Rikina	M	Rikina Wdc	Chairman			Dange Shuni
Rafi'U Marina	M	Rudu Amanawa	Secretary		08107596633	Dange Shuni
Aminu Bunun Dam.	M	Tuntube Tsefe	Chairman		08032104065	Dange Shuni
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Name	Sex	Organization	Designation	Email	Phone #	LGA
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Murjanatu Abdullahi	F	Dagu maternity	CHEW		08025158656
Aishatu Ya'U	F	Dagu maternity	JCHEW		07053255345
Khadija U. Bununu	F	Town maternity	RM/RN I/C	khadijausman82@yahoo.com	08063523552

		bununu				
Huraira Mahmud	F	Town maternity bununu	RM/RN			
Aminu Bashar	M		in charge	aminubello@yahoo.com	08036289779	
Jummai Saleh	F	Zindi maternity	in charge		0806221349	
Adamu Adamu	F	Zindi maternity				
Halima Hassan	F	Zindi maternity				
Fatima M. Goni	F	Zindi maternity	I/Staff		07063421335	
Hauwa Muhammad Ahmad	F	MPHC Zabi	maternity i/c	hauwaadasuwa@yahoo.com	08096180275	
Umar A. Shehu	M	MPHC Zabi	incharge	sheuumar34@yahoo.com	08037865414	
Helen Audu	F	Alkalari town maternity	CNO		08051640852	
Micloth Kombolo	F	Alkalari town maternity	PMO		08058014028	
Maimuna Musa	F	Alkalari town maternity	JCHEW		08169158161	
Sarauniya Mathew	F	MCH tirwun	nurse/midwife		07085357947	
Chinyere Adieze	F	general hospital	midwife		07084759633	
Yusuf Jibrin	M	gada PHC	nurse		08058624541	
Habiba Magaji	F	baima maternity	CHEW		08142573118	
Bala Luke Mohammed	M	baima maternity	head of immunization		08136803259	
Hafsat Musa	F	gar maternity	PCHEW		08066577852	
Sama'Ila Danladi	M	gar maternity	EHT		08138586925	

WDCs:

Name	Sex	Organization	Designation	Email	Phone #	LGA
Muatapha Aliyu Salihu	M	WDC	Chairman Doguwa		08034816117	Giade
Babaji Haladu	M	WDC	Chairman Kurba		08029237333	Giade
Mamman Garba	M	WDC	Chairman Faguji		08187121463	Giade
Sarkin Aska	M	WDC	Chairman		07083118087	Giade

Name	Sex	Organization	Designation	Email	Phone #	LGA
			Isawa			
Magajia Ibrahim	M	WDC	Secretary Juhudu		08034181551	Giade
Haruna Hussaini	M	WDC	Secretary Isawa		08085946017	Giade
Musa M Abdu	M	WDC	Secretary S/sara		07083044006	Giade
Abdu Sabon Sara	M	WDC	Chairman s/Sara		08089017382	Giade
Saleh Abdu	M	WDC	Secretary Giade B		08064819649	Giade
Mohammed Usman	M	WDC	Chairman Giade B		08062211466	Giade
Mohammed Abdullaahi	M	WDC	Chairman Jugudu		08096164651	Giade
Saidu Sule K	M	WDC	Secretary Kurba		08081849181	Giade
Abba Abdulkadir	M	WDC	Secretary S/Sara B		08094338635	Giade
Shehu Mohammed	M	WDC	Secretary Faguji		08097061069	Giade
Abubakar Wakili	M	WDC	Chairman S/Sara B		08090997564	Giade
Abdulkarim Shehu	M	WDC	Secretary		08069102313	Shira
Isa Rufai Dango	M	WDC	Secretary		08032067258	Shira
Abba Saidu	M	WDC	Secretary		08032871240	Shira
Musa Isa	M	WDC	Secretary		07039435823	Shira
Sani Mohammed Dango	M	WDC	Chairman		08065532438	Shira
Samaila Ahmed	M	WDC	Chairman		08149539623	Shira
Haruna Mailaida	M	WDC	Chairman		07062523723	Shira
Badamasi Kaniji	M	WDC	D/Chairman		07063268249	Shira
Garba Danladi	M	WDC	Secretary		08032105690	Shira

Name	Sex	Organization	Designation	Email	Phone #	LGA
Wakili Gimba	M	WDC	Chairman		08162521824	Shira
Mohammed Musa	M	WDC	Chairman		08022349261	Shira
Bala Baraya	M	WDC	Chairman		08087801450	Dass
Ibrahim Abubakar	M	WDC	Chairman		07089352099	Dass
Ibrahim Dikko	M	WDC	SECRETARY		08081702777	Dass
Yusuf Ishaku	M	WDC	Secretary		08025083606	Dass
Atiku Y Musa	M	WDC	Secretary		08058636624	Dass
Hanifa Aliyu	F	CBHV	Member		08088298999	Dass
Fatsuma Mohammed	F	CBHV	Member		-	Dass
Lawiza Adamu	F	CBHV	Member		07058527126	Dass
Atika Tambaya	F	CBHV	Member		08075181216	Dass
Kauna Ishaku	F	CBHV	Member		08083517490	Dass
Alh Maimako Bako	M	WDC	Secretary		08022242809	Dass
Usman Rabo	M	WDC	Chairman		-	Dass
Iliya Jiukiri	M	WDC	Chairman		07083394955	Dass
Alh Umar	M	WDC	Chairman		07058494927	Dass
Danjuma Daniel	M	WDC	Secretary		08080997413	Dass
Aishatu Hussaini	F	WDC	Women leader	aishausainitula@gmail.com	0806588356 08081390665	Misau
Alh. Yahaya Iliyasu	M	WDC	Chairman		08060341794	Misau
Abubakar Yakubu	M	WDC	Secretary kukadi A	abubakaryakubu@gmail.com	07039231054	Misau
Babangida Ibrahim	M	WDC	Chairman		08069245493	Misau
Bappayo Itaji	M	WDC	Chairman		08139760427	Misau
Kawu Dan Baba	M	CBHV	D/chairman		08137661578	Misau

Name	Sex	Organization	Designation	Email	Phone #	LGA
Sule Kuna	M	CBHV	Chairman	sulekunaabalenh@gmail.com	07056407800	Misau
Umar Al Hassan	M	CBHV	Secretary		08082493110	Misau
Wakilin Dalwaili	M	CBHV	Chairman		08060792169	Misau
Abdullahi Saleh	M	CBHV	Secretary		07037435463	Misau
Dada Idris	F	WDC	Women leader		08135196946	Misau
Bashar Yakubu	M	WDC	Secretary		07031392339	Misau
Abdulssalam Ahmed	M	WDC	Chairman		08067668864	Misau
Altine A Yusuf	F	CBHV	Women leader		07068046585	Misau
Dala Abdullahi	F	CBHV	Member		-	Misau
Walida Mohammed	F	CBHV	Member		08032712301	Misau
Hajiya Maimuna Shuhu	F	CBHV	Member		08067153856	Misau
Bashir Aliyu	M	WDC	Secretary		08082651820	Tafawa Balewa
Jatau Shehu	M	WDC			07038767588	Tafawa Balewa
Aliyu a Bawa	M	WDC	Chairman		07082293929	Tafawa Balewa
Ibrahim Haruna Gital	M	WDC	Secretary Bula B		08076666489	Tafawa Balewa
Aburrasheed M Yau	M	WDC	Secretary		07082293094	Tafawa Balewa
Adamu Umar Gital	M	CBHV	Chairman		08073503658	Tafawa Balewa
Shehu Musa	M	CBHV	Secretary		07050277742	Tafawa Balewa
Hajaratu Istifanus	F	CBHV	Volunteer		07011475477	Tafawa Balewa
Habiba Mohammed	F	CBHV	Volunteer		-	Tafawa Balewa

Name	Sex	Organization	Designation	Email	Phone #	LGA
Hassan Bala	M	CBHV	Chairman		09028849085	Tafawa Balewa
Umar Ibrahim	M	WDC	Chairman		07083170072	Tafawa Balewa
Lydia nyami	F	WDC	Volunteer		08153484901	Tafawa Balewa
Ibrahim Ajiji	M	WDC	Chairman		07058053519	Tafawa Balewa
Sani Abubakar	M	WDC	Secretary		08100658673	Tafawa Balewa
Ummi Hussaini	F	WDC	Volunteer		-	Tafawa Balewa

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- 29 Q2-PY1 TSHIP Report
- 30 Q2-PY4 TSHIP Report
- 31 Q2-PY5 TSHIP Report
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ANNEX V: LIST OF LGAS AND HEALTH FACILITIES VISITED BY THE EVALUATION TEAM

Sokoto state:

Date	Health Facilities
Monday 29 June 2015	<u>Sokoto North LGA:</u> • Kofar Rini Clinic • Gidan Dare Gandu Dispensary <u>Sokoto South LGA:</u> • Sokoto Specialist Hospital • Turaki Basic Health Clinic
Tuesday 30 June 2015	<u>Wurno LGA:</u> • Sabon Garin Liman Dispensary • Achida Model Primary Health Centre <u>Gwadabawa:</u> • Kiliya Dispenasry • Sakamaru Dispensary
Wednesday 1 July 2015	<u>Dange Shuni:</u> • Wababe Dispensary • Rikina Dispensary <u>Rabah LGA:</u> • Gawakuke PHC • Gidan Almajir Dispensary
Thursday 2 July 2015	<u>Kware LGA:</u> • Mallamar Yari Dispensary • Zamau Community Dispensary <u>Yabo LGA:</u> • Yabo General Hospital • Addam Dispensary

Date	Health Facilities
Friday 3 July 2015	<u>Bodinga LGA:</u> • Darhela Upgraded Dispensary • Madorawa Dispensary <u>Wamakko LGA:</u> • Yarume Dispensary • Yarlabbe Dispensary

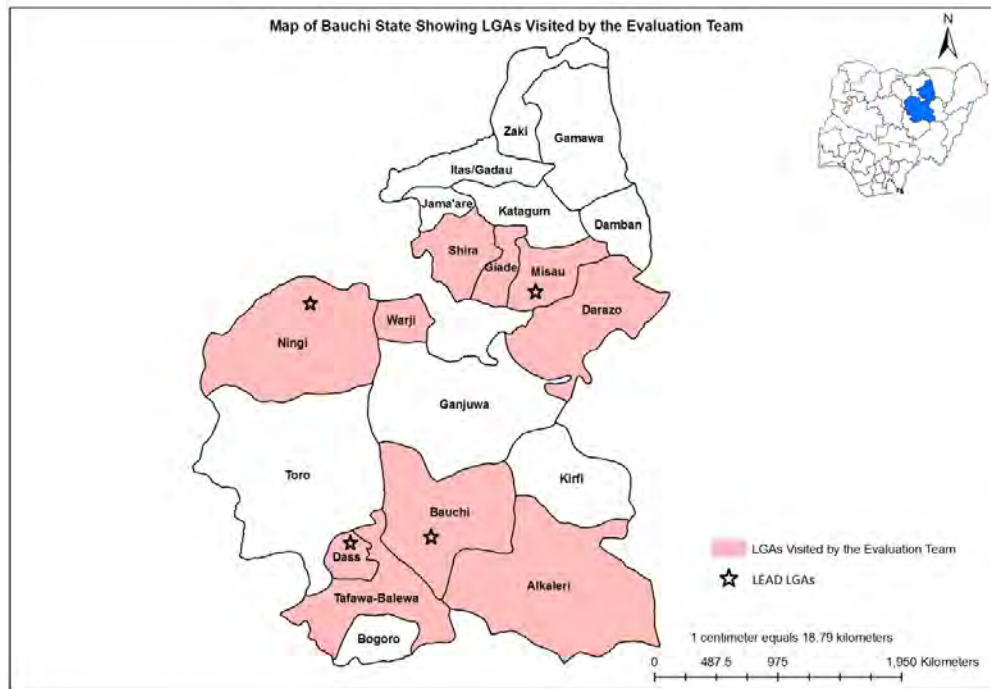
Bauchi state:

Date	Health Facilities
Monday 6 July 2015	<u>Bauchi LGA:</u> • Tirwun Maternal and Child Health Clinic • Federal Low Cost Health Centre <u>Dass LGA:</u> • Dabardak Maternity • Bashi Mat/Clinic (replaced with Town maternity)
Tuesday 7 July 2015	<u>Darazo LGA</u> • Sabu Maternity (replaced with Aisha Yuguda Under 5 Clinic) • Garin Abare Health Centre (replaced with Wahu Health Center) <u>Shira LGA:</u> • Yana General Hospital (replaced with Shira General Hospital) • Nahuce Maternity (replaced with MPHIC Feggo)
Wednesday 8 July 2015	<u>Ningi LGA:</u> • Kwalangwadi Maternity (replaced with Ningi General Hospital) • Batu Health Clinic (replaced with Gadar Maiwa PHC) <u>Misau LGA:</u> • Misau Town Maternity • Zindi Maternity
Thursday 9 July 2015	<u>Warji LGA:</u> • Ingila Maternity (replaced with Dagu Maternity)

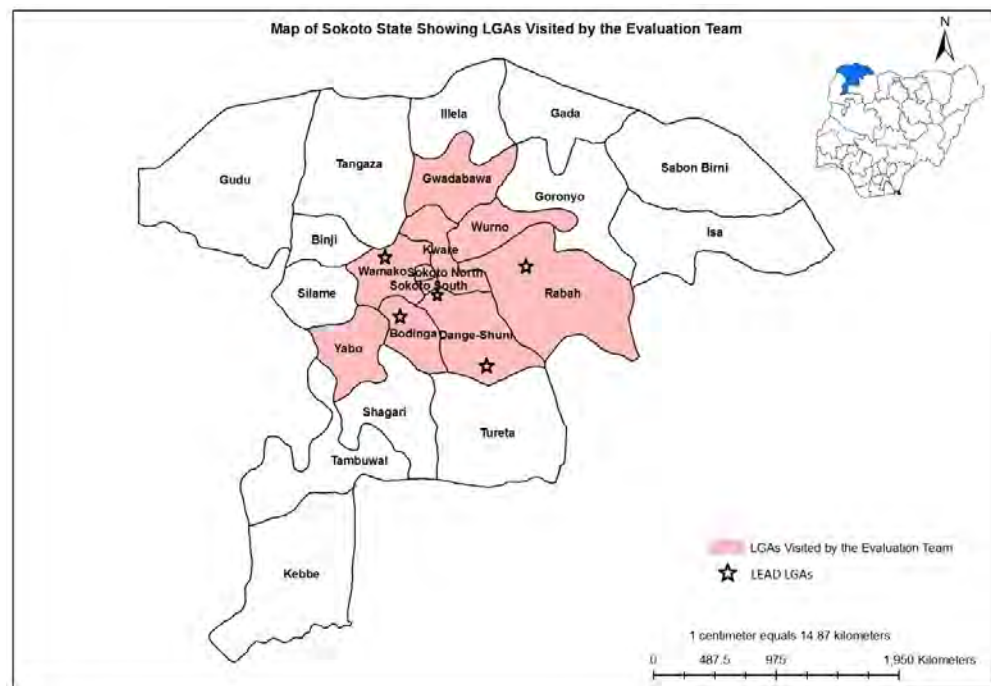
Date	Health Facilities
	- Baima Maternity <u>Giade LGA:</u> - Zabi Model PHC - Yandore Maternity (replaced with Giade MCH)
Friday 10 July 2015	<u>Alkaleri LGA:</u> - Gar Maternity - Kumbala Health Centre (replaced with Town Maternity Alkaleri) <u>Tafawa Balewa LGA:</u> - Shall Dispensary (replaced with Bununu Maternity) - Zwall Maternity

ANNEX VI: MAP OF TSHIP STATES SHOWING LGAS VISITED BY THE EVALUATION TEAM

Bauchi



Sokoto



ANNEX VII: QUANTITATIVE AND QUALITATIVE DATA ANALYSES

- a) Trend Analysis of Performance/Service-level Indicators
- b) Health Facilities Rapid Assessment
- c) Key Informant Interviews Notes
- d) Focus Group Discussions Notes

a) Trend Analysis of Performance/Service-level Indicators

Intervention: IMMUNIZATION

TSHIP Performance Indicator:

% of children who received DPT3 vaccine by 12 months of age

NDHS		LQAS			TSHIP reported project-life achievement for <i>service level Indicator</i> : Number of children who received DPT3 by 12 months of age in USG assisted programs														
2008	2013	2012	2013	2014	FY 2010			FY 2011			FY 2012			FY 2013			FY 2014		
					<i>Bauchi</i>	<i>Sokoto</i>	<i>Total</i>	<i>Bauchi</i>	<i>Sokoto</i>	<i>Total</i>	<i>Bauchi</i>	<i>Sokoto</i>	<i>Total</i>	<i>Bauchi</i>	<i>Sokoto</i>	<i>Total</i>	<i>Bauchi</i>	<i>Sokoto</i>	<i>Total</i>
% of children who received DPT3 vaccine by 12 months of age		Children 12-23 months receiving DPT3 vaccination (card & reported) before 12 months			93,911	107,871	201,782	107,664	121,017	228,681	69,158	86,749	155,907	126,203	154,710	280,913	218,342	140,783	359,125
North East (12.4%)	North East (20.6%)	Bauchi State (10.5%)	Sokoto State (2.2%)	Bauchi State (12.0%)	Comments: From a sample size of 20 Service Providers (SP) in health facilities and 40 Clients, findings from TSHIP EOP evaluation indicated that the percentage of respondents that believed IMMUNIZATION intervention was the most utilized in health facilities were – <u>SP</u>: Bauchi state (17.8%); Sokoto state (17.3%) & Both states (17.7%). <u>Clients</u>: Bauchi state (21.4%); Sokoto state (17.8%) & Both states (19.6%). Also the percentage of <u>Clients</u> who mentioned receiving immunization service were Bauchi state (81.8%); Sokoto state (42.1%) & Both states (69.4%).														
Bauchi State (1.0%)	Bauchi State (12.5%)	Sokoto State (4.1%)																	
North West (9.1%)	North West (13.9%)																		
Sokoto State (2.0%)	Sokoto State (2.6%)																		
National	National (38.2%)																		

(35.4%)

% of children (12-23 months) who received all basic vaccinations

North East	North East
(7.6%)	(14.2%)
Bauchi State	Bauchi State
(1.0%)	(6.1%)
North West	North West
(6.0%)	(9.6%)
Sokoto State	Sokoto State
(1.0%)	(1.4%)
National	National
(22.7%)	(25.3%)

Intervention: DELIVERY

TSHIP Performance Indicator:

% of births attended by a skilled doctor, nurse or midwife

NDHS		LQAS			TSHIP reported project-life achievements for <i>service level Indicator</i> : # of deliveries with a skilled birth attendant in USG Programs																																												
2008	2013	2012	2013	2014	FY 2010			FY 2011			FY 2012			FY 2013			FY 2014																																
					<i>Bauch i</i>	<i>Sokot o</i>	<i>Tota l</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Tota l</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Tota l</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>																														
<i>% delivered in a health facility</i>					12,075			5,693			17,768			51,291			42,175			93,466			65,492			31,245			96,737			72,299			51,615			123,914			85,782			36,005			121,787		
					# of women receiving active management of the third stage of labor (AMSTL) through USG supported programs																																												
					2,852			1,323			4,175			17,943			17,293			35,236			30,197			17,182			47,379			54,217			41,292			95,509			73,764			33,484			107,248		
North East (12.8%)	North East (19.5%)	Bauchi State (N/A)	Sokoto State (9.6%)	Bauchi State (14.9%)																																													
Bauchi State (13.0%)	Bauchi State (16.9%)	Sokoto State (N/A)																																															
North West (8.4%)	North West (11.5%)																																																
Sokoto State (4.4%)	Sokoto State (4.7%)																																																
National (35.0%)	National (35.8%)																																																
					<i>Comments:</i>																																												
					From a sample size of 20 Service Providers (SP) in health facilities and 40 Clients, findings from TSHIP EOP evaluation indicated that the percentage of respondents that believed DELIVERY intervention was the most utilized in health facilities during TSHIP implementation were – <u>SP</u> : Bauchi state (8.9%); Sokoto state (6.2%) & Both state (7.7%) – <u>Clients</u> : Bauchi state (21.4%); Sokoto states (17.8%) & Both state (19.6%).																																												

% delivered by a skilled provider		Mothers of children 0-23 months whose births were attended by SBA		
North East	North East	Bauchi State	Sokoto State	Bauchi State
(15.5%)	(19.9%)	(17.9%)	(14.9%)	(25.0%)
Bauchi State	Bauchi State	Sokoto State		
(15.7%)	(16.3%)	(12.1%)		
North West	North West			
(9.8%)	(12.3%)			
Sokoto State	Sokoto State			
(5.1%)	(5.4%)			
National	National			
(38.9%)	(38.1%)			

Intervention: FAMILY PLANNING

TSHIP Performance Indicator :

1. Couple years of protection (CYP) in USG supported programs
2. Modern contraceptive rates

NDHS

LQAS

TSHIP reported project-life achievements for service level Indicator:

of counselling visits for FP/RH as a result of USG assistance

2008	2013	2012	2013	2014	FY 2010			FY 2011			FY 2012			FY 2013			FY 2014		
					Bauch i	Sokot o	Tota l	Bauch i	Sokot o	Tota l	Bauch i	Sokot o	Total	Bauch i	Sokot o	Total	Bauch i	Sokot o	Total
% of currently married women aged 15-49 current use of any modern contraceptive method Women 15-49 using a modern method of FP					15,980	9,104	25,084	39,692	47,333	87,025	76,488	119,572	196,060	96,356	133,336	229,692	103,204	121,988	225,192
					Couple years protection (CYP) in USG supported programs														
					See table ??														
North East (3.5%)	North East (2.7%)	Bauchi State (6.8%)	Sokoto State (8.0%)	Bauchi State (4.7%)															
Bauchi State (2.0%)	Bauchi State (2.1%)	Sokoto State (6.9%)																	
North West (2.5%)	North West (3.6%)																		
Sokoto State 1.9%)	Sokoto State (0.7%)																		
National (9.7%)	National (9.8%)																		
					Comments:														
					From a sample size of 20 Service Providers (SP) in health facilities and 40 Clients, findings from TSHIP EOP evaluation indicated that the percentage of respondents that believed FAMILY PLANNING interventions were the most utilized in health facilities during TSHIP implementation were – <u>SP</u> : Bauchi state (14.9%); Sokoto state (14.8%) & Both state (14.4%) – <u>Clients</u> : Bauchi state (9.7%); Sokoto state (3.7%) & Both states (6.8%).														

Bauchi State (N/A)	Sokoto State (7.8%)	Bauchi State (4.7%)
Sokoto State (N/A)		

Intervention: TREATMENT OF CHILDHOOD DIARRHOEA

TSHIP Performance Indicator:

% of children under-five years old with diarrhoea treated with oral rehydration therapy

NDHS		LQAS			TSHIP reported project-life achievement for <i>service level Indicator</i> : ??														
2008	2013	2012	2013	2014	FY 2010			FY 2011			FY 2012			FY 2013			FY 2014		
					<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>
% of children under 5, with diarrhoea given ORS		Children months who received ORS and zinc	0-59		??	??	??	??	??	??	??	??	??	??	??	??	??	??	??
North East (0.3%)	North East (28.5%)	Bauch i State (3.7%)	Sokot o State (1.3%)	Bauch i State (1.8%)	<i>Comments:</i> From a sample size of 20 Service Providers (SP) in health facilities and 40 Clients, findings from TSHIP EOP evaluation indicated that the percentage of respondents that believed TREATMENT OF CHILDHOOD DIARRHOEA intervention was the most utilized in health facilities were – <u>SP</u> : Bauchi state (13.9%); Sokoto state (16.0%) & Both states (14.9%). <u>Clients</u> : Bauchi state (14.5%); Sokoto state (21.5%) & Both states (17.9%)														
Bauchi State (N/A)	Bauchi State (N/A)	Sokot o State (1.1%)																	
North West	North West (33.7%)																		

(0.7%)	Sokoto State	(N/A)
(N/A)	National	
(0.7%)		(33.7%)
% of children under 5, with diarrhoea given zinc		
North East	North East	
(0.3%)		(0.8%)
Bauchi State	Bauchi State	
(N/A)		(N/A)
North West	North West	
(0.7%)		(3.1%)
Sokoto State	Sokoto State	
(N/A)		(N/A)
National (0.7%)	National	(2.3%)
Intervention: NUTRITION (VITAMIN A)		

TSHIP Performance Indicator:																			
NDHS					TSHIP reported project-life achievement for <i>service level Indicator</i> : # of children under 5years of age who received vitamin A from USG-supported programs														
2008	2013	2012	2013	2014	FY 2010			FY 2011			FY 2012			FY 2013			FY 2014		
					Bauchi	Sokoto	Total	Bauchi	Sokoto	Total	Bauchi	Sokoto	Total	Bauchi	Sokoto	Total	Bauchi	Sokoto	Total
% of children aged 6-59 months, given vitamin A supplements in past 6 months					??	537,858	??	??	1,375,438	??	??	1,375,606	??	??	1,387,407	??	??	1,452,598	??
Children 0-59 months, who received vitamin A supplementation within last 6 months																			
North East	North East	Bauchi State**	Sokoto State	Bauchi State**															
(18.6%)	(31.1%)	(32.1%)	(30.2%)	(31.0%)															
	Bauchi State	Sokoto State**																	
(12.0%)	(36.3%)	(39.%)																	
	North West																		
	(26.1%)																		
North West	Sokoto State																		
(13.9%)	(17.9%)																		
Sokoto State	National																		
(5.0%)	(41.3%)																		
National																			
(25.8%)																			

Comments:

From a sample size of 20 Service Providers (SP) in health facilities and 40 Clients, findings from TSHIP EOP evaluation indicated that the percentage of respondents that believed NUTRITION intervention was the most utilized in health facilities were – SP: Bauchi state (6.9%); Sokoto state (8.6%) & Both states (7.7%). Clients: Bauchi state (2.1%); Sokoto state (9.6%) & Both states (5.7%)

)

*** Children 6-23 months given vitamin A within six months preceding LQAS*

**** Children 6-59 months given vitamin A (from card record & mother)*

Intervention: MALARIA
TSHIP Performance Indicator:

NDHS		LQAS			TSHIP reported project-life achievement for <i>service level Indicator:</i>														
					# of cases of malaria in children treated with ACT														
2008	2013	2012	2013	2014	FY 2010			FY 2011			FY 2012			FY 2013			FY 2014		
					<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>	<i>Bauch i</i>	<i>Sokot o</i>	<i>Total</i>
% of children aged under 5, with fever who received ACT (specific anti-malarial drug)					99,283	16,298	115,581	66,237	55,655	121,892	89,669	54,969	144,638	80,207	170,654	250,861	147,837	343,166	491,003
Children 0-59 months, with fever provided with ACT																			
North East	North East	Bauch i State	Sokot o State	Bauch i State															
(1.9%)	(3.7%)	(5.8%)	(3.5%)	(16.4%)															
Bauchi State	Bauchi State	Sokot o State																	
(0.3%)	(1.4%)	(4.3%)																	
North West	North West																		
(2.1%)	(5.3%)																		
Sokoto State	Sokoto State																		
(4.3%)	(8.2%)																		
National	National				Comments:														
(2.4%)	(6.0%)				From a sample size of 20 Service Providers (SP) in health facilities and 40 Clients, findings from TSHIP EOP evaluation indicated that the percentage of respondents that believed MALARIA intervention was the most utilized in health facilities were – <u>SP</u> : Bauchi state (18.8%); Sokoto state (19.8%) & Both states (19.3%). <u>Clients</u> : Bauchi state (18.6%); Sokoto state (23.0%) & Both states (20.7%)														

b) Health Facilities Rapid Assessment

ANC service provision (Period)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Monthly	2	5.1	5.3	5.3
	Once a week	15	38.5	39.5	44.7
	Twice a week	15	38.5	39.5	84.2
	3 times weekly	1	2.6	2.6	86.8
	Daily	5	12.8	13.2	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Delivery service provision (Period)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Daily	29	74.4	85.3	85.3
	Depend on service de	1	2.6	2.9	88.2
	No midwife in H	1	2.6	2.9	91.2
	Not in operation	2	5.1	5.9	97.1
	Sometime attend	1	2.6	2.9	100.0
	Total	34	87.2	100.0	
Missing	No response	5	12.8		
Total		39	100.0		

Family Planning service provision (Period)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Monthly	3	7.7	7.9	7.9
	Once a week	1	2.6	2.6	10.5
	3 times ?	1	2.6	2.6	13.2
	Daily	29	74.4	76.3	89.5
	Anytime Clients	1	2.6	2.6	92.1
	Every two months	1	2.6	2.6	94.7
	No	1	2.6	2.6	97.4
	When needed	1	2.6	2.6	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Nutrition service provision (Period)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Monthly	1	2.6	3.1	3.1
	Once a week	8	20.5	25.0	28.1
	Twice a week	3	7.7	9.4	37.5
	Daily	16	41.0	50.0	87.5
	No	1	2.6	3.1	90.6
	Not in operation	1	2.6	3.1	93.8
	When needed	1	2.6	3.1	96.9
	When there is n	1	2.6	3.1	100.0
	Total	32	82.1	100.0	
Missing	No response	7	17.9		
Total		39	100.0		

Immunization service provision (Period)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Monthly	4	10.3	11.1	11.1
	Once a week	18	46.2	50.0	61.1
	Twice a week	10	25.6	27.8	88.9
	3 sessions in a week	1	2.6	2.8	91.7
	3 times a week	1	2.6	2.8	94.4
	Daily	1	2.6	2.8	97.2
	Not in operation	1	2.6	2.8	100.0
	Total	36	92.3	100.0	
Missing	No response	3	7.7		
Total		39	100.0		

Malaria (prv/trmt) service provision (Period)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Monthly	1	2.6	2.6	2.6
	Once a week	1	2.6	2.6	5.1
	Twice a week	1	2.6	2.6	7.7
	Daily	35	89.7	89.7	97.4
	Anytime	1	2.6	2.6	100.0
	Total	39	100.0	100.0	

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

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	30	76.9	76.9	76.9
	No	9	23.1	23.1	100.0
	Total	39	100.0	100.0	

If Yes, does staff member live or stay at this health centre when on night call?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	16	41.0	53.3	53.3
	No	14	35.9	46.7	100.0
	Total	30	76.9	100.0	
Missing	No response	1	2.6		
	Not applicable	8	20.5		
	Total	9	23.1		
Total		39	100.0		

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

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	9	23.1	32.1	32.1
	No	19	48.7	67.9	100.0
	Total	28	71.8	100.0	
Missing	No response	2	5.1		
	Not applicable	9	23.1		
	Total	11	28.2		
Total		39	100.0		

Is the Staff house adequate?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	15	38.5	75.0	75.0
	No	5	12.8	25.0	100.0
	Total	20	51.3	100.0	
Missing	No response	6	15.4		
	Not applicable	13	33.3		
	Total	19	48.7		
Total		39	100.0		

When was the HF renovation?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2000	1	2.6	2.9	2.9
	2007	1	2.6	2.9	5.9
	2008	2	5.1	5.9	11.8
	2009	1	2.6	2.9	14.7
	2010	6	15.4	17.6	32.4
	2011	5	12.8	14.7	47.1
	2012	3	7.7	8.8	55.9
	2013	6	15.4	17.6	73.5
	2014	3	7.7	8.8	82.4
	2015	1	2.6	2.9	85.3
	2015 (2 months ago)	1	2.6	2.9	88.2
	Constructed in 2010	1	2.6	2.9	91.2
	No	1	2.6	2.9	94.1
	Not renovated	2	5.1	5.9	100.0
	Total	34	87.2	100.0	

Missing	No response	1	2.6		
	Not applicable	4	10.3		
	Total	5	12.8		
Total		39	100.0		

Did TSHIP renovated the HF

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	16	41.0	50.0	50.0
	No	16	41.0	50.0	100.0
	Total	32	82.1	100.0	
Missing	Not applicable	7	17.9		
Total		39	100.0		

If it is not TSHIP, Who did?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	CIDA	1	2.6	6.3	6.3
	FHI 360	2	5.1	12.5	18.8
	LGA	3	7.7	18.8	37.5
	MDG	4	10.3	25.0	62.5
	MDG & State Govt.	1	2.6	6.3	68.8
	State Govt.	2	5.1	12.5	81.3
	SURE-P	1	2.6	6.3	87.5
	UNICEF	1	2.6	6.3	93.8
	WDC	1	2.6	6.3	100.0
	Total	16	41.0	100.0	
Missing	No response	2	5.1		

Not applicable	21	53.8		
Total	23	59.0		
Total	39	100.0		

What part of the building were renovated?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	A new HF was built	1	2.6	3.1	3.1
	All	2	5.1	6.3	9.4
	All parts	1	2.6	3.1	12.5
	All parts (State Govt) & Borehole (MDG)	1	2.6	3.1	15.6
	All the structure	1	2.6	3.1	18.8
	Complete building	1	2.6	3.1	21.9
	Door, demarcate Labour room	1	2.6	3.1	25.0
	Entire building & student Hostel	1	2.6	3.1	28.1
	Fence and houses were newly constructed	1	2.6	3.1	31.3
	HF area, toilet, tank connected to toilet	1	2.6	3.1	34.4
	Insertion room & ANC dept.	1	2.6	3.1	37.5
	Lab extended, Immunization shed & Office for ANC	1	2.6	3.1	40.6
	Labour room, RI, Female ward, HCT	1	2.6	3.1	43.8
	Maternity ward & Labour room	1	2.6	3.1	46.9
	Not renovated since constructed	1	2.6	3.1	50.0
	Not yet	1	2.6	3.1	53.1
	The entire building	1	2.6	3.1	56.3
	The whole building	1	2.6	3.1	59.4

	The whole HF	5	12.8	15.6	75.0
	The whole HF building	1	2.6	3.1	78.1
	The whole HF including mid-wife's house	1	2.6	3.1	81.3
	Toilet area and fencing of the toilet	1	2.6	3.1	84.4
	TSHIP - Maternity & Theatre S/Govt wards lab & cas	1	2.6	3.1	87.5
	TTiles the floor, extend wards & built lab.	1	2.6	3.1	90.6
	Whole HF and staff quarters	1	2.6	3.1	93.8
	Whole O&G Dept.	1	2.6	3.1	96.9
	Windows, doors, roof & painting	1	2.6	3.1	100.0
	Total	32	82.1	100.0	
Missing	Not applicable	7	17.9		
Total		39	100.0		

Do you think the renovation improved the quality of care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	30	76.9	100.0	100.0
Missing	No response	1	2.6		
	Not applicable	8	20.5		
	Total	9	23.1		
Total		39	100.0		

Do you think the renovation improved how much the community use the HF?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	29	74.4	96.7	96.7
	No	1	2.6	3.3	100.0
	Total	30	76.9	100.0	
Missing	No response	1	2.6		
	Not applicable	8	20.5		
	Total	9	23.1		
Total		39	100.0		

Is there an ORT corner in the HF?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	33	84.6	84.6	84.6
	No	6	15.4	15.4	100.0
	Total	39	100.0	100.0	

Is there a waiting area in the HF?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	36	92.3	94.7	94.7
	No	2	5.1	5.3	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

What is the main source of water in the facility?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Tank water	3	7.7	7.7	7.7
	Well	6	15.4	15.4	23.1
	Piped water	3	7.7	7.7	30.8
	Bore water	19	48.7	48.7	79.5
	Other stored water	3	7.7	7.7	87.2
	No water source	4	10.3	10.3	97.4
	No water - HF buy water	1	2.6	2.6	100.0
	Total	39	100.0	100.0	

Is the drainage for water adequate?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	18	46.2	50.0	50.0
	No	18	46.2	50.0	100.0
	Total	36	92.3	100.0	
Missing	No response	2	5.1		
	Not applicable	1	2.6		
	Total	3	7.7		
Total		39	100.0		

Are toilets available for patients?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	36	92.3	94.7	94.7
	No	2	5.1	5.3	100.0

	Total	38	97.4	100.0
Missing	No response	1	2.6	
Total		39	100.0	

Are these toilets able to be used at present?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	30	76.9	85.7	85.7
	No	5	12.8	14.3	100.0
	Total	35	89.7	100.0	
Missing	No response	4	10.3		
Total		39	100.0		

Do patients use the toilet?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	23	59.0	82.1	82.1
	2	4	10.3	14.3	96.4
	Sometimes	1	2.6	3.6	100.0
	Total	28	71.8	100.0	
Missing	99	11	28.2		
Total		39	100.0		

What is the source of power for the facility_1?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NEPA/PHCN	26	66.7	66.7	66.7
	Generator	4	10.3	10.3	76.9
	Kerosene	2	5.1	5.1	82.1
	No energy source	5	12.8	12.8	94.9
	Recharge lamp	1	2.6	2.6	97.4
	Touch light	1	2.6	2.6	100.0
	Total	39	100.0	100.0	

What is the source of power for the facility_2?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Generator	15	38.5	71.4	71.4
	Kerosene	1	2.6	4.8	76.2
	Solar	4	10.3	19.0	95.2
	Torch light	1	2.6	4.8	100.0
	Total	21	53.8	100.0	
Missing	Not applicable	18	46.2		
Total		39	100.0		

What is the source of power for the facility_3?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Kerosene	1	2.6	12.5	12.5
	Solar	6	15.4	75.0	87.5
	Solar lantern	1	2.6	12.5	100.0

Total		8	20.5	100.0
Missing	Not applicable	31	79.5	
Total		39	100.0	

What is the source of power for the facility_4?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Solar	1	2.6	100.0	100.0
Missing	Not applicable	38	97.4		
Total		39	100.0		

What is the source of power for the facility_5?

		Frequency	Percent
Missing	Not applicable	39	100.0

What is the source of power for the facility_6?

		Frequency	Percent
Missing	Not applicable	39	100.0

What is the source of power for the facility_7?

		Frequency	Percent
Missing	Not applicable	39	100.0

Is there a place for counselling?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	28	71.8	71.8	71.8
	No	11	28.2	28.2	100.0
	Total	39	100.0	100.0	

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

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	28	71.8	84.8	84.8
	No	5	12.8	15.2	100.0
	Total	33	84.6	100.0	
Missing	No response	3	7.7		
	Not applicable	3	7.7		
	Total	6	15.4		
Total		39	100.0		

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

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	28	71.8	84.8	84.8
	No	5	12.8	15.2	100.0
	Total	33	84.6	100.0	
Missing	No response	3	7.7		
	Not applicable	3	7.7		
	Total	6	15.4		
Total		39	100.0		

Is there a separate room/area for examinations?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	28	71.8	73.7	73.7
	No	10	25.6	26.3	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

If NO, Is there a separate area within the counselling room for examinations (e.g. curtained area)?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	4.0	4.0
	Yes	17	43.6	68.0	72.0
	No	7	17.9	28.0	100.0
	Total	25	64.1	100.0	
Missing	No response	8	20.5		
	Not applicable	6	15.4		
	Total	14	35.9		
Total		39	100.0		

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

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	29	74.4	80.6	80.6
	No	7	17.9	19.4	100.0
	Total	36	92.3	100.0	
Missing	No response	1	2.6		
	Not applicable	2	5.1		
	Total	3	7.7		
Total		39	100.0		

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

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	31	79.5	81.6	81.6
	No	7	17.9	18.4	100.0
	Total	38	97.4	100.0	
Missing	Not applicable	1	2.6		
Total		39	100.0		

Is the examination room clean?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	29	74.4	74.4	74.4
	No	10	25.6	25.6	100.0
	Total	39	100.0	100.0	

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

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	29	74.4	74.4	74.4
	No	10	25.6	25.6	100.0
	Total	39	100.0	100.0	

Where is most equipment stored?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In a locked cabinet/cupboard	18	46.2	47.4	47.4
	In an unlocked shelf	5	12.8	13.2	60.5
	Drawer	1	2.6	2.6	63.2
	In a locked store room	1	2.6	2.6	65.8
	In a room	1	2.6	2.6	68.4
	In a store	1	2.6	2.6	71.1
	In a store room	1	2.6	2.6	73.7
	In the IC's office	1	2.6	2.6	76.3
	In the Labour room	1	2.6	2.6	78.9
	In the store at the staff quarters	1	2.6	2.6	81.6
	Inside the store	1	2.6	2.6	84.2
	Kept in store and attimes in the cupboard	1	2.6	2.6	86.8
	No equipment in this HF	1	2.6	2.6	89.5
	On the floor of the counseling room	1	2.6	2.6	92.1
	Store	1	2.6	2.6	94.7
	Store in the In-charge Office	1	2.6	2.6	97.4

	Stored in the dispensary	1	2.6	2.6	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

BP Apparatus - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.6	2.6	2.6
	1	13	33.3	34.2	36.8
	2	8	20.5	21.1	57.9
	3	7	17.9	18.4	76.3
	4	2	5.1	5.3	81.6
	5	3	7.7	7.9	89.5
	6	2	5.1	5.3	94.7
	8	2	5.1	5.3	100.0
	Total	38	97.4	100.0	
Missing	System	1	2.6		
Total		39	100.0		

BP Apparatus - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	3	7.7	8.8	8.8
	1	11	28.2	32.4	41.2
	2	12	30.8	35.3	76.5
	3	5	12.8	14.7	91.2

	5	2	5.1	5.9	97.1
	8	1	2.6	2.9	100.0
	Total	34	87.2	100.0	
Missing	No response	3	7.7		
	Not applicable	1	2.6		
	System	1	2.6		
	Total	5	12.8		
Total		39	100.0		

BP Apparatus - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	22	56.4	75.9	75.9
	No	6	15.4	20.7	96.6
	STOP	1	2.6	3.4	100.0
	Total	29	74.4	100.0	
Missing	No response	9	23.1		
	Not applicable	1	2.6		
	Total	10	25.6		
Total		39	100.0		

Air ways infant - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	13	33.3	43.3	43.3
	1	9	23.1	30.0	73.3
	2	4	10.3	13.3	86.7

	3	1	2.6	3.3	90.0
	5	1	2.6	3.3	93.3
	20	1	2.6	3.3	96.7
	50	1	2.6	3.3	100.0
	Total	30	76.9	100.0	
Missing	No response	8	20.5		
	System	1	2.6		
	Total	9	23.1		
Total		39	100.0		

Air ways infant - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	9	23.1	52.9	52.9
	2	5	12.8	29.4	82.4
	3	1	2.6	5.9	88.2
	20	1	2.6	5.9	94.1
	50	1	2.6	5.9	100.0
	Total	17	43.6	100.0	
Missing	No response	8	20.5		
	Not applicable	13	33.3		
	System	1	2.6		
	Total	22	56.4		
Total		39	100.0		

Air ways infant - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	7.1	7.1
	Yes	11	28.2	78.6	85.7
	No	2	5.1	14.3	100.0
	Total	14	35.9	100.0	
Missing	No response	17	43.6		
	Not applicable	8	20.5		
	Total	25	64.1		
Total		39	100.0		

Airways resuscitation - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	13	33.3	44.8	44.8
	1	9	23.1	31.0	75.9
	2	4	10.3	13.8	89.7
	4	2	5.1	6.9	96.6
	6	1	2.6	3.4	100.0
	Total	29	74.4	100.0	
Missing	No response	9	23.1		
	System	1	2.6		
	Total	10	25.6		
Total		39	100.0		

Airways resuscitation - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	9	23.1	64.3	64.3
	2	2	5.1	14.3	78.6
	4	2	5.1	14.3	92.9
	6	1	2.6	7.1	100.0
	Total	14	35.9	100.0	
Missing	No response	11	28.2		
	Not applicable	13	33.3		
	System	1	2.6		
	Total	25	64.1		
Total		39	100.0		

Airways resuscitation - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	8.3	8.3
	Yes	10	25.6	83.3	91.7
	Don't know	1	2.6	8.3	100.0
	Total	12	30.8	100.0	
Missing	No response	20	51.3		
	Not applicable	7	17.9		
	Total	27	69.2		
Total		39	100.0		

Urine testing stick - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	10	25.6	40.0	40.0
	1	5	12.8	20.0	60.0
	2	5	12.8	20.0	80.0
	3	2	5.1	8.0	88.0
	100	3	7.7	12.0	100.0
	Total	25	64.1	100.0	
Missing	No response	13	33.3		
	System	1	2.6		
	Total	14	35.9		
Total		39	100.0		

Urine testing stick - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	12.8	41.7	41.7
	2	4	10.3	33.3	75.0
	3	2	5.1	16.7	91.7
	100	1	2.6	8.3	100.0
	Total	12	30.8	100.0	
Missing	No response	16	41.0		
	Not applicable	10	25.6		
	System	1	2.6		
	Total	27	69.2		
Total		39	100.0		

Urine testing stick - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	11.1	11.1
	Yes	8	20.5	88.9	100.0
	Total	9	23.1	100.0	
Missing	No response	24	61.5		
	Not applicable	6	15.4		
	Total	30	76.9		
Total		39	100.0		

Ambubag (resuscitation bag) - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	15	38.5	45.5	45.5
	1	9	23.1	27.3	72.7
	2	6	15.4	18.2	90.9
	3	1	2.6	3.0	93.9
	6	1	2.6	3.0	97.0
	10	1	2.6	3.0	100.0
	Total	33	84.6	100.0	
Missing	No response	5	12.8		
	System	1	2.6		
	Total	6	15.4		
Total		39	100.0		

Ambubag (resuscitation bag) - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	10	25.6	55.6	55.6
	2	5	12.8	27.8	83.3
	3	1	2.6	5.6	88.9
	6	1	2.6	5.6	94.4
	10	1	2.6	5.6	100.0
	Total	18	46.2	100.0	
Missing	No response	5	12.8		
	Not applicable	15	38.5		
	System	1	2.6		
	Total	21	53.8		
Total		39	100.0		

Ambubag (resuscitation bag) - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	7.7	7.7
	Yes	11	28.2	84.6	92.3
	No	1	2.6	7.7	100.0
	Total	13	33.3	100.0	
Missing	No response	19	48.7		
	Not applicable	7	17.9		
	Total	26	66.7		
Total		39	100.0		

Extractor vacuum obstetric/forceps - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	13	33.3	44.8	44.8
	1	8	20.5	27.6	72.4
	2	4	10.3	13.8	86.2
	3	1	2.6	3.4	89.7
	6	1	2.6	3.4	93.1
	8	1	2.6	3.4	96.6
	100	1	2.6	3.4	100.0
	Total	29	74.4	100.0	
Missing	No response	9	23.1		
	System	1	2.6		
	Total	10	25.6		
Total		39	100.0		

Extractor vacuum obstetric/forceps - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	9	23.1	69.2	69.2
	2	1	2.6	7.7	76.9
	3	1	2.6	7.7	84.6
	6	1	2.6	7.7	92.3
	8	1	2.6	7.7	100.0
	Total	13	33.3	100.0	
Missing	No response	12	30.8		
	Not applicable	13	33.3		
	System	1	2.6		

Total	26	66.7		
Total	39	100.0		

Extractor vacuum obstetric/forceps - Reliability?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	8.3	8.3
Yes	9	23.1	75.0	83.3
No	2	5.1	16.7	100.0
Total	12	30.8	100.0	
Missing				
No response	21	53.8		
Not applicable	6	15.4		
Total	27	69.2		
Total	39	100.0		

Foley catheter (urine collection) - How many?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
0	14	35.9	50.0	50.0
1	6	15.4	21.4	71.4
2	1	2.6	3.6	75.0
3	2	5.1	7.1	82.1
6	1	2.6	3.6	85.7
10	1	2.6	3.6	89.3
20	2	5.1	7.1	96.4
28	1	2.6	3.6	100.0
Total	28	71.8	100.0	

Missing	No response	10	25.6		
	System	1	2.6		
	Total	11	28.2		
Total		39	100.0		

Foley catheter (urine collection) - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.6	8.3	8.3
	1	5	12.8	41.7	50.0
	2	1	2.6	8.3	58.3
	3	2	5.1	16.7	75.0
	6	1	2.6	8.3	83.3
	20	2	5.1	16.7	100.0
	Total	12	30.8	100.0	
Missing	No response	14	35.9		
	Not applicable	12	30.8		
	System	1	2.6		
	Total	27	69.2		
Total		39	100.0		

Foley catheter (urine collection) - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	11.1	11.1
	Yes	7	17.9	77.8	88.9
	No	1	2.6	11.1	100.0

	Total	9	23.1	100.0
Missing	No response	23	59.0	
	Not applicable	7	17.9	
	Total	30	76.9	
Total		39	100.0	

Is there a refrigerator? - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	7	17.9	19.4	19.4
	1	18	46.2	50.0	69.4
	2	7	17.9	19.4	88.9
	3	2	5.1	5.6	94.4
	4	1	2.6	2.8	97.2
	10	1	2.6	2.8	100.0
	Total	36	92.3	100.0	
Missing	No response	2	5.1		
	System	1	2.6		
	Total	3	7.7		
Total		39	100.0		

Is there a refrigerator? - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.6	4.5	4.5
	1	13	33.3	59.1	63.6
	2	4	10.3	18.2	81.8

	3	2	5.1	9.1	90.9
	4	1	2.6	4.5	95.5
	5	1	2.6	4.5	100.0
	Total	22	56.4	100.0	
Missing	No response	9	23.1		
	Not applicable	7	17.9		
	System	1	2.6		
	Total	17	43.6		
Total		39	100.0		

Is there a refrigerator? - Reliability?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	6.3	6.3
Yes	12	30.8	75.0	81.3
No	2	5.1	12.5	93.8
Don't know	1	2.6	6.3	100.0
Total	16	41.0	100.0	
Missing	No response	19	48.7	
	Not applicable	4	10.3	
	Total	23	59.0	
Total	39	100.0		

Glove surgeon (different sizes)? - How many?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0	4	10.3	12.1	12.1

	1	7	17.9	21.2	33.3
	2	3	7.7	9.1	42.4
	4	1	2.6	3.0	45.5
	10	1	2.6	3.0	48.5
	20	1	2.6	3.0	51.5
	50	3	7.7	9.1	60.6
	100	10	25.6	30.3	90.9
	150	1	2.6	3.0	93.9
	200	2	5.1	6.1	100.0
	Total	33	84.6	100.0	
Missing	No response	5	12.8		
	System	1	2.6		
	Total	6	15.4		
Total		39	100.0		

Glove surgeon (different sizes)? - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	4	10.3	18.2	18.2
	2	3	7.7	13.6	31.8
	4	1	2.6	4.5	36.4
	10	1	2.6	4.5	40.9
	20	1	2.6	4.5	45.5
	50	2	5.1	9.1	54.5
	100	7	17.9	31.8	86.4
	150	1	2.6	4.5	90.9
	200	2	5.1	9.1	100.0

	Total	22	56.4	100.0
Missing	No response	11	28.2	
	Not applicable	5	12.8	
	System	1	2.6	
	Total	17	43.6	
Total		39	100.0	

Glove surgeon (different sizes)? - Reliability?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	5.1	11.1	11.1
Yes	16	41.0	88.9	100.0
Total	18	46.2	100.0	
Missing	No response	17	43.6	
	Not applicable	4	10.3	
Total	21	53.8		
Total	39	100.0		

Hurrican lamp - kerosene operated or rechargeable - How many?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0	8	20.5	25.0	25.0
1	10	25.6	31.3	56.3
2	10	25.6	31.3	87.5
3	2	5.1	6.3	93.8
5	1	2.6	3.1	96.9
10	1	2.6	3.1	100.0

	Total	32	82.1	100.0
Missing	No response	5	12.8	
	System	2	5.1	
	Total	7	17.9	
Total		39	100.0	

Hurrican lamp - kerosene operated or rechargeable - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	8	20.5	40.0	40.0
	2	10	25.6	50.0	90.0
	3	1	2.6	5.0	95.0
	5	1	2.6	5.0	100.0
	Total	20	51.3	100.0	
Missing	No response	9	23.1		
	Not applicable	9	23.1		
	System	1	2.6		
	Total	19	48.7		
Total		39	100.0		

Hurrican lamp - kerosene operated or rechargeable - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	6.3	6.3
	Yes	14	35.9	87.5	93.8
	No	1	2.6	6.3	100.0

	Total	16	41.0	100.0
Missing	No response	17	43.6	
	Not applicable	6	15.4	
	Total	23	59.0	
Total		39	100.0	

Intravenous administration set - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	12	30.8	48.0	48.0
	1	4	10.3	16.0	64.0
	2	3	7.7	12.0	76.0
	4	1	2.6	4.0	80.0
	5	2	5.1	8.0	88.0
	20	2	5.1	8.0	96.0
	100	1	2.6	4.0	100.0
	Total	25	64.1	100.0	
Missing	No response	13	33.3		
	System	1	2.6		
	Total	14	35.9		
Total		39	100.0		

Intravenous administration set - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	3	7.7	25.0	25.0
	2	3	7.7	25.0	50.0

	4	1	2.6	8.3	58.3
	5	2	5.1	16.7	75.0
	20	2	5.1	16.7	91.7
	100	1	2.6	8.3	100.0
	Total	12	30.8	100.0	
Missing	No response	13	33.3		
	Not applicable	13	33.3		
	System	1	2.6		
	Total	27	69.2		
Total		39	100.0		

Intravenous administration set - Reliability?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	8.3	8.3
Yes	11	28.2	91.7	100.0
Total	12	30.8	100.0	
Missing	No response	22	56.4	
	Not applicable	5	12.8	
Total	27	69.2		
Total	39	100.0		

Microscope - How many?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0	12	30.8	38.7	38.7
1	12	30.8	38.7	77.4

	2	4	10.3	12.9	90.3
	3	1	2.6	3.2	93.5
	5	1	2.6	3.2	96.8
	39	1	2.6	3.2	100.0
	Total	31	79.5	100.0	
Missing	No response	7	17.9		
	System	1	2.6		
	Total	8	20.5		
Total		39	100.0		

Microscope - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	12	30.8	70.6	70.6
	2	3	7.7	17.6	88.2
	3	1	2.6	5.9	94.1
	39	1	2.6	5.9	100.0
	Total	17	43.6	100.0	
Missing	No response	10	25.6		
	Not applicable	11	28.2		
	System	1	2.6		
	Total	22	56.4		
Total		39	100.0		

Microscope - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	8.3	8.3
	Yes	8	20.5	66.7	75.0
	No	2	5.1	16.7	91.7
	Don't know	1	2.6	8.3	100.0
	Total	12	30.8	100.0	
Missing	No response	21	53.8		
	Not applicable	6	15.4		
	Total	27	69.2		
Total		39	100.0		

RDTs - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	3	7.7	10.7	10.7
	1	2	5.1	7.1	17.9
	3	2	5.1	7.1	25.0
	10	1	2.6	3.6	28.6
	13	1	2.6	3.6	32.1
	14	2	5.1	7.1	39.3
	15	1	2.6	3.6	42.9
	17	1	2.6	3.6	46.4
	20	2	5.1	7.1	53.6
	25	1	2.6	3.6	57.1
	30	1	2.6	3.6	60.7
	100	7	17.9	25.0	85.7

	350	1	2.6	3.6	89.3
	375	1	2.6	3.6	92.9
	675	1	2.6	3.6	96.4
	1300	1	2.6	3.6	100.0
	Total	28	71.8	100.0	
Missing	No response	10	25.6		
	System	1	2.6		
	Total	11	28.2		
Total		39	100.0		

RDts - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2	5.1	10.0	10.0
	3	2	5.1	10.0	20.0
	10	1	2.6	5.0	25.0
	13	1	2.6	5.0	30.0
	14	2	5.1	10.0	40.0
	15	1	2.6	5.0	45.0
	20	2	5.1	10.0	55.0
	25	1	2.6	5.0	60.0
	30	1	2.6	5.0	65.0
	100	3	7.7	15.0	80.0
	350	1	2.6	5.0	85.0
	375	1	2.6	5.0	90.0
	675	1	2.6	5.0	95.0
	1300	1	2.6	5.0	100.0

Missing	Total	20	51.3	100.0
	No response	14	35.9	
	Not applicable	4	10.3	
	System	1	2.6	
	Total	19	48.7	
Total		39	100.0	

RDTs - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	5.9	5.9
	Yes	15	38.5	88.2	94.1
	Don't know	1	2.6	5.9	100.0
	Total	17	43.6	100.0	
Missing	No response	20	51.3		
	Not applicable	2	5.1		
	Total	22	56.4		
Total		39	100.0		

Oxygen BP 3,800L (full) - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	21	53.8	84.0	84.0
	1	3	7.7	12.0	96.0
	3	1	2.6	4.0	100.0
	Total	25	64.1	100.0	

Missing	No response	13	33.3		
	System	1	2.6		
	Total	14	35.9		
Total		39	100.0		

Oxygen BP 3,800L (full) - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2	5.1	66.7	66.7
	3	1	2.6	33.3	100.0
	Total	3	7.7	100.0	
Missing	No response	16	41.0		
	Not applicable	19	48.7		
	System	1	2.6		
	Total	36	92.3		
Total		39	100.0		

Oxygen BP 3,800L (full) - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	20.0	20.0
	Yes	1	2.6	20.0	40.0
	No	3	7.7	60.0	100.0
	Total	5	12.8	100.0	
Missing	No response	27	69.2		
	Not applicable	7	17.9		

Total	34	87.2		
Total	39	100.0		

Weighing machine - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	2	5.1	5.9	5.9
	1	5	12.8	14.7	20.6
	2	13	33.3	38.2	58.8
	3	4	10.3	11.8	70.6
	4	5	12.8	14.7	85.3
	5	4	10.3	11.8	97.1
	12	1	2.6	2.9	100.0
	Total	34	87.2	100.0	
Missing	No response	4	10.3		
	System	1	2.6		
	Total	5	12.8		
Total		39	100.0		

Weighing machine - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.6	3.6	3.6
	1	6	15.4	21.4	25.0
	2	11	28.2	39.3	64.3
	3	4	10.3	14.3	78.6
	4	3	7.7	10.7	89.3

	5	2	5.1	7.1	96.4
	10	1	2.6	3.6	100.0
	Total	28	71.8	100.0	
Missing	No response	8	20.5		
	Not applicable	2	5.1		
	System	1	2.6		
	Total	11	28.2		
Total		39	100.0		

Weighing machine - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	4.2	4.2
	Yes	22	56.4	91.7	95.8
	No	1	2.6	4.2	100.0
	Total	24	61.5	100.0	
Missing	No response	14	35.9		
	Not applicable	1	2.6		
	Total	15	38.5		
Total		39	100.0		

Autoclave or other sterilization method - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	9	23.1	32.1	32.1
	1	15	38.5	53.6	85.7
	2	2	5.1	7.1	92.9

	3	1	2.6	3.6	96.4
	5	1	2.6	3.6	100.0
	Total	28	71.8	100.0	
Missing	No response	9	23.1		
	Not applicable	1	2.6		
	System	1	2.6		
	Total	11	28.2		
Total		39	100.0		

Autocave or other sterilization method - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.6	6.7	6.7
	1	11	28.2	73.3	80.0
	2	1	2.6	6.7	86.7
	3	1	2.6	6.7	93.3
	5	1	2.6	6.7	100.0
	Total	15	38.5	100.0	
Missing	No response	13	33.3		
	Not applicable	10	25.6		
	System	1	2.6		
	Total	24	61.5		
Total		39	100.0		

Autoclave or other sterilization method - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	7.1	7.1
	Yes	10	25.6	71.4	78.6
	No	2	5.1	14.3	92.9
	Don't know	1	2.6	7.1	100.0
	Total	14	35.9	100.0	
Missing	No response	19	48.7		
	Not applicable	6	15.4		
	Total	25	64.1		
Total		39	100.0		

**Cold chain equipment for vaccines & drugs (Thermometer/Temperature & drugs) -
How many?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	20	51.3	52.6	55.3
	1.0	1	2.6	2.6	57.9
	No	16	41.0	42.1	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Cold chain equipment for vaccines & drugs (Thermometer/Temperature & drugs) - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	6	15.4	60.0	60.0
	2	3	7.7	30.0	90.0
	5	1	2.6	10.0	100.0
	Total	10	25.6	100.0	
Missing	No response	12	30.8		
	Not applicable	16	41.0		
	System	1	2.6		
	Total	29	74.4		
Total		39	100.0		

Cold chain equipment for vaccines & drugs (Thermometer/Temperature & drugs) - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	8.3	8.3
	Yes	10	25.6	83.3	91.7
	No	1	2.6	8.3	100.0
	Total	12	30.8	100.0	
Missing	No response	18	46.2		
	Not applicable	9	23.1		
	Total	27	69.2		
Total		39	100.0		

Cold chain equipment for vaccines & drugs (Temperature registers) - How many?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	9.1	9.1
Yes	3	7.7	27.3	36.4
No	7	17.9	63.6	100.0
Total	11	28.2	100.0	
Missing No response	28	71.8		
Total	39	100.0		

Cold chain equipment for vaccines & drugs (Temperature registers) - # in working order

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0	1	2.6	33.3	33.3
1	1	2.6	33.3	66.7
5	1	2.6	33.3	100.0
Total	3	7.7	100.0	
Missing No response	29	74.4		
Not applicable	6	15.4		
System	1	2.6		
Total	36	92.3		
Total	39	100.0		

Cold chain equipment for vaccines & drugs (Temperature registers) - Reliability?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	33.3	33.3

	Yes	2	5.1	66.7	100.0
	Total	3	7.7	100.0	
Missing	No response	32	82.1		
	Not applicable	4	10.3		
	Total	36	92.3		
Total		39	100.0		

Vaccine cold boxes - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	12	30.8	38.7	38.7
	1	8	20.5	25.8	64.5
	2	2	5.1	6.5	71.0
	3	3	7.7	9.7	80.6
	5	1	2.6	3.2	83.9
	7	1	2.6	3.2	87.1
	10	2	5.1	6.5	93.5
	15	1	2.6	3.2	96.8
	30	1	2.6	3.2	100.0
	Total	31	79.5	100.0	
Missing	No response	7	17.9		
	System	1	2.6		
	Total	8	20.5		
Total		39	100.0		

Vaccine cold boxes - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	7	17.9	43.8	43.8
	2	2	5.1	12.5	56.3
	3	3	7.7	18.8	75.0
	5	1	2.6	6.3	81.3
	10	1	2.6	6.3	87.5
	15	1	2.6	6.3	93.8
	30	1	2.6	6.3	100.0
	Total	16	41.0	100.0	
Missing	No response	11	28.2		
	Not applicable	11	28.2		
	System	1	2.6		
	Total	23	59.0		
Total		39	100.0		

Vaccine cold boxes - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	7.1	7.1
	Yes	12	30.8	85.7	92.9
	No	1	2.6	7.1	100.0
	Total	14	35.9	100.0	
Missing	No response	19	48.7		
	Not applicable	6	15.4		
	Total	25	64.1		

Total	39	100.0		

Vaccine ice packs - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	7	17.9	20.0	20.0
	1	1	2.6	2.9	22.9
	2	2	5.1	5.7	28.6
	3	1	2.6	2.9	31.4
	4	2	5.1	5.7	37.1
	6	1	2.6	2.9	40.0
	7	1	2.6	2.9	42.9
	8	4	10.3	11.4	54.3
	10	5	12.8	14.3	68.6
	11	2	5.1	5.7	74.3
	12	1	2.6	2.9	77.1
	14	1	2.6	2.9	80.0
	16	1	2.6	2.9	82.9
	19	1	2.6	2.9	85.7
	24	1	2.6	2.9	88.6
	32	1	2.6	2.9	91.4
	43	1	2.6	2.9	94.3
	45	1	2.6	2.9	97.1
	100	1	2.6	2.9	100.0
	Total	35	89.7	100.0	
Missing	No response	3	7.7		
	System	1	2.6		

Total	4	10.3		
Total	39	100.0		

Vaccine ice packs - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	2	5.1	8.7	8.7
	3	1	2.6	4.3	13.0
	4	2	5.1	8.7	21.7
	6	1	2.6	4.3	26.1
	8	3	7.7	13.0	39.1
	10	5	12.8	21.7	60.9
	11	3	7.7	13.0	73.9
	12	1	2.6	4.3	78.3
	14	1	2.6	4.3	82.6
	24	1	2.6	4.3	87.0
	32	1	2.6	4.3	91.3
	43	1	2.6	4.3	95.7
	45	1	2.6	4.3	100.0
	Total	23	59.0	100.0	
Missing	No response	8	20.5		
	Not applicable	7	17.9		
	System	1	2.6		
	Total	16	41.0		
Total		39	100.0		

Vaccine ice packs - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	6.7	6.7
	Yes	14	35.9	93.3	100.0
	Total	15	38.5	100.0	
Missing	No response	20	51.3		
	Not applicable	4	10.3		
	Total	24	61.5		
Total		39	100.0		

Vaccine carrier - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	4	10.3	11.8	11.8
	1	9	23.1	26.5	38.2
	2	9	23.1	26.5	64.7
	3	5	12.8	14.7	79.4
	4	1	2.6	2.9	82.4
	5	1	2.6	2.9	85.3
	8	1	2.6	2.9	88.2
	10	1	2.6	2.9	91.2
	12	1	2.6	2.9	94.1
	23	2	5.1	5.9	100.0
	Total	34	87.2	100.0	
Missing	No response	4	10.3		
	System	1	2.6		
	Total	5	12.8		

Total	39	100.0		

Vaccine carrier - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	12.8	20.8	20.8
	2	7	17.9	29.2	50.0
	3	5	12.8	20.8	70.8
	4	1	2.6	4.2	75.0
	5	1	2.6	4.2	79.2
	8	1	2.6	4.2	83.3
	10	1	2.6	4.2	87.5
	12	1	2.6	4.2	91.7
	23	2	5.1	8.3	100.0
	Total	24	61.5	100.0	
Missing	No response	10	25.6		
	Not applicable	4	10.3		
	System	1	2.6		
	Total	15	38.5		
Total		39	100.0		

Vaccine carrier - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	6.3	6.3
	Yes	15	38.5	93.8	100.0
	Total	16	41.0	100.0	

Missing	No response	20	51.3		
	Not applicable	3	7.7		
	Total	23	59.0		
Total		39	100.0		

Delivery (Mama) kits - How many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.9	2.9
	0	1	2.6	2.9	5.7
	1	1	2.6	2.9	8.6
	Yes	6	15.4	17.1	25.7
	11	1	2.6	2.9	28.6
	No	25	64.1	71.4	100.0
	Total	35	89.7	100.0	
Missing	No response	4	10.3		
Total		39	100.0		

Delivery (Mama) kits - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	2.6	33.3	33.3
	2	1	2.6	33.3	66.7
	6	1	2.6	33.3	100.0
	Total	3	7.7	100.0	
Missing	No response	13	33.3		
	Not applicable	22	56.4		

System	1	2.6		
Total	36	92.3		
Total	39	100.0		

Delivery (Mama) kits - Reliability?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	12.5	12.5
Yes	3	7.7	37.5	50.0
No	3	7.7	37.5	87.5
It has finis	1	2.6	12.5	100.0
Total	8	20.5	100.0	
Missing No response	24	61.5		
Not applicable	7	17.9		
Total	31	79.5		
Total	39	100.0		

Long lasting insecticidal nets (LLINs) - How many?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.7	2.7
0	1	2.6	2.7	5.4
1	1	2.6	2.7	8.1
Yes	22	56.4	59.5	67.6
No	11	28.2	29.7	97.3
22	1	2.6	2.7	100.0
Total	37	94.9	100.0	

Missing	No response	2	5.1		
Total		39	100.0		

Long lasting insecticidal nets (LLINs) - # in working order

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	2.6	8.3	8.3
	3	1	2.6	8.3	16.7
	4	1	2.6	8.3	25.0
	6	1	2.6	8.3	33.3
	16	1	2.6	8.3	41.7
	20	1	2.6	8.3	50.0
	24	1	2.6	8.3	58.3
	42	1	2.6	8.3	66.7
	50	1	2.6	8.3	75.0
	70	1	2.6	8.3	83.3
	125	1	2.6	8.3	91.7
	160	1	2.6	8.3	100.0
	Total	12	30.8	100.0	
Missing	No response	12	30.8		
	Not applicable	14	35.9		
	System	1	2.6		
	Total	27	69.2		
Total		39	100.0		

Long lasting insecticidal nets (LLINs) - Reliability?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	7.1	7.1
	Yes	10	25.6	71.4	78.6
	No	2	5.1	14.3	92.9
	It has finis	1	2.6	7.1	100.0
	Total	14	35.9	100.0	
Missing	No response	19	48.7		
	Not applicable	6	15.4		
	Total	25	64.1		
Total		39	100.0		

Albendazole tablets - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	23	59.0	60.5	63.2
	No	14	35.9	36.8	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Albendazole tablets - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	4.2	4.2

	Yes	3	7.7	12.5	16.7
	No	20	51.3	83.3	100.0
Total		24	61.5	100.0	
Missing	No response	1	2.6		
	Not applicable	14	35.9		
	Total	15	38.5		
Total		39	100.0		

Albendazole tablets - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.1	3.1
	Yes	16	41.0	50.0	53.1
	No	15	38.5	46.9	100.0
	Total	32	82.1	100.0	
Missing	No response	6	15.4		
	Not applicable	1	2.6		
	Total	7	17.9		
Total		39	100.0		

Amoxicillin capsules 500mg - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	11	28.2	28.9	31.6
	11	1	2.6	2.6	34.2
	No	25	64.1	65.8	100.0

Total	38	97.4	100.0
Missing No response	1	2.6	
Total	39	100.0	

Amoxicillin capsules 500mg - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	7.7	7.7
No	12	30.8	92.3	100.0
Total	13	33.3	100.0	
Missing No response	1	2.6		
Not applicable	25	64.1		
Total	26	66.7		
Total	39	100.0		

Amoxicillin capsules 500mg - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.8	3.8
Yes	14	35.9	53.8	57.7
No	11	28.2	42.3	100.0
Total	26	66.7	100.0	
Missing No response	12	30.8		
Not applicable	1	2.6		
Total	13	33.3		
Total	39	100.0		

Chlorhexidine - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	29	74.4	74.4	76.9
No	9	23.1	23.1	100.0
Total	39	100.0	100.0	

Chlorhexidine - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.8	3.8
Yes	1	2.6	3.8	7.7
No	23	59.0	88.5	96.2
22	1	2.6	3.8	100.0
Total	26	66.7	100.0	
Missing				
No response	3	7.7		
Not applicable	10	25.6		
Total	13	33.3		
Total	39	100.0		

Chlorhexidine - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.1	3.1
Yes	13	33.3	40.6	43.8

	No	18	46.2	56.3	100.0
	Total	32	82.1	100.0	
Missing	No response	6	15.4		
	Not applicable	1	2.6		
	Total	7	17.9		
Total		39	100.0		

Condoms - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	36	92.3	92.3	94.9
No	2	5.1	5.1	100.0
Total	39	100.0	100.0	

Condoms - Quantity available (pcs)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	2.6	20.0	20.0
	2	1	2.6	20.0	40.0
	17	1	2.6	20.0	60.0
	90	1	2.6	20.0	80.0
	164	1	2.6	20.0	100.0
	Total	5	12.8	100.0	
Missing	No response	33	84.6		
	System	1	2.6		
	Total	34	87.2		

Total	39	100.0		

Condoms - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.1	3.1
Yes	4	10.3	12.5	15.6
No	27	69.2	84.4	100.0
Total	32	82.1	100.0	
Missing				
No response	5	12.8		
Not applicable	2	5.1		
Total	7	17.9		
Total	39	100.0		

Condoms - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.9	2.9
Yes	7	17.9	20.0	22.9
No	27	69.2	77.1	100.0
Total	35	89.7	100.0	
Missing				
No response	4	10.3		
Total	39	100.0		

Contraceptive, (oral and injectables) - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	33	84.6	84.6	87.2
No	5	12.8	12.8	100.0
Total	39	100.0	100.0	

Contraceptive, (oral and injectables) - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.4	3.4
Yes	2	5.1	6.9	10.3
No	26	66.7	89.7	100.0
Total	29	74.4	100.0	
Missing				
No response	5	12.8		
Not applicable	5	12.8		
Total	10	25.6		
Total	39	100.0		

Contraceptive, (oral and injectables) - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.3	3.3
Yes	8	20.5	26.7	30.0
No	21	53.8	70.0	100.0
Total	30	76.9	100.0	
Missing				
No response	9	23.1		

Total	39	100.0		

IUCDs - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.7	2.7
Yes	14	35.9	37.8	40.5
No	22	56.4	59.5	100.0
Total	37	94.9	100.0	
Missing No response	2	5.1		
Total	39	100.0		

IUCDs - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	6.3	6.3
Yes	1	2.6	6.3	12.5
No	14	35.9	87.5	100.0
Total	16	41.0	100.0	
Missing No response	4	10.3		
Not applicable	19	48.7		
Total	23	59.0		
Total	39	100.0		

IUCDs - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.7	3.7
	Yes	11	28.2	40.7	44.4
	No	15	38.5	55.6	100.0
	Total	27	69.2	100.0	
Missing	No response	11	28.2		
	Not applicable	1	2.6		
	Total	12	30.8		
Total		39	100.0		

Implant (contraceptive) - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	23	59.0	60.5	63.2
	No	14	35.9	36.8	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Implant (contraceptive) - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	4.8	4.8
	No	20	51.3	95.2	100.0

	Total	21	53.8	100.0
Missing	No response	4	10.3	
	Not applicable	14	35.9	
	Total	18	46.2	
Total		39	100.0	

Implant (contraceptive) - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.3	3.3
Yes	10	25.6	33.3	36.7
No	19	48.7	63.3	100.0
Total	30	76.9	100.0	
Missing	No response	8	20.5	
	Not applicable	1	2.6	
Total	9	23.1		
Total	39	100.0		

Cotrimazazole tablets 80mg - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	17	43.6	43.6	46.2
No	21	53.8	53.8	100.0
Total	39	100.0	100.0	

Cotrimazazole tablets 80mg - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	5.9	5.9
	No	15	38.5	88.2	94.1
	22	1	2.6	5.9	100.0
	Total	17	43.6	100.0	
Missing	No response	1	2.6		
	Not applicable	21	53.8		
	Total	22	56.4		
Total		39	100.0		

Cotrimazazole tablets 80mg - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.3	3.3
	Yes	18	46.2	60.0	63.3
	No	11	28.2	36.7	100.0
	Total	30	76.9	100.0	
Missing	No response	9	23.1		
Total		39	100.0		

Coartem (or otherACT) - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	33	84.6	84.6	87.2

No	5	12.8	12.8	100.0
Total	39	100.0	100.0	

Coartem (or otherACT) - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.7	3.7
Yes	1	2.6	3.7	7.4
No	25	64.1	92.6	100.0
Total	27	69.2	100.0	
Missing				
No response	6	15.4		
Not applicable	6	15.4		
Total	12	30.8		
Total	39	100.0		

Coartem (or otherACT) - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.2	3.2
Yes	12	30.8	38.7	41.9
No	17	43.6	54.8	96.8
Don't know	1	2.6	3.2	100.0
Total	31	79.5	100.0	
Missing				
No response	7	17.9		
Not applicable	1	2.6		
Total	8	20.5		

Total	39	100.0		

Diazepam injection for ivi, rectal use - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	5	12.8	13.2	15.8
No	32	82.1	84.2	100.0
Total	38	97.4	100.0	
Missing No response	1	2.6		
Total	39	100.0		

Diazepam injection for ivi, rectal use - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	14.3	14.3
No	6	15.4	85.7	100.0
Total	7	17.9	100.0	
Missing No response	1	2.6		
Not applicable	31	79.5		
Total	32	82.1		
Total	39	100.0		

Diazepam injection for ivi, rectal use - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid		1	2.6	3.6	3.6
	Yes	22	56.4	78.6	82.1
	No	5	12.8	17.9	100.0
	Total	28	71.8	100.0	
Missing	No response	8	20.5		
	Not applicable	3	7.7		
	Total	11	28.2		
Total		39	100.0		

Ergometrine - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	14	35.9	36.8	39.5
	No	23	59.0	60.5	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Ergometrine - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	7.7	7.7
	No	12	30.8	92.3	100.0
	Total	13	33.3	100.0	
Missing	No response	3	7.7		

Not applicable	23	59.0		
Total	26	66.7		
Total	39	100.0		

Ergometrine - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.6	3.6
Yes	15	38.5	53.6	57.1
No	12	30.8	42.9	100.0
Total	28	71.8	100.0	
Missing No response	9	23.1		
Not applicable	2	5.1		
Total	11	28.2		
Total	39	100.0		

Ferrous sulphate/iron/folic acid - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	27	69.2	71.1	73.7
No	10	25.6	26.3	100.0
Total	38	97.4	100.0	
Missing Not applicable	1	2.6		
Total	39	100.0		

Ferrous sulphate/iron/folic acid - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	4.0	4.0
Yes	1	2.6	4.0	8.0
No	23	59.0	92.0	100.0
Total	25	64.1	100.0	
Missing				
No response	4	10.3		
Not applicable	10	25.6		
Total	14	35.9		
Total	39	100.0		

Ferrous sulphate/iron/folic acid - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.7	3.7
Yes	11	28.2	40.7	44.4
No	15	38.5	55.6	100.0
Total	27	69.2	100.0	
Missing				
No response	10	25.6		
Not applicable	2	5.1		
Total	12	30.8		
Total	39	100.0		

Intravenous fluids - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid		1	2.6	2.6	2.6
	Yes	23	59.0	60.5	63.2
	No	14	35.9	36.8	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Intravenous fluids - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	4.3	4.3
	No	22	56.4	95.7	100.0
	Total	23	59.0	100.0	
Missing	No response	3	7.7		
	Not applicable	13	33.3		
	Total	16	41.0		
Total		39	100.0		

Intravenous fluids - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.7	3.7
	Yes	11	28.2	40.7	44.4
	No	15	38.5	55.6	100.0
	Total	27	69.2	100.0	
Missing	No response	9	23.1		

	Not applicable	3	7.7		
	Total	12	30.8		
Total		39	100.0		

MgSO4 - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	7	17.9	18.4	21.1
	No	29	74.4	76.3	97.4
	22	1	2.6	2.6	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

MgSO4 - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	12.5	12.5
	Yes	1	2.6	12.5	25.0
	No	6	15.4	75.0	100.0
	Total	8	20.5	100.0	
Missing	No response	2	5.1		
	Not applicable	29	74.4		
	Total	31	79.5		
Total		39	100.0		

MgSO4 - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.4	3.4
Yes	24	61.5	82.8	86.2
No	4	10.3	13.8	100.0
Total	29	74.4	100.0	
Missing				
No response	8	20.5		
Not applicable	2	5.1		
Total	10	25.6		
Total	39	100.0		

Misoprostol - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	25	64.1	64.1	66.7
No	13	33.3	33.3	100.0
Total	39	100.0	100.0	

Misoprostol - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	4.3	4.3
No	22	56.4	95.7	100.0
Total	23	59.0	100.0	

Missing	No response	3	7.7		
	Not applicable	13	33.3		
	Total	16	41.0		
Total		39	100.0		

Misoprostol - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.0	3.0
	Yes	18	46.2	54.5	57.6
	No	14	35.9	42.4	100.0
	Total	33	84.6	100.0	
Missing	No response	5	12.8		
	Not applicable	1	2.6		
	Total	6	15.4		
Total		39	100.0		

Oral rehydration therapy - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	16	41.0	41.0	43.6
	No	22	56.4	56.4	100.0
	Total	39	100.0	100.0	

Oral rehydration therapy - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	6.3	6.3
	No	15	38.5	93.8	100.0
	Total	16	41.0	100.0	
Missing	No response	3	7.7		
	Not applicable	20	51.3		
	Total	23	59.0		
Total		39	100.0		

Oral rehydration therapy - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.2	3.2
	Yes	23	59.0	74.2	77.4
	No	6	15.4	19.4	96.8
	Don't know	1	2.6	3.2	100.0
	Total	31	79.5	100.0	
Missing	No response	6	15.4		
	Not applicable	2	5.1		
	Total	8	20.5		
Total		39	100.0		

Oxytocin (pitocin, syntocinon) - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	22	56.4	57.9	60.5
	No	15	38.5	39.5	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Oxytocin (pitocin, syntocinon) - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	4.5	4.5
	Yes	1	2.6	4.5	9.1
	No	20	51.3	90.9	100.0
	Total	22	56.4	100.0	
Missing	No response	2	5.1		
	Not applicable	15	38.5		
	Total	17	43.6		
Total		39	100.0		

Oxytocin (pitocin, syntocinon) - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.4	3.4
	Yes	12	30.8	41.4	44.8

	No	16	41.0	55.2	100.0
	Total	29	74.4	100.0	
Missing	No response	9	23.1		
	Not applicable	1	2.6		
	Total	10	25.6		
Total		39	100.0		

Paracetamol paediatric elixir - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	20	51.3	51.3	53.8
No	18	46.2	46.2	100.0
Total	39	100.0	100.0	

Paracetamol paediatric elixir - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	4.8	4.8
No	19	48.7	90.5	95.2
22	1	2.6	4.8	100.0
Total	21	53.8	100.0	
Missing	Not applicable	18	46.2	
Total	39	100.0		

Paracetamol paediatric elixir - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.4	3.4
	Yes	14	35.9	48.3	51.7
	No	13	33.3	44.8	96.6
	Don't know	1	2.6	3.4	100.0
	Total	29	74.4	100.0	
Missing	No response	8	20.5		
	Not applicable	2	5.1		
	Total	10	25.6		
Total		39	100.0		

Paralehyde IMI 5 mls - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	1	2.6	2.6	5.3
	No	36	92.3	94.7	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Paralehyde IMI 5 mls - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	33.3	33.3

	No	2	5.1	66.7	100.0
	Total	3	7.7	100.0	
Missing	No response	2	5.1		
	Not applicable	34	87.2		
	Total	36	92.3		
Total		39	100.0		

Paralehyde IMI 5 mls - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.2	3.2
Yes	25	64.1	80.6	83.9
11	1	2.6	3.2	87.1
No	4	10.3	12.9	100.0
Total	31	79.5	100.0	
Missing	No response	8	20.5	
Total	39	100.0		

Pethidine 500mg/1 ml injection - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	1	2.6	2.6	5.1
No	37	94.9	94.9	100.0
Total	39	100.0	100.0	

Pethidine 500mg/1 ml injection - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	25.0	25.0
No	3	7.7	75.0	100.0
Total	4	10.3	100.0	
Missing Not applicable	35	89.7		
Total	39	100.0		

Pethidine 500mg/1 ml injection - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.3	3.3
Yes	24	61.5	80.0	83.3
No	4	10.3	13.3	96.7
Don't know	1	2.6	3.3	100.0
Total	30	76.9	100.0	
Missing No response	7	17.9		
Not applicable	2	5.1		
Total	9	23.1		
Total	39	100.0		

Quinine - 600mg in 10ml vial - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	6	15.4	15.4	17.9

No	32	82.1	82.1	100.0
Total	39	100.0	100.0	

Quinine - 600mg in 10ml vial - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	14.3	14.3
No	6	15.4	85.7	100.0
Total	7	17.9	100.0	
Missing No response	1	2.6		
Not applicable	31	79.5		
Total	32	82.1		
Total	39	100.0		

Quinine - 600mg in 10ml vial - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.4	3.4
Yes	22	56.4	75.9	79.3
No	6	15.4	20.7	100.0
Total	29	74.4	100.0	
Missing No response	8	20.5		
Not applicable	2	5.1		
Total	10	25.6		
Total	39	100.0		

Sulphadoxine with pyrimethamine - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	25	64.1	64.1	66.7
No	13	33.3	33.3	100.0
Total	39	100.0	100.0	

Sulphadoxine with pyrimethamine - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	4.5	4.5
Yes	1	2.6	4.5	9.1
No	20	51.3	90.9	100.0
Total	22	56.4	100.0	
Missing				
No response	4	10.3		
Not applicable	13	33.3		
Total	17	43.6		
Total	39	100.0		

Sulphadoxine with pyrimethamine - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.4	3.4
Yes	6	15.4	20.7	24.1
No	22	56.4	75.9	100.0
Total	29	74.4	100.0	

Missing	No response	9	23.1		
	Not applicable	1	2.6		
	Total	10	25.6		
Total		39	100.0		

Vitamin K injection 1 mg in 0.5 or 1 ml - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	8	20.5	20.5	23.1
No	30	76.9	76.9	100.0
Total	39	100.0	100.0	

Vitamin K injection 1 mg in 0.5 or 1 ml - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	10.0	10.0
Yes	2	5.1	20.0	30.0
No	7	17.9	70.0	100.0
Total	10	25.6	100.0	
Missing	Not applicable	29	74.4	
Total	39	100.0		

Vitamin K injection 1 mg in 0.5 or 1 ml - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.2	3.2
Yes	23	59.0	74.2	77.4
No	7	17.9	22.6	100.0
Total	31	79.5	100.0	
Missing				
No response	7	17.9		
Not applicable	1	2.6		
Total	8	20.5		
Total	39	100.0		

Water for injection 10ml vial - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	16	41.0	41.0	43.6
No	22	56.4	56.4	100.0
Total	39	100.0	100.0	

Water for injection 10ml vial - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	6.3	6.3
No	15	38.5	93.8	100.0
Total	16	41.0	100.0	
Missing				
No response	1	2.6		

	Not applicable	22	56.4		
	Total	23	59.0		
Total		39	100.0		

Water for injection 10ml vial - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.9	2.9
	Yes	19	48.7	54.3	57.1
	No	15	38.5	42.9	100.0
	Total	35	89.7	100.0	
Missing	No response	4	10.3		
Total		39	100.0		

Vitamin A - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	20	51.3	52.6	55.3
	No	17	43.6	44.7	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Vitamin A - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	4.8	4.8
No	20	51.3	95.2	100.0
Total	21	53.8	100.0	
Missing				
No response	2	5.1		
Not applicable	16	41.0		
Total	18	46.2		
Total	39	100.0		

Vitamin A - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.2	3.2
Yes	17	43.6	54.8	58.1
No	13	33.3	41.9	100.0
Total	31	79.5	100.0	
Missing				
No response	7	17.9		
Not applicable	1	2.6		
Total	8	20.5		
Total	39	100.0		

Zinc tablets - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6

	Yes	12	30.8	31.6	34.2
	No	25	64.1	65.8	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Zinc tablets - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	7.1	7.1
	No	13	33.3	92.9	100.0
	Total	14	35.9	100.0	
Missing	No response	1	2.6		
	Not applicable	24	61.5		
	Total	25	64.1		
Total		39	100.0		

Zinc tablets - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.3	3.3
	Yes	15	38.5	50.0	53.3
	No	14	35.9	46.7	100.0
	Total	30	76.9	100.0	
Missing	No response	8	20.5		
	Not applicable	1	2.6		

Total	9	23.1		
Total	39	100.0		

BCG - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.7	2.7
Yes	28	71.8	75.7	78.4
No	8	20.5	21.6	100.0
Total	37	94.9	100.0	
Missing				
No response	1	2.6		
Not applicable	1	2.6		
Total	2	5.1		
Total	39	100.0		

BCG - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.7	3.7
Yes	16	41.0	59.3	63.0
No	10	25.6	37.0	100.0
Total	27	69.2	100.0	
Missing				
No response	3	7.7		
Not applicable	9	23.1		
Total	12	30.8		
Total	39	100.0		

BCG - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.2	3.2
	Yes	8	20.5	25.8	29.0
	No	22	56.4	71.0	100.0
	Total	31	79.5	100.0	
Missing	No response	7	17.9		
	Not applicable	1	2.6		
	Total	8	20.5		
Total		39	100.0		

DPT - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.8	2.8
	Yes	24	61.5	66.7	69.4
	No	11	28.2	30.6	100.0
	Total	36	92.3	100.0	
Missing	No response	3	7.7		
Total		39	100.0		

DPT - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.7	3.7
Yes	14	35.9	51.9	55.6
No	12	30.8	44.4	100.0
Total	27	69.2	100.0	
Missing				
No response	1	2.6		
Not applicable	11	28.2		
Total	12	30.8		
Total	39	100.0		

DPT - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.3	3.3
Yes	9	23.1	30.0	33.3
No	20	51.3	66.7	100.0
Total	30	76.9	100.0	
Missing				
No response	8	20.5		
Not applicable	1	2.6		
Total	9	23.1		
Total	39	100.0		

Hepatitis B - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid		1	2.6	2.8	2.8
	Yes	27	69.2	75.0	77.8
	No	8	20.5	22.2	100.0
	Total	36	92.3	100.0	
Missing	No response	3	7.7		
Total		39	100.0		

Hepatitis B - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.4	3.4
	Yes	15	38.5	51.7	55.2
	No	13	33.3	44.8	100.0
	Total	29	74.4	100.0	
Missing	No response	2	5.1		
	Not applicable	8	20.5		
	Total	10	25.6		
Total		39	100.0		

Hepatitis B - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.3	3.3
	Yes	8	20.5	26.7	30.0
	No	21	53.8	70.0	100.0
	Total	30	76.9	100.0	

Missing	No response	8	20.5		
	Not applicable	1	2.6		
	Total	9	23.1		
Total		39	100.0		

Measles - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.8	2.8
	Yes	28	71.8	77.8	80.6
	No	7	17.9	19.4	100.0
	Total	36	92.3	100.0	
Missing	No response	3	7.7		
Total		39	100.0		

Measles - Expired?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.4	3.4
	Yes	15	38.5	51.7	55.2
	No	13	33.3	44.8	100.0
	Total	29	74.4	100.0	
Missing	No response	3	7.7		
	Not applicable	7	17.9		
	Total	10	25.6		
Total		39	100.0		

Measles - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.3	3.3
Yes	8	20.5	26.7	30.0
No	21	53.8	70.0	100.0
Total	30	76.9	100.0	
Missing				
No response	8	20.5		
Not applicable	1	2.6		
Total	9	23.1		
Total	39	100.0		

Polio - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.7	2.7
Yes	28	71.8	75.7	78.4
No	8	20.5	21.6	100.0
Total	37	94.9	100.0	
Missing				
No response	2	5.1		
Total	39	100.0		

Polio - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.6	3.6

	Yes	13	33.3	46.4	50.0
	No	14	35.9	50.0	100.0
	Total	28	71.8	100.0	
Missing	No response	3	7.7		
	Not applicable	8	20.5		
	Total	11	28.2		
Total		39	100.0		

Polio - Stock out in the last six months?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.3	3.3
	Yes	9	23.1	30.0	33.3
	No	20	51.3	66.7	100.0
	Total	30	76.9	100.0	
Missing	No response	8	20.5		
	Not applicable	1	2.6		
	Total	9	23.1		
Total		39	100.0		

Tetanus toxoid - Available?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.6	2.6
	Yes	29	74.4	76.3	78.9
	No	8	20.5	21.1	100.0

	Total	38	97.4	100.0
Missing	No response	1	2.6	
	Total	39	100.0	

Tetanus toxoid - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.6	3.6
Yes	14	35.9	50.0	53.6
No	13	33.3	46.4	100.0
Total	28	71.8	100.0	
Missing	No response	3	7.7	
	Not applicable	8	20.5	
Total	11	28.2		
Total	39	100.0		

Tetanus toxoid - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.4	3.4
Yes	6	15.4	20.7	24.1
No	22	56.4	75.9	100.0
Total	29	74.4	100.0	
Missing	No response	9	23.1	
	Not applicable	1	2.6	
Total	10	25.6		

Total	39	100.0		

Yellow Fever Vaccine - Available?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.7	2.7
Yes	28	71.8	75.7	78.4
No	8	20.5	21.6	100.0
Total	37	94.9	100.0	
Missing No response	2	5.1		
Total	39	100.0		

Yellow Fever Vaccine - Expired?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.7	3.7
Yes	13	33.3	48.1	51.9
No	13	33.3	48.1	100.0
Total	27	69.2	100.0	
Missing No response	4	10.3		
Not applicable	8	20.5		
Total	12	30.8		
Total	39	100.0		

Yellow Fever Vaccine - Stock out in the last six months?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.7	3.7
Yes	5	12.8	18.5	22.2
No	21	53.8	77.8	100.0
Total	27	69.2	100.0	
Missing				
No response	10	25.6		
Not applicable	2	5.1		
Total	12	30.8		
Total	39	100.0		

Are storage facilities for commodities adequate?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.8	2.8
Yes	27	69.2	75.0	77.8
No	8	20.5	22.2	100.0
Total	36	92.3	100.0	
Missing				
No response	3	7.7		
Total	39	100.0		

How often does the facility get fresh supplies of drugs?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Every week	5	12.8	13.2	15.8

	Every months	14	35.9	36.8	52.6
	Every quarter	8	20.5	21.1	73.7
	Cannot recall last time received	2	5.1	5.3	78.9
	Any time	1	2.6	2.6	81.6
	Bi-monthly	4	10.3	10.5	92.1
	Every 2 months	2	5.1	5.3	97.4
	Yearly	1	2.6	2.6	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

How often does the facility get fresh supplies of vaccines?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.7	2.7
Every week	22	56.4	59.5	62.2
Every months	7	17.9	18.9	81.1
Cannot recall last time received	2	5.1	5.4	86.5
Don't know	1	2.6	2.7	89.2
Bi-monthly	1	2.6	2.7	91.9
Depend on vaccine utiliza	1	2.6	2.7	94.6
Every 2 months	1	2.6	2.7	97.3
Every 2 weeks	1	2.6	2.7	100.0
Total	37	94.9	100.0	
Missing	No response	2	5.1	
Total	39	100.0		

Does your facility experience stock outs?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.7	2.7
Every week	6	15.4	16.2	18.9
Every months	7	17.9	18.9	37.8
Every quarter	6	15.4	16.2	54.1
Cannot recall last time received	6	15.4	16.2	70.3
Don't know	3	7.7	8.1	78.4
Bi-monthly	1	2.6	2.7	81.1
Depend on drug not often	1	2.6	2.7	83.8
Depend on stock level	1	2.6	2.7	86.5
No	1	2.6	2.7	89.2
Some quarterly, yearly	1	2.6	2.7	91.9
Sometimes	1	2.6	2.7	94.6
Stock out not frequent	1	2.6	2.7	97.3
Stockout are rare	1	2.6	2.7	100.0
Total	37	94.9	100.0	
Missing No response	2	5.1		
Total	39	100.0		

Is there a system in place that tracks the medicines coming in and out of the pharmacy

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6

	Yes	24	61.5	63.2	65.8
	No	13	33.3	34.2	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

Is 'on-hand' inventory checked on a regular basis? i.e. pull expired, counts

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Every week	10	25.6	25.6	28.2
Every months	18	46.2	46.2	74.4
Every quarter	5	12.8	12.8	87.2
Cannot recall last time received	1	2.6	2.6	89.7
Don't know	3	7.7	7.7	97.4
Daily	1	2.6	2.6	100.0
Total	39	100.0	100.0	

Are patients counseled when being dispensed their medication?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	33	84.6	84.6	84.6
?	2	5.1	5.1	89.7
Yes	3	7.7	7.7	97.4
No	1	2.6	2.6	100.0
Total	39	100.0	100.0	

Does the pharmacy have appropriate reference books/tools?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	12	30.8	31.6	34.2
No	25	64.1	65.8	100.0
Total	38	97.4	100.0	
Missing No response	1	2.6		
Total	39	100.0		

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

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	28	71.8	71.8	74.4
No	10	25.6	25.6	100.0
Total	39	100.0	100.0	

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

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	32	82.1	82.1	82.1
?	1	2.6	2.6	84.6
Yes	3	7.7	7.7	92.3
No	3	7.7	7.7	100.0

Total	39	100.0	100.0

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

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	34	87.2	87.2	89.7
No	4	10.3	10.3	100.0
Total	39	100.0	100.0	

If community outreach activities were carried out, how many?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	12.8	16.1	16.1
	2	4	10.3	12.9	29.0
	3	5	12.8	16.1	45.2
	4	8	20.5	25.8	71.0
	6	2	5.1	6.5	77.4
	7	1	2.6	3.2	80.6
	11	1	2.6	3.2	83.9
	12	4	10.3	12.9	96.8
	16	1	2.6	3.2	100.0
	Total	31	79.5	100.0	
Missing	No response	5	12.8		
	Not applicable	2	5.1		
	System	1	2.6		

Total	8	20.5		
Total	39	100.0		

Are 'health talks' (group lectures or discussions with clients) held regularly?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	37	94.9	94.9	97.4
No	1	2.6	2.6	100.0
Total	39	100.0	100.0	

Is some record kept for each consultation?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	33	84.6	86.8	89.5
No	4	10.3	10.5	100.0
Total	38	97.4	100.0	
Missing No response	1	2.6		
Total	39	100.0		

Is this record updated?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes, for all consultation	30	76.9	78.9	81.6

	Yes, for some consultation	3	7.7	7.9	89.5
	No	4	10.3	10.5	100.0
	Total	38	97.4	100.0	
Missing	No response	1	2.6		
Total		39	100.0		

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

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.0	3.0
Yes	4	10.3	12.1	15.2
No	28	71.8	84.8	100.0
Total	33	84.6	100.0	
Missing	No response	6	15.4	
Total	39	100.0		

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

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0	26	66.7	83.9	83.9
1	1	2.6	3.2	87.1
3	1	2.6	3.2	90.3
7	1	2.6	3.2	93.5
9	1	2.6	3.2	96.8
16	1	2.6	3.2	100.0
Total	31	79.5	100.0	
Missing	No response	6	15.4	

	Not applicable	1	2.6		
	System	1	2.6		
	Total	8	20.5		
Total		39	100.0		

Are there any medical records?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	3.0	3.0
	Yes	29	74.4	87.9	90.9
	No	2	5.1	6.1	97.0
	6	1	2.6	3.0	100.0
	Total	33	84.6	100.0	
Missing	No response	6	15.4		
Total		39	100.0		

Are there any immunization records?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	2.6	2.7	2.7
	Yes	36	92.3	97.3	100.0
	Total	37	94.9	100.0	
Missing	No response	2	5.1		
Total		39	100.0		

Are there any ANC records?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	35	89.7	92.1	94.7
No	2	5.1	5.3	100.0
Total	38	97.4	100.0	
Missing No response	1	2.6		
Total	39	100.0		

Are there any delivery records?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	27	69.2	69.2	71.8
No	11	28.2	28.2	100.0
Total	39	100.0	100.0	

Are there any child (U5) register?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.9	2.9
Yes	14	35.9	41.2	44.1
No	19	48.7	55.9	100.0
Total	34	87.2	100.0	
Missing No response	5	12.8		
Total	39	100.0		

Are there any Rx dispensing report?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.7	2.7
Yes	18	46.2	48.6	51.4
No	18	46.2	48.6	100.0
Total	37	94.9	100.0	
Missing No response	2	5.1		
Total	39	100.0		

In what condition is the record card system?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.8	2.8
No records	2	5.1	5.6	8.3
Well ordered	26	66.7	72.2	80.6
Partially ordered, still useable	7	17.9	19.4	100.0
Total	36	92.3	100.0	
Missing No response	3	7.7		
Total	39	100.0		

Who is responsible for keeping client records?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6

All health staff	18	46.2	46.2	48.7
One person	18	46.2	46.2	94.9
In charge of each unit	1	2.6	2.6	97.4
OC or CHEW	1	2.6	2.6	100.0
Total	39	100.0	100.0	

If one person is responsible for keeping client records, specify position?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	6.3	6.3
A Volunteer Staff	1	2.6	6.3	12.5
Each unit head has his own records	1	2.6	6.3	18.8
Health Information Technician	1	2.6	6.3	25.0
HIM Officer	1	2.6	6.3	31.3
In charge	5	12.8	31.3	62.5
In-charge	1	2.6	6.3	68.8
M&E Officer	3	7.7	18.8	87.5
Medical Record Officer	1	2.6	6.3	93.8
Record Officer	1	2.6	6.3	100.0
Total	16	41.0	100.0	
Missing				
No response	6	15.4		
999	17	43.6		
Total	23	59.0		
Total	39	100.0		

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

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes always	12	30.8	31.6	34.2
Yes sometimes	11	28.2	28.9	63.2
No	14	35.9	36.8	100.0
Total	38	97.4	100.0	
Missing No response	1	2.6		
Total	39	100.0		

Is there a daily activity register?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.6	2.6
Yes	33	84.6	86.8	89.5
No	4	10.3	10.5	100.0
Total	38	97.4	100.0	
Missing No response	1	2.6		
Total	39	100.0		

What is the target population covered by the centre_1?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	2.9	2.9
105	1	2.6	2.9	5.9
111	1	2.6	2.9	8.8

	146	1	2.6	2.9	11.8
	1556	1	2.6	2.9	14.7
	164	1	2.6	2.9	17.6
	241	1	2.6	2.9	20.6
	253	1	2.6	2.9	23.5
	300	1	2.6	2.9	26.5
	315	1	2.6	2.9	29.4
	317	1	2.6	2.9	32.4
	328	1	2.6	2.9	35.3
	330	1	2.6	2.9	38.2
	334	1	2.6	2.9	41.2
	343	1	2.6	2.9	44.1
	35	1	2.6	2.9	47.1
	Don't know	6	15.4	17.6	64.7
	40	1	2.6	2.9	67.6
	419	1	2.6	2.9	70.6
	444	1	2.6	2.9	73.5
	512	1	2.6	2.9	76.5
	524	1	2.6	2.9	79.4
	550	1	2.6	2.9	82.4
	552	1	2.6	2.9	85.3
	58	1	2.6	2.9	88.2
	737	1	2.6	2.9	91.2
	738	1	2.6	2.9	94.1
	861	1	2.6	2.9	97.1
	92	1	2.6	2.9	100.0
	Total	34	87.2	100.0	
Missing	No response	5	12.8		

Total	39	100.0		

What is the target population covered by the centre_2?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.3	3.3
100	1	2.6	3.3	6.7
1133	1	2.6	3.3	10.0
1140	1	2.6	3.3	13.3
1585	1	2.6	3.3	16.7
1670	1	2.6	3.3	20.0
1756	1	2.6	3.3	23.3
2095	1	2.6	3.3	26.7
2099	1	2.6	3.3	30.0
249	1	2.6	3.3	33.3
2760	1	2.6	3.3	36.7
3696	1	2.6	3.3	40.0
3961	1	2.6	3.3	43.3
Don't know	9	23.1	30.0	73.3
4095	1	2.6	3.3	76.7
4306	1	2.6	3.3	80.0
4499	1	2.6	3.3	83.3
457	1	2.6	3.3	86.7
470	1	2.6	3.3	90.0
4708	1	2.6	3.3	93.3
728	1	2.6	3.3	96.7
978	1	2.6	3.3	100.0
Total	30	76.9	100.0	

Missing	No response	9	23.1		
Total		39	100.0		

What is the target population covered by the centre_3?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.0	3.0
10068	1	2.6	3.0	6.1
119	1	2.6	3.0	9.1
1300	1	2.6	3.0	12.1
1334	1	2.6	3.0	15.2
1337	1	2.6	3.0	18.2
1393	1	2.6	3.0	21.2
1650	1	2.6	3.0	24.2
1837	1	2.6	3.0	27.3
1857	1	2.6	3.0	30.3
2039	1	2.6	3.0	33.3
2305	1	2.6	3.0	36.4
2516	1	2.6	3.0	39.4
2816	1	2.6	3.0	42.4
2886	1	2.6	3.0	45.5
3036	1	2.6	3.0	48.5
396	1	2.6	3.0	51.5
Don't know	8	20.5	24.2	75.8
4065	1	2.6	3.0	78.8
4202	1	2.6	3.0	81.8
4736	1	2.6	3.0	84.8
73	1	2.6	3.0	87.9

	802	1	2.6	3.0	90.9
	89	1	2.6	3.0	93.9
	900	2	5.1	6.1	100.0
	Total	33	84.6	100.0	
Missing	No response	6	15.4		
Total		39	100.0		

What is the target population covered by the centre_4?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.6	3.1	3.1
10475	1	2.6	3.1	6.3
11440	1	2.6	3.1	9.4
13117	1	2.6	3.1	12.5
13750	1	2.6	3.1	15.6
13800	1	2.6	3.1	18.8
16332	1	2.6	3.1	21.9
18,000	1	2.6	3.1	25.0
18194	1	2.6	3.1	28.1
18479	1	2.6	3.1	31.3
21530	1	2.6	3.1	34.4
3536	1	2.6	3.1	37.5
3640	1	2.6	3.1	40.6
Don't know	9	23.1	28.1	68.8
460	1	2.6	3.1	71.9
5192	1	2.6	3.1	75.0
6077	1	2.6	3.1	78.1

	6330	1	2.6	3.1	81.3
	7500	1	2.6	3.1	84.4
	7880	1	2.6	3.1	87.5
	7920	1	2.6	3.1	90.6
	8350	1	2.6	3.1	93.8
	8440	1	2.6	3.1	96.9
	9290	1	2.6	3.1	100.0
	Total	32	82.1	100.0	
Missing	No response	7	17.9		
Total		39	100.0		

c) Key Informant Interviews Notes

Key Informant Interviews with 100 Women Group Members

1. How was your group formed? What is/are the objective(s) of the group (Probe: Who helped you to organize your group?)

The group was formed across the 20 LGAs in Bauchi state. CBOs. Faith Based Organizations came together to form the 100 women groups. Each LGA had these groups. Last year we formed a state group (2014). TSHIP helped us to form this group. We have a coordinator here in Bauchi city, who coordinates all the groups.

2. What is your linkage with TSHIP Project?

Our relationship with TSHIP is very cordial. They provided a series of trainings, about four. We came for quarterly review meetings. They trained us on record keeping. Budget tracking and good governance. Income generation skills. We were doing just advocacy and awareness raising. TSHIP took us beyond this. Strengthening business skills and management. Record keeping and reporting. We reported at the quarterly meetings on our activities and accomplishments.

3. Have you been trained by TSHIP? • What did they train you on? See above

• How have you or your members used the training?

We are practicing the skills that they taught. They help solve problems on the ground. We want to know how to keep records and document our work. These are necessary.

Now we keep records. Since TSHIP has trained us we keep attendance at meetings. We take minutes on meetings. We track funds and record transactions. Before we did not know how to do this.

4. How can you describe the financial status of your members before (the group did not exist before TSHIP) TSHIP and with TSHIP intervention?

Before we did not contribute anything. TSHIP trained us how to contribute monthly. We set aside monthly and put it in the bank. We opened an account. TSHIP taught us how to do this. We registered the 100 women group as a body, with the help of TSHIP.

5. Have your group been able to secure loan from any source? Name the Source. How have you used the loan?

Not yet. We have tried. Bauchi state government linked us with the Bauchi State Microfinance Bank, but it did not work. We are still working on this. There are talks. We are waiting to be assessed.

[Do you think you will succeed?] “We are going to try”

6. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how have these roles affect health-seeking behavior in your community?

The work of TSHIP is for women and children to strengthen their health. Normally our women deliver at home.

Because of this misoprostol and chlorhexidine are necessary and good. Since TSHIP has gotten women to attend ANC and HF. If you go to the hospital you will see many changes. TSHIP supplied equipment and trained staff.

[Are men accepting these changes?] Yes. They are accepting. They allow their wives to go to HF.

7. What is the most significant health change you observed in your community due to TSHIP intervention? Explain.

Child spacing. Before no one wanted this. It is not stopping giving birth. It is giving the woman a rest. Men now understand the benefit to the mother, the father and the child. The men, now they know. "Even when the men do not know, the women find a way." We used drama to teach this. We invited men to watch. They came and watched. They saw the dangers of not allowing their wives to go for child spacing.

Without child spacing there are too many children too fast. They do not go to school. What can they do? They go to beg.

8. What are the things you feel TSHIP could have done better for your group?

We want more TSHIP. TSHIP changed our lives. We want microcredit. If women get small, small loan. Women with income can send their children to school, but books.

We want more projects on health. Women would know more about their health.

Other comments: There is one group in each LGA. Each group sends two people, president and secretary, to quarterly review meetings. These representatives train members back in the LGA.

[How will continue these meeting without THIP?] "We will contribute. We cannot stop it. We want more knowledge. TSHIP has given me the courage to speak in public to many different kinds of people."

Key Informant Interviews with Development Partners

(WHO, UNICEF, EMERGENCY OPERATIONS CENTER (EOC))

1. What health outcomes did you see from TSHIP project?

The major outcome is improvement in child survival through RI. There is improvement, but there is need for more effort. The state must sustain the improvements and build on them. The new government must pick this up.

If we look at the polio program in the state, for 23 months now there is no polio case (WPV) in the state. TSHIP contributed to this. We have been meeting all the requirement for surveillance in the state. TSHIP's major contributions were in training and supervision.

TSHIP has done a lot in the last five years to change the lives of people in Bauchi. What I have observed is a change in health seeking behavior at the community level. We work hand-in-hand with TSHIP. We collaborate on polio and we see less resistance in TSHIP communities. The health facility improvements TSHIP has worked on have helped.

We sometimes see people revert back to old behaviors, but TSHIP has changed health systems, and this will last longer. There is community ownership of the changes.

RI status. If you go to the LGAs you will see outreach. They go to places that others can't penetrate, the most remote. Once I saw them get 100 previously unimmunized children in a remote hamlet. I saw Life Helpers [TSHIP sub grantee] in action and was impressed.

Also the CBHVs. There was some overlap with our community mobilizers. So TSHIP collaborated in separating out some women working for both.

We have coordinating meetings monthly, along with the EOC (polio Emergency Operations Center) meetings weekly.

Birth Registration has been a very successful component. Inclusion in the system is important. The Population Commission has done well. TSHIP helped drive this and promote it.

Without TSHIP the state workers will revert back to their old habits. Some CBHVs will carry on.

TSHIP has been working since the inception to strengthen HS here. Here in Sokoto health services are not under one roof. This fragmentation means we do not see all of what TSHIP does. I learned about CBHV program when TSHIP midterm evaluation asked me about them. I doubt that I will see any changes from TSHIP five years from now. I score TSHIP very low on communication with our agency.

2. What interactions did you have with TSHIP?

At the initial stage immunizations were under SPHCDA. The state's immunizations were all consolidated under EOC, polio, RI, all. All the stakeholders were included. TSHIP was a major partner.

TSHIP was involved in planning, operational activities, IPDs (ten per year), outbreak responses. TSHIP was involved in implementation and evaluation.

TSHIP provided TA in RI. M&E. Supportive Supervision.

Meetings were held every two months for the state task force for immunizations. TSHIP participated in these, COP or DCOP.

Next level meetings are the strategic technical group. Met as needed by circumstances.

There are work plans for polio, RI, etc.

Operational working group: met every two weeks.

Under that were the sub-working groups: Financial, Logistics (vaccine security, cold chain, included TSHIP), Training working group (TSHIP), Social Mobilization working group (TSHIP). M&E & supervision working group (TSHIP). Sub-working groups meet twice a month.

We are collaborating with them very well. We have the state interagency forum. We all meet and discuss and plan. In policy, the state originates and we must adhere and promote. We can and do advocate, together more than apart. We would invite TSHIP. At the LGA levels there was good collaboration. It is integrated. Planning: There were monthly, scheduled meetings. At the state level we meet twice weekly (EOC) in large gathering, including both us and TSHIP. For IPV activities we met every day.

Capacity Building: Training of personnel, especially polio. State, LGA and Ward level trainings.

Workplans: We coordinate to avoid duplication and guarantee coverage.

Gender: We observed TSHIP engaged in gender activities.

Service Delivery: Immunizations. Surveillance. DQS (data quality surveys) for immunizations. Also RI. "We are trying to make a change in the coverage."

Planning: Yes.

Trainings: Yes. Including some with FOMWAN.

Work plans Yes. They did the Immunization work plan together.

Gender: Yes, and this is difficult. CBHVs are important in this. The sub grantees also contributed to this. Teaching men to help with chores when women deliver. Getting men to support ANC. It has not worked as well with deliveries outside the home.

Service Delivery: No.

Twice weekly coordination partners meetings.

TSHIP is a member of EOC. We plan immunization program together. TSHIP has bailed us out of problems, e.g., ice pack shortage.

Trainings: TSHIP conducts A LOT of trainings, but few with us. Only immunization.

Gender. Have not seen.

Service Delivery: TSHIP engaged teams for immunization campaigns, and outreach for routine immunizations.

3. Could TSHIP's collaboration with other partners been better?

I would like to see improvements in some areas. They could have communicated better at the beginning. The EOC meetings solved this problem mostly. EOC meets once a week minimum; more as needed, sometimes even daily. I would like to see TSHIP work with us at the activity level. They could extend WHO's reach and that would help immensely.

Prior to the establishment of the EOC TSHIP would sometimes move ahead without carrying along the state. The establishment of EOC fixed this.

TSHIP would have done more to interact with SBPHCDA and HMB. They could have collaborated with the state more. "Our only wish for TSHIP is for it to last longer. TSHIP took responsibility, so many instances."

They should use more sub grantees to support CBHVs. Where they are supported, CBHVs perform better. The sub grantees make a big difference.

Yes. More communication. Especially with other state partners. They could have one better involving other partners in their activities.

4. What recommendations will you make for future programming?

HR. If TSHIP could help with the staffing and training of health personnel. This is a big problem. TSHIP has helped very much with building capacity of health workers, but there is much more to do.

Community participation in health activities. TSHIP has helped but, again, there is great need. CBHVs. WDCs.

The Tripartite, now Quadripartite, structure has taken over some of the roles of TSHIP. What would be best would be for what is in existence to be enhanced, rather than a new project. So a new TSHIP might have more limited role in immunizations and USAID would take this up directly.

Tripartite: Gates, Bauchi State, Dangote Foundation. Later joined by USAID. USAID does not contribute to the basket fund, but contributes technical assistance. I would include other states. It should cover the other states that are similar to Sokoto and Bauchi. "TSHIP [in Sokoto] is well targeted." "Mother and Child health has really improved."

TSHIP was very independent. This is good. If you allow the state government to interfere too much, the program will suffer.

TSHIP produces genuine data, the state not so much.

The communities should be the direct beneficiaries of the project.

Some health services fall under SMOH and some under MLG, and this causes many problems. Kano is an example where they fixed that.

I recommend that the project management should be embedded in the SMOH, and should be mandated to work closely with the state. They should not act independently, as they have.

They can copy the operations of agencies like UNICEF. We know everything that UNICEF is doing.

If there is close collaboration then problems will be dealt with earlier and more effectively.

"No more surprises."

Focus more on RI. It is THE problem.

Focus more on the quality of data.

At the beginning of the project they should aim toward sustainability. TSHIP activities are not sustainable.

Themes: Development partners had positive experience with TSHIP as reflected in most of the answers to the interview questions show. The EOC in both states had some negative comments concerning TSHIP's communications and collaboration with the EOC. Some of this seemed to be directed at USAID as much as TSHIP.

Key Informant Interviews Focus States Strategy Partners

LEAD, SIDHAS, NEI, DELIVER

1. What interactions did you have with TSHIP?

- Planning
- Policies
- Capacity Building
- Work plans Strategic plans etc.
- Regular, scheduled or ad-hoc interactions
- Gender First and foremost we are both USAID projects in targeted states. We therefore needed to create an environment for collaboration. There is an aspect of health that is governance. We had to cooperate. We attended each others' meetings, especially planning meetings. Most of our stakeholders in common. We planned together. We have a strong relationship maintained throughout implementation. TSHIP concentrated on health; LEAD had a role in this.

We had work planning meetings every year. We also attended each others' workshops. Our strongest collaboration was in Community Mobilization, especially WDCs

In the first place NEI, LEAD and TSHIP were all part of FSS in Bauchi and Sokoto. We had a common understanding. "We are here to support each other and leverage on what we do together." TSHIP was accommodating NEI from day one. They helped us get started, even to giving us room to work. We held joint COP meetings, monthly at first and then quarterly, spearheaded by LEAD. Beyond that we need to talk to MEMS1 to guide us with indicators to measure how we collaborated. This did not work out as hoped. What we did internally among ourselves was to share our quarterly work plans. We could build on this easily. We also invited each other to our work planning exercises, and cooperated on schedules, activities etc. We used the teacher-training platform to advocate for RI.

We participate, and sometimes host, the IP meetings. At a more direct level, at the implementation level there are a lot of intersections between SIDHAS and TSHIP. In all the 41 sites that we are supporting we see the footsteps of TSHIP. We see their work in rehabbed facilities, ANC attendance, HMIS. So while we do not have joint programming, we do see their impact and benefit from their work. TSHIP produced an ANC booklet with the SMOH. We made a lot of recommendations and instead of producing one of our own, we will contribute to the next one.

Setting priorities is done together. This is a big collaboration

LEAD had to depend on TSHIP for help with LEAD's health portfolio.

Great care was taken to avoid duplication and overlap in LGA and WDC levels

- Planning yes
- Policies yes TSHIP provides policy frameworks in health; LEAD helps bring them about through advocacy

- Work plans Strategic plans etc. “We work on them together.”
- Regular, scheduled or ad-hoc interactions: Monthly at first, now quarterly, and as needed.
- Gender Integration Yes. We work together on gender

We do logistics. We focus on areas where TSHIP is working, to make sure commodities are there. We mostly work on FP commodities. FMOH supplies contraceptives. DELIVER also moves malaria commodities. DELIVER/TSHIP do joint trainings on contraceptive logistics. No policy interaction. No joint work planning. There are regular, scheduled meetings (bi monthly) to coordinate, and other meetings as activities call for them

2. What activities did you implement with TSHIP?

- Advocacy
- Others please mention

We did not really implement activities together, but pieces of them. We had IP meetings regularly. Hosting of the meeting rotated among the major projects. We did gender mainstreaming together. TSHIP did a survey on gender mainstreaming, and wanted us to participate but it did not happen.

TSHIP used WDCs. For us, our program was more systems strengthening, only for education. We did not cover the whole state, only ten LGAs. In each LGA only ten centers. We set up Community Coalitions. We asked TSHIP to include them in their WDC activities, to represent education program and serve as a resource.

Adolescent RH: We set up vulnerable groups. We brought in TSHIP to help us with this, give technical guidance. This was integrated into our program. Also worked on girls sanitation/hygiene (pads)

- Work planning
- 100 women group (was done together)
- WDCs
- LEAD did budget strategy with TSHIP 2010-11

Just commodity logistics.

3. How did the process of collaboration evolve?

- What drove the process?
- Formal or informal or both?

The collaboration was formal and informal, both. I wish the collaboration had been stronger and more.

Very consistent collaboration. Initially we wanted to harmonize the work plans. Look for areas of synergy. That did not really happen. Part of this was due to scheduling conflicts.

Both formal and informal. USAID asked for it. We wanted it.

The collaboration became stronger over the life of the project. We are working for the same goals, in the same places, but not on the same aspects. We need each other. We ensure that we work together for quality services to the clients.

4. What outcomes did you see from focus state strategy collaboration with TSHIP and others?

The biggest outcome for me was the recent focus by TSHIP on health governance. Education and governance must be a part of any health project. This gave LEAD a role, through LGAs, WDCs.

I think that the FSS is one of the best strategies that came out of USAID. Bringing LEAD, TSHIP and NEI together at the same time achieved more that they would have without it. Harmonizing sectors and goals works well. I think FSS has worked well.

We launched on the same day. Each time we met with the state government, we could have joint meetings or presentations. This gave us more strength and credibility. It increased our effectiveness. Also helped in joint planning. Each project was asked to demonstrate in concrete terms, successes. FSS helped with this.

It is not palpable. It is not obvious. One would expect to see more. More of an additive or synergistic effect. But I do not see it.

“It works. It is very helpful.”

“Health and Education do not go well without governance doing well.”

Without TSHIP there is going to be a really big problem. There are issues cropping up already. The state needs someone to push before they will perform. TSHIP has tried to put some sustainability plans on the ground. We are trying to help. We are advocating for the release of funds after TSHIP is done.

Working together makes us both stronger. I do not know much about FSS. It is a name I have heard. We work together because it is good for us and improves quality service to clients. Without collaboration there is duplication and confusion. It also saves costs and time.

5. Did you collaborate with TSHIP on health systems strengthening?

If yes what did you do?

What was the result of the collaboration?

No. We just started that recently and did not collaborate with TSHIP on that.

No. That was their thematic area. We both did SS, but NEI did not do HSS.

No.

Advocacy, especially in the area of HR

Strengthen the budget systems.

This worked well

Yes. Commodities logistics.

6. How could TSHIP have collaborated better with other partners?

What could they have done differently? The have a set of wonderful staff. Unofficially we see each other all the time. TSHIP staff reached out to LEAD. We had a strong relationship. Officially, we worked together closely. At the end there was an exodus of staff. The changing of COPs took a toll on TSHIP's smooth operations. There

was instability. The last COP dealt with this but by then the project was close to ending.

For me, I think that TSHIP could have done better if we had a written, expressly-stated agreement. We wanted to see how TSHIP could use our schools as a platform for delivering health information. That could not happen for bureaucratic reasons. But overall TSHIP was very helpful.

I think that this is not just a TSHIP problem. It could have been better if there were a common framework. Sort of an MOU among the USAID funded projects. It should be practical as well as strategic. There should be a harmony among the different work plans. It bothers me going to a HF and running into TSHIP staff, each of us with our own vehicles. This is unnecessary and not productive. NEI, w/health educators. UNICEF Pathfinder, ENGENDER Health.

We all come together, have meetings. Issues come out.

When TSHIP came on ground, they should not have done anything without consulting local communities.

TSHIP needed to talk more with Government, not just SMOH.

TSHIP should have spent more time in the communities. They should have followed up more. I would have like to see more real community level involvement.

7. Was there a gender aspect to your collaboration with TSHIP?

We did gender mainstreaming together. TSHIP did a survey on gender mainstreaming, and wanted us to participate but it did not happen. There was a change of leadership and the idea floundered.

Yes. There was a joint committee set up for gender. We produced a document/plan on how to move forward. We all participated in technical meetings, presentations, etc.

Not at all. The hundred women group was a gender activity. They did a lot of work for the health sector. Especially ANC, labor and delivery.

8. What recommendations will you make for future programming? I cannot say much on that as a non-health person. Programmatically I was not too involved. The only thing I can say with a strong voice is about the community level interventions. They should continue with that. This worked very well. In terms of facilities and hospitals, there are big problems with HR and maintenance. A new project should work on building the skills of personnel, and work on getting the HFs staffed at appropriate levels.

“There is hope for sustainability for the three FSS projects in Bauchi and Sokoto.”

FSS. If you can pull the three projects into one project, it would be huge. This was tried under COMPASS and it was cumbersome. Better plan would be a joint indicator or indicators, maybe in policy and advocacy, or perhaps data. This would compel synergy, and get past the negotiating stage.

The main interventions should stay the same. USAID should stick it out until the state is fully capable. More use of local NGOs. More use of local traditional and religious leaders.

There were too many changes at COP level. The project got off to a slow start.

Participation of the host communities, both state government and local communities. Right from the design of the project. Next I would consider the issue of the consortium. Consortia slow down project startup. They work out their differences on project time. The statewide coverage of the project was good. The idea of FSS and unifying the projects is good. I would not change the focus states strategy. I would strengthen it. It has worked.

“I think that TSHIP was the right size.” It was not too big. They covered the whole state, and that was good.

More community involvement. Most of their work and strategies should be community based. Work with the services (ANC, RI, FP, RH, CH) at the level of service.

(Key Informant Interviews with State Officials)

Question 1. What is the most significant change in the health care system in the state due to contribution of TSHIP (addressing weaknesses, building on strengths, and leveraging on opportunities)?

- HMIS
- M&E
- Capacity building
- Community Participation/WDCs
- Malaria case management
- ISS
- LLINs
- CDI+
- FP/RH
- MNCH/ANC
- Health facilities renovation
- MNCH/ANC
- Health facilities renovation
- HMIS
- Capacity building
- Community Participation/WDCs
- Provision and maintenance of lifesaving equipment
- Kangaroo care
- EOC/AMTSL
- Established HREC
- The creation of HREC has streamlined, organized, and created a database of data and research.
- MNCH/ANC
- Service delivery integration
- RI
- HMIS
- Community participation/WDCs
- CBHVs
- Health facilities renovation
- HSS
- Misoprostol/Chlorhexidine
- Rewrite essential drugs list
- Provision and maintenance of lifesaving equipment

- Established DMMA
- HMIS
- Capacity building
- The area of HMIS. Definitely the biggest change. We were having a lot of problems collecting data from offices/HFs. Through TSHIP we turned this around.
- Interagency/state collaboration
- Evidence-based budgeting
- Policy formulation
- Misoprostol/Chlorhexidine
- Essential drugs list
- Community participation/WDCs
- Establishing DMMA
- CBHVs
- MNCH/ANC
- RI
- It has introduced new dimensions in health care delivery. Not business as usual. Health facilities are doing things differently. This has improved health care services especially in maternal health and immunizations.
- MNCH/ANC
- Misoprostol/Chlorhexidine
- Community participation/WDCs
- LLINs
- Provision and maintenance of lifesaving equipment
- ORT corners
- Sub-grantees
- HMIS
- Birth registration
- FP/RH
- HMIS
- Formed Health Data Consultative Committee
- MNCH/ANC
- Community participation/WDCs
- Kangaroo care
- CHBVs
- HSS
- HMIS
- Capacity building

- Provision and maintenance of lifesaving equipment
- Before TSHIP we had only paper reporting. Now we have computerized system. We are trained. Everyone is producing data. We learned more and more. Big change.
- mixed
- Establishing HREC
- Interagency/state collaboration
- Misoprostol/chlorhexidine
- Community participation/WDCs
- Developing State Health Strategic Plan
- CBHVs
- MNCH/ANC
- Health facilities renovation
- Capacity building
- Community participation/WDCs
- Provision and maintenance of lifesaving equipment
- [uncertain] There are gaps in capacity in the state. Some things TSHIP did, they did because the state staff could not. TSHIP tried to build the capacity of staff in the state to take these roles, but not fully. Abdullahi Hussan, Dir. Primary Health Care, Ministry of Local Government [uncertain]
- "We are in the process now."
- Interagency/state collaboration
- Evidence-based budgeting
- Establishing DMMA
- FP/RH
- Established HREC
- HMIS
- Community participation/WDCs
- Attended deliveries
- Due to intense social and community mobilization there is a change in community participation in health.
- Establishing HREC
- HSS
- Capacity building
- Community participation/WDCs
- Birth registration
- Community participation/WDCs
- Health facilities renovation
- Established HREC

- Misoprostol/chlorhexidine
- RI
- HMIS
- Capacity building
- Provision and maintenance of lifesaving equipment
- ISS
- Developed State Health Strategic Plan
- Established DMMA
- ORT corners
- HR for Health Policy

Themes: The most frequently mentioned changes in the health care system were community participation, with 11 responses, HMIS with ten, MNHC/ANC with 7 and provision of misoprostol/chlorhexidine and provision of lifesaving equipment at six each. Health facility renovation and the establishment of the Health Research Ethics committee received five mentions each. Establishment of DMMA and the CBHV program followed with four each. Interagency/state collaboration, HSS and RI received three mentions each. Nine program areas were cited twice: rewriting the essential drugs list, evidence-based budgeting, policy formulation, birth registration, integrated supportive supervision, LLINs distribution, kangaroo care, development of the State Health Strategic Plan, and ORT corners at health facilities. Nine program areas were mentioned once: M&E, service delivery integration, forming the Health Data Consultative Committee, malaria case management, EOC/AMTSL, sub-grantees (local NGOs, CSOs), development of the draft HR for Health Policy, and attended deliveries.

Question 2. How has TSHIP intervention contributed to MDGs Goals 4 and 5 in the state?

- Capacity building
- Malaria case management
- TSHIP trained, but did not bring commodities. What good is training in malaria without drugs and nets? We have a gap of ACTs. Drugs take time to arrive from national level. We need more commodities. Without them training is wasted.
- MNCH/ANC
- CBHVs
- HF renovation
- Capacity building
- Community participation/WDCs
- MNCH/ANC
- HF renovation
- Service delivery integration
- Kangaroo Care
- EOC/AMTSL MNCH/ANC

- Capacity building
- Misoprostol/Chlorhexidine
- ISS
- TSHIP worked hard in MNCH, ANC. They trained at all levels. TSHIP reached every ward. TSHIP got state to give more and more supportive supervision. Bauchi is now one of the top at giving supportive supervision.
- TSHIP has played a major role in reducing maternal mortality. The misoprostol/chlorhexidine intervention is excellent
- Capacity building
- Pre-service training
- Service delivery integration
- They introduced community midwifery and the college of nursing science. This increased access to quality health care. They have done well in that.
- Capacity building
- Community participation/ WDCs
- Misoprostol/Chlorhexidine
- Capacity building of health care providers has made a big difference. Provision of misoprostol and chlorhexidine. The reactivation of WDCs has helped in referrals and attendance in the rural areas. This took more than a year to get them really functioning. NCH/ANC
- HF renovation
- Capacity building
- Community participation/WDCs
- Service delivery integration
- Malaria case management
- Misoprostol/chlorhexidine
- Capacity building
- Service delivery integration
- Policy formulation
- It has improved the process. It has improved the facilities. It has improved the capacity of the officials to handle health issues in Sokoto. It has improved attitudes. Helped in organizing a series of trainings. Importation of new ideas that improved. Health care delivery system.
- MNCH/ANC
- Misoprostol/chlorhexidine
- LLINs
- ORT corners
- EOC/ emergency trolleys
- There has been a reduction in maternal deaths. With the introduction of Misoprostol and chlorhexidine deaths went down.
- Policy formulation

- HMIS/M&E
- Birth registration
- Identification of data. Evidence. Policy changes come from evidence which come from data. We collected a lot of data that raised a lot of eyebrows. People asked questions. Where did these deaths come from? What is the main cause of death? The figures were high.

No answer

- Misoprostol/chlorhexidine
- Family Planning
- HMIS/M&E
- Attended deliveries
- Malaria case management
- Misoprostol/Chlorhexidine
- ORT corners
- They were able to do many trainings and improve the capacity of all levels of health care providers, so that they provide better service.
- HMIS/M&E
- Because we use the data, we analyze it. We learn from it. We identify problems. We process it. All because of TSHIP.
- [mixed • Service delivery integration
- Misoprostol/chlorhexidine
- Birth registrations
- ORT corners/zinc
- Maternal death review (started in 2010 but faltered). We are working on a protocol for the state and on developing legislation. No answer
- Dr. Robinson Yusuf, Director of Medical Services, Standing in for the Acting Permanent Secretary, SMOH [uncertain] There are gaps in capacity in the state. Some things TSHIP did, they did because the state staff could not. TSHIP tried to build the capacity of staff in the state to take these roles, but not fully. Abdullahi Hussan, Dir. Primary Health Care, Ministry of Local Government [uncertain]
- "We are in the process now."
- No answer
- MNCH/ANC
- CBHVs
- Attended deliveries
- Misoprostol/chlorhexidine
- The data show significant improvement (esp RI), but surveys show little improvement. The surveys do not reflect the investment that has been made by many partners. There is a reduction in both maternal and child mortality.
- MNCH/ANC

- Capacity building
- Misoprostol/chlorhexidine
- Provision and maintenance of lifesaving equipment
- Capacity building
- Provision and maintenance of lifesaving equipment
- Misoprostol/Chlorhexidine
- MNCH/ANC
- HF renovation
- Capacity building
- ISS
- Provision and maintenance of lifesaving equipment
- HSS
- ORT corners
- Whatever [TSHIP] did, they did within the framework of the MDGs and the state strategic health development plan.

Themes: An analysis of the frequency of responses shows that capacity building and the distribution of misoprostol/chlorhexidine were most mentioned by respondents at ten times apiece. MNCH/ANC followed with eight. ORT corners and service delivery integration came next at five each. Four respondents listed health facility renovations. Community participation, malaria case management and the provision and maintenance of lifesaving equipment got three mentions apiece. All the rest were cited either twice or only one time each and include: attended deliveries, policy formulation, HMIS/M&E, birth registration, ISS, pre-service training, kangaroo care, family planning, LLIN distribution, EOC/AMTSL, and HSS.

Question 3. What do you know about the effectiveness of TSHIP in improving the quality of the services in the state in terms of supporting coordination, monitoring and supervision, policy development/implementation? What could TSHIP have done better?

- For us they improved:
 - M&E
 - ISS
 - We did not do policy work together
 - HSS
 - Policy, Health Strategic Plan, Minimum Health Care Package, Maternal Audit legislation
 - Capacity Building
 - The trainings/workshops in policy and advocacy were very helpful. They helped get systems organized.
 - SBMR
 - Policy (Health Strategic Plan

- ISS
- Integrated Supportive Supervision is very important. We have integrated this into our systems. There was a series of trainings before the program started. We define gaps; make a plan to treat the gaps.
- Established HREC
- Policy
- TSHIP has organized and improved how research is done and approved in Sokoto.
- ISS
- TSHIP was essential in supportive supervision improvements here.
- Adding Miso/Chlor
- Better procurement systems (DMMA)
- Rational use of drugs
- TSHIP collaborated well with my department. "TSHIP came with its own mandate. They should have planned with the state. Both sides harmonize now, but not at the beginning."
- Policy, established HREC, created DMMA, Minimum Health Care package, HR for Health, many others
- ISS
- Service delivery integration
- Interagency/state collaboration
- Rewrote essential drugs list
- Gender integration
- "TSHIP strengthened the referral system."
- Health facility renovation
- Renovation of clinics and dispensaries—I wish they could have done more. More engagement with the state assembly. More use of State Assembly in planning and budgeting.
- Community distribution of misoprostol /chlorhexidine
- Policy, essential drugs list, DMMA
- HMIS
- "In terms of monitoring, TSHIP has supported my agency. For the first year TSHIP supported our M&E heavily. They trained us. They helped with establishing policy. They rebuilt HMIS."
- Policy
- ISS
- Policy & supervision. Yes, as I said, new approach. End of business as usual.
- [could have done better:] Avoiding running a parallel system. When partnership is closer, ownership is easier.
- We saw this from a distance. We did not participate. We would like to have benefited from this. There is a special unit within TSHIP for policy. They worked with us. Not much happened. We would like to see more of the sub grantees. More with misoprostol and Chlorhexidine. We are worried what will happen without them [TSHIP]

- Policy
- We find TSHIP very responsive to our own plight. Before TSHIP we had a document of gender national policy. Many pieces were not applicable to us. So we started developing our own policy. TSHIP was valuable in giving us technical assistance and training. They helped me personally. They helped our staff. They helped us develop our gender policy document. The gender policy is all-inclusive. It covers health, agriculture, governance, across sectors.
- They helped us with the framework for 100 women groups. TSHIP gave us the concept and helped us develop the program. We use the groups as foot soldiers for the ministry. They are change catalysts in their communities. Because of the series of trainings they have received, they are change agents. They are watchdogs for the MWA, keeping watch for problems and bringing them to our attention.
- TSHIP came to us for help for advocacy.
- HMIS
- Capacity building
- ISS
- Services must be monitored. In my area, we try to get HFs to report all services provided. This was a difficult change. People were trained and retrained. Slowly we are capturing the work of the HFs. Quality of data is getting better.
- Interagency/state collaboration
- Policy
- ISS
- They really did a lot. They did supportive supervision. They mentored. They did OJT. The state learned a lot from TSHIP on how to coordinate, monitor and supervise. They helped with policies and guidelines, strategies.
- Before TSHIP I did not know how to use email. Now I use analytical software.
- [mixed • ISS
- Policy
- HMIS
- TSHIP supported ISS at first with PHCDA and HMB. Now they are doing it with us.
- Policy. TSHIP has done a lot. Pre-service strategic plan. Community midwifery program. TSHIP began HR for health, but this has run into a major hitch and stalled. TSHIP did start early enough on this, but after challenges they let it drop. TSHIP tried to get a referral system for the state, but the policy has not seen the light of day.
- ISS
- Policy/advocacy
- TSHIP provided supportive supervision in HF and elsewhere. They promoted and facilitated midwifery services in remote villages.
- Dr. Robinson Yusuf, Director of Medical Services, Standing in for the Acting Permanent Secretary, SMOH [uncertain] There are gaps in capacity in the state. Some things TSHIP did, they did because the state staff could not. TSHIP tried to build the capacity of staff in the state to take these roles, but not fully. Abdullahi Hussan, Dir. Primary Health Care, Ministry of Local Government
[uncertain]

- "We are in the process now."
- Interagency/state collaboration
- Evidence-based budgeting
- Policy
- Health Strategic Plan
- Interagency/state collaboration
- HMIS
- ISS
- TSHIP has been supporting coordination meetings, especially RH, FP, CH. They coordinate the state in data. They support ISS.
- There were some structural problems that came to the fore. My vision as commissioner was the integration of all partners into a single whole. There was some inflexibility on the part of TSHIP to being integrated fully, a reluctance to be pulled into the state plan. We were wary of TSHIP becoming a parallel ministry. We were able to overcome most of this, but there were structural problems that prevented TSHIP from being as effective a collaborator as it could have been.
- Interagency/state collaboration
- M&E
- They have improved the use of data, and telling the state to record and maintain data. They taught the state how to use data. TSHIP and the state both included Population Commission in their workshops and meetings for M&E.
- Interagency/state collaboration
- HMIS
- Capacity building
- ISS
- Minimum Health Care Package
- They started some things that they could not finish. They could not see all of their programs through (HR for health, pre-service education)

Themes: Analysis of frequency of responses by keywords reveals that of the 23 respondents: ISS=11, policy=9, interagency/state collaboration=7, HMIS=6, capacity building=5, M&E=4, and Health Research Ethics Committee (HREC)=3. Misoprostol/Chlorhexidine, the Health Strategic Plan, DMMA, Gender, Minimum Health Care Package, and the essential drugs list were each mentioned twice. Birth registration, service delivery integration, evidence-based budgeting, HSS, SBMR and health facility renovations were each mentioned once.

Question 4. Did TSHIP collaborate with SMOH on the development of Standard Operating Procedures (SOPs) for health staff? When? Are these SOPs in use?

No	Yes
Yes	Yes
Yes	No

- Yes
 - NA
 - Yes
- DELIVER did more of them than TSHIP.
 - Yes
 - NA
 - No
 - NA
 - Yes
 - Yes
 - NA
 - Yes
 - NA
- 9. Aminu Abubakar Ibrahim, Permanent Secretary, Ministry of Budget and Economic Planning NA
- 10. Dr. MS Iabaran, Exec. Secy. SPHCDA Yes
- Mostly at the Health Facilities and lower levels.
 - Yes
 - Yes
- For health facilities mainly
 - Yes
 - Yes
 - Yes

Themes: Fifteen state officials reported that TSHIP developed or helped them to develop SOPs during the project. Three said that TSHIP had no role in this, and five said that the question did not apply to them. Among the 15 who collaborated with TSHIP on SOP development, all reported this as a positive experience. When asked if the SOPs were in current use, all said that they were.

Question 5. How has TSHIP collaborated with other organizations and projects in the state?

- Badly.
- When TSHIP came, we supported TSHIP. We were cooperative. The relationship changed with the changes in leadership at TSHIP. There were issues of territory, payment of volunteers. TSHIP paid volunteers while BACATMA did not. "It was tough." "Some of our volunteers were also their volunteers. It gave me a headache."
 - Well.
 - Well. Well.
 - No answer. Well.
- They work with MLG and LGA better. They were very collaborative. But not with Pharmacy dept so much.
 - Well. Well.
 - Well.
- Mixed. When partnering with the state, this should be done together. In the case of TSHIP, they implement workplans approved by their headquarters—by themselves.

- Well. Well.
 - Well. Well.
 - Well. No answer
 - Well. No answer
 - Well. Well
 - Well
- They made us understand that we should own the intervention ourselves. They would call and ask where are you on this? What is progress? They make us stay on task. They were pushy, but they were only making us do our job. They facilitated our collaboration with HF personnel.
 - Well.
- They were very good. They did not waste time. They were very collaborative. They worked through the SMOH, and the system.
- **Themes:** Eighteen of the state officials interviewed had a positive impression of TSHIP's collaboration. Many of them spoke highly of it. Two respondents felt negatively about it.

Question 6. What is the evidence of ownership of the interventions supported by TSHIP? Give specific examples, did this change over time?

- [state owns or will take over] "State has always owned the malaria program." [state owns or will take over]
- Uncertain [state owns or will take over]
- "It's our problem now. We are now registered at the national level to operate in Sokoto. TSHIP helped with this."
- Uncertain [state owns or will take over]
- I know they have done well at the community level with this. My department was not directly involved. Ownership in the community is strong, especially with RI and misoprostol /Chlorhexidine
- [state owns or will take over] "The activities to sustain are at the periphery. It's really SPCHDA that will own these. Looking back, the major issue is not TSHIP but the system." [state owns or will take over]
- [state owns or will take over] "The state has taken full ownership of this agency, which was started with guidance from TSHIP. The state enacted, A law to provide for the establishment of Bauchi State Drugs and Medical Consumables Management Agency and other matters connected thereto." [uncertain]
- It is difficult for me to say. The interventions all over the state must impact with the locals. What I do know is that once a new idea is brought—it is hard to go back. People will maintain what is beneficial to them.
- [TSHIP owns. [ed: hard time communicating this question] They wished that the physical property of the project had been given to them, like COMPASS did. [state owns or will take over]
- They really want to keep these activities going. The FMOH has adopted the Sokoto model for birth registration and uses it across Nigeria.
- [state owns or will own] "Before the project ended they came to us and planned this process with us. They told us that we are in the driver's seat and must take control and carry on after they leave.

The handover has funding implications. The change of government also has implications for this as well. This is a period of uncertainty. We have not received salaries for two months. We are not talking of activities now.” [state owns or will take over]

- It is our system. Not TSHIP’s.
- [state owns or will take over]
- The state will take over the CBHVs. The main body is the WDCs. The state knows they need to sustain this program. [state owns or will take over]
- When TSHIP leaves we are going to write a memo to all concerned and promise to maintain this work and ask for cooperation to keep the system working.
- [mixed] [mixed]
- There are gaps in capacity in the state. Some things TSHIP did, they did because the state staff could not. TSHIP tried to build the capacity of staff in the state to take these roles, but not fully. [mixed]
- TSHIP has helped LGAs and MLG a lot, raising our capacity to take over. “I don’t think that the state can fund these activities the way that TSHIP has done.”
- Dr. Robinson Yusuf, Director of Medical Services, Standing in for the Acting Permanent Secretary, SMOH [uncertain] There are gaps in capacity in the state. Some things TSHIP did, they did because the state staff could not. TSHIP tried to build the capacity of staff in the state to take these roles, but not fully. Abdullahi Hussan, Dir. Primary Health Care, Ministry of Local Government [uncertain]
- “We are in the process now.”
- [did not address the question] [TSHIP owns]
- This is an area where we noticed a weakness in the program.
- Not too well. In 2013 I had cause to write to the USAID Mission about the approach. TSHIP had its own limitations in the way it was designed. Particularly about the CBHVs. The state felt that the way to go about it was to strengthen the CHEWs. TSHIP leadership felt differently. They wanted to train a corps of 1-2000 volunteers (CBHVs). TSHIP went ahead and implemented this without our support. They then wrote to us and said they were ready to hand this over to the state. I reminded them that I had told them not to do this, but use the CHEWs instead. We are struggling to pay the CHEWS as it is.
- [state owns or will take over]
- TSHIP got my office (pop comm.) and Health (PHCDA) to work together. TSHIP is gone, but we still work together on birth registrations. TSHIP taught that we are inseparable. We are fused as one. This is here to stay.
- [state owns or will take over]

Themes: Of the 23 state officials interviewed, 14 stated that they believed that ownership of TSHIP activities now resided with the state or would with the closing of the project. Four said they were uncertain. Two believed that ownership resided with TSHIP and three thought it was mixed between state and TSHIP ownership.

Question 7. What recommendations would you give to sustain what TSHIP has done on MNCH/FP/RH service in the state?

- We have other partners to help with supportive supervision, which will go on.

- "We have two problems, corruption and commitment." There is money, but it does not get released or it disappears. The present government is supportive. They are willing to budget for health.
- "Malaria does not stop when projects end."
- "We need more from partners." The state will wish to carry these things further, with TSHIP or any project. We hope that USAID will also continue. We want the communities to feel ownership of health services and the state will work to see that they do.
- I would recommend that there be a graduation period, over time, so that the state can be at full capacity to take responsibility. Handover should begin before the project ends.
TSHIP would not support our bimonthly meetings because they said if we could not, we probably should not be in business. So we had to make a sustainability plan and raise revenue. We now have registration fees and funds. We also have been applying for research grants. And we are seeking state funding.
- This is where the problem is. Sustainability from the government side. We hope that there will be changes following the last elections. But states are weak at sustaining programs like this.
The SMOH and MLG should form a committee to take some of these responsibilities to ensure that these activities continue. If it is not done, the moment they leave it will deteriorate. "TSHIP has done well and we need to sustain it." Without a committee it will not happen. It should have happened before now.
- Looking back, the major issue is not TSHIP but the system. It is fragmented. The ministry is not in control. There are coordination issues. CBHVs: They are making our facilities more active. The volunteers bring people into the facilities.
- [Will the LGAs fund them after TSHIP goes?] Hon. Dpy. Speaker: We have created a provision in the state budget for this. We want to make provision from each and every LGA.
- USAID should insist that states deliver budgeted monies as promised as a condition for projects like TSHIP.
- If another program is designed, the focus should be social mobilization. Community involvement is key.
- Sometimes the issue I have with bringing together state activities and donor projects: "Not part of our mandate." There is a lack of flexibility.
- I would like to see state officials brought in at the conceptualization stage, from before the beginning of design.
- DMMA needs a donor forum for drugs procurement. These should meet regularly, and include all stakeholders who work in drug procurement. First, TSHIP should hand over records of all its activities. Hand over all its tangible resources that can be used to sustain what they have built. Then, additionally, before departing there is need to know from TSHIP its experience in the implementation of its programs, the challenges, the successes. If there is interest to sustain, government can have easier task of continuing.
- That's a big problem. They can shoulder some but not all. We need more years. It is too early for TSHIP to leave. There are going to be problems.
- [Q: can CBHVs keep up their work?]
- TSHIP set up this distribution channel. I do not know if it can continue without TSHIP.
- Community midwifery program started here but did not work due to lack of funding. This kind of program would really help here. We [MLG] were involved in recruiting them, but it did not work.
We are trying to establish links with other offices and stakeholders to keep things

going. We collaborate with NGOs. A lot of NGOs. TSHIP has helped population commission to establish relationships to carry on without them.

- The Population Commission has raised outside funds using their work assisted by TSHIP.
 - No answer. No answer.
 - No answer. When TSHIP leaves we are going to write a memo to all concerned and promise to maintain this work. And ask for cooperation to keep the system working.
- When we go for supportive supervision we say that even though TSHIP is gone you still have an obligation to record and report data. We want this system to work and will hold you responsible.
- [mixed Funds. [CBHVs] "We will have to sensitize and advocate for the continuation of this program." [Will LGAs pay for this program?] "Inshallah. We are hopeful. This program saves lives."
- Dr. Robinson Yusuf, Director of Medical Services, Standing in for the Acting Permanent Secretary, SMOH [uncertain] There are gaps in capacity in the state. Some things TSHIP did, they did because the state staff could not. TSHIP tried to build the capacity of staff in the state to take these roles, but not fully. Abdullahi Hussan, Dir. Primary Health Care, Ministry of Local Government [uncertain]
- "We are in the process now."
- "Sustainability starts with the full participation of the partners. TSHIP did this." They worked in the system, on the system. In sustainability and ownership there wasn't much in that aspect. We are afraid that activities will drop off when they leave.
- There is room for USAID projects and the state government to have a closer relationship than they did under TSHIP.
- The state should have a say in where funds are spent.
- There was a physical suppression that hurt collaboration. TSHIP had its own friends and its own ideas about where to use funds.
- TSHIP was not enough a part of the state health care delivery program.
- There will be sustainability issues. The problem here is leadership. If there is political will to sustain some of the USAID programs, this will be a tremendous lift. "USAID should hammer on the political leadership. Get an MOU defining the role of the state in sustainability." "If you cannot guarantee continuing these interventions we will take the project to a different state."
- We have been discussing sustainability for a long time before the project ended. TSHIP pushed us. There are problems. TSHIP tried to plan for sustainability.
- **Themes:** There is a lot of concern about the sustainability of TSHIP activities after the project closes. Of the 23 respondents, three did not answer. Thirteen had suggestions for how to sustain project gains and activities. Most of these suggestions required action from the state governments and agencies, while some were directed at TSHIP along the lines of better and earlier planning for sustainability. A few seemed to accept that sustainability would simply be a casualty of the project's end.

Key Informant Interviews with TSHIP Program Staff

Question 1. What will project beneficiaries in this state be doing differently five years from now

as a result of the TSHIP project?

Decision makers, bureaucrats, legislators, politicians . . . will be able to initiate policies that benefit the welfare of women and children. They will understand the problems of the community, and translate that knowledge into policy.

What communities, CSOs, and families will do differently is manage their health needs on their own. They will advocate for change.

Resource mobilization. Beneficiaries will be able to mobilize local resources to help meet their health needs.

Problem identification. Beneficiaries will be able to identify and prioritize needs. They will be demanding services, not just family planning. They are more enlightened. They know the benefits. They will ask for FP and utilize it for better health. If they cannot get what they want from HF, they will pursue from the private sector. There is demand.

We have raised the capacity of staff to collect and report HMIS data from HFs up. There have been big improvements in data.

At LGA level there have been improvements but not as pronounced. There were many diverse systems before. It is difficult to standardize but we have succeeded. SMOH supported standardization.

These changes were carefully done with sustainability in mind. Of course there will be challenges (funds) but the systems are in place. The last administration prioritized the use of data for decision-making. This helped. Community co-management of services. Community health structures. This is TSHIP's greatest legacy. Monthly meetings. The collaboration can be sustained.

Demand is up. Utilization is up.

What I think that will be high up on the sustained list is Community Structures. The WDCs and the CBHVs. Communities like these programs, which address community needs.

Misoprostol and chlorhexidine. These are in demand. There is now a local source. Women are starting to be heard, and this intervention is proof.

FP has seen progress, but this will be harder to sustain without support.

HMIS. This is an area of success. QA needs work. Bauchi is now over 80% in completeness. Bauchi is #2 in Nigeria. The structure has been established. TSHIP cannot take all the credit; the time had come.

HMIS to be greatly improved, and the improvements should last. Data is being gathered, being organized, being used. This helps planning and budgeting.

HR in health. We expect that they will perform at a higher level. But they must stay. We expect the HFs improvements should be maintained. nds of mothers. CBHVs and misoprostol/chlorhexidine.

Health seeking behavior, esp. among women, has changed. They are more likely to go to HFs to seek treatment. They are more likely to save money for emergencies. They are more aware of danger signs in pregnancy. They are more likely to support interventions, especially at later stages [of pregnancy]. They are more likely to demand from the government, demand support, demand quality. They are more likely to contribute to their HF. More likely to respond to emergencies. Families will use HFs for emergencies.

Service providers are more likely to be evidence based. They are more competent now.

LGAs are more likely to provide supportive supervision to facilities.

At the SMOH they are more likely to use their new policies developed under TSHIP.

They have workplans, that are well thought out. They use data for decision-making.

They will be more able to independently engage in successful health seeking behavior.

Beneficiaries will be better able to participate in the sorts of activities that TSHIP implemented.

They will be better able to plan health services, and mobilize funds.

They will demand more services.

Individuals and families in the communities will continue to pass along the messages and information that they have learned. Their health seeking behavior has changed and will stay changed. They have taken control of their health. They participate demand is

Traditional and religious leaders have become involved in health care and health seeking behavior. They will continue to support these new behaviors. Before they were in the way. Now they call us. This is very helpful

At the State level SMOH, MLG, MWA were very vertical before. Bauchi strategic health and development plan brought us together.

These things will go on when we are gone. The stakeholders will appreciate the enormity of the health system challenges here in Sokoto. They now know the importance of working together, as an integrated program team, with communities. This has changed the way they work and think.

They will value data more and use it more. "They will take evidence-based planning seriously." And evidence-based budgeting.

They will procure based on specific need and priority, not just "shop" for supplies.

Beneficiaries will be involved in the design and implementation of health activities.

Staff will be more qualified. (Aside from the obvious problem of understaffing)

Community level intervention has come to stay in Sokoto.

In the area of documentation, they will be stronger and more organized. HMIS improvements have been institutionalized. Data is part of decision making, budgeting and planning. They care about data now.

Pre-service training at health schools/institutions. Use of modern techniques (anatomic models)

Beneficiaries will still use policy documents adopted by the states. HREC

Community systems. WDCs. Community involvement. These will stay. We will see mothers taking their kids to HF for immunization, voluntarily. We will see much improved service delivery in the state. It should last five years and beyond. Men and women will all talk about FP.

SMOH, MLG, Ministry of Women's Affairs, other line agencies—Now they have a better focus. They know that they cannot just swing into anything without better planning. They have learned to be goal and objective oriented. They have learned to budget. They understand the need for supportive supervision. We really drove that hard. They understand integration as an approach that is better. MCH supervisors understand the need to go to HF and do proper coaching. These are the things we have put in place to assure sustainability of project activities and gains. We have stressed that documentation is necessary.

We have identified a group of committed men at the Ward levels, and trained them to "spread the gospel" of child spacing benefits. No one pays them. EMAP "Expanded Male as Partners". We believe that these men will continue after the project ends, as they are doing what they do without pay and are dedicated.

HF service providers have reduced waiting time. Clients' rights are respected. Infection prevention is a priority now. Communities will be empowered and organized, I hope. We have gotten active communities and CSO to raise and spend money and demand services. Demand is up and should stay up.

What I think they will do differently from previous practices. . . Starting with service providers: We have instituted the principle of quality service delivery, as compared to how it was before, when quality did not matter. On the community aspect: TSHIP has instituted a basic channel of awareness. We have planted awareness on how to take care of their health and how to seek services. We have also encouraged them that health services are not for the government, but for them. They should participate and have a sense of ownership.

We have brought services to the beneficiaries' doorsteps. They now expect ANC, FP, CH. They will continue to access these. Before they were not aware. In the community the WDCs, the religious leaders, the CBHVs--they will still go house to house to mobilize and counsel. Also they were trained on ORS and home management of diarrhea. They will do this when they need it.

HMIS. There will be better data and better use of data.

Patients/clients will come for service more, and come earlier.

Clients will die less frequently, not as early. Maternal and newborn mortality will be less.

Themes: The TSHIP program staff is very optimistic about the changes in behaviors and systems that TSHIP will leave behind, both at the community level and at the HSS levels in health facilities and the ministries. They are particularly optimistic about the use of HMIS and data, the demand for services, and lasting change at the community level concerning participation in the health care system, and people's control over, and decisions concerning, their own health.

Question 2. What worked and what did not? What are your five best practices? What factors contributed to success/best practice.

1. Community participation
2. Working through the state at all levels
3. Quality of care
4. HMIS

1. Capacity building
2. Service integration
3. MCH coordinators
4. Traditional and religious leaders

1. M&E
2. HMIS
3. Capacity building

1. Interagency/state collaboration
2. Working through the state at all levels

1. CBHVs
2. Working through the state at all levels
3. Community participation
4. Working through sub grantees

1. CBHVs
2. Misoprostol/chlorhexidine
3. RI strengthening
4. HMIS

1. Health facility renovation
 2. Capacity building
 3. CBHVs
 4. Male involvement
 5. Community participation/WDCs
 6. Pre-service training
 7. HMIS
 8. SBMR
-
1. Community participation
 2. Misoprostol/chlorhexidine
 3. Birth registration
 4. Maternal health audit/accountability
 5. Policy champions
 6. Public-private partnership (PPP)
-
1. Control of funds
 2. Capacity building
 3. Traditional and religious leaders
 4. ISS
 5. Health facility renovation
 6. ORT corners
 7. FP
-
1. Evidence-based advocacy
 2. Community participation
 3. Capacity building
 4. Gender Inclusion
-
1. AMTSL
 2. ORT corners
 3. LQAS surveys
 4. Misoprostol/chlorhexidine
 5. SBMR
-
1. Refocusing the project
 2. CBHVs
 3. Misoprostol/chlorhexidine
 4. Service integration
 5. HMIS
 6. Task shifting
-
1. Capacity building
 2. CBHVs
 3. HMIS
 4. Task shifting
 5. ISS
 6. ORT corners
 7. Expanded male as partners (EMAP)
-
1. Capacity building

2. Community participation
 3. Misoprostol/chlorhexidine
 4. ISS
 5. Transparent commodity supply
-
1. RI strengthening
 2. ISS
 3. Community participation
 4. CBHVs
 5. Traditional and religious leaders
-
1. Misoprostol/chlorhexidine
 2. 100 Women Group
-
1. Misoprostol/chlorhexidine
 2. Covering states in their entirety, every LGA
 3. Community participation
 4. HMIS
 5. Working through the state at all levels
 6. Traditional and religious leaders

Themes: The 17 respondents from TSHIP's program staff mentioned four best practices seven times each: community participation; community distribution of misoprostol and chlorhexidine; capacity building and HMIS. They cited Community Based Health Volunteers six times and working through the state at all levels five times. Working through traditional and religious leaders and integrated supportive supervision (ISS) each got four mentions. Five best practices were cited twice each: ORT corners, health facility renovation, Standards-Based Management and Recognition (SBMR), service integration and routine immunization (RI) strengthening. Another 25 best practices were mentioned one time each, showing a wide diversity of opinion among the TSHIP staff.

Question 3. How did the Focus State Strategy contribute to TSHIP's success?

It really helped. I work on the group that coordinates this. During the quarterly meetings we bring our workplans. We find areas of coordination. We avoid duplication. If we are renovating a facility, another IP might bore a well there.

We work together in the field with LEAD.

We formed a security focal persons group to address security issues. We meet monthly and exchange information. We protect each other.

FSS helps us work better. There is collaboration. With LEAD there was capacity building of LGA authorities and this extended to health. It strengthened the enabling environment and created demand. With NEI the collaboration with schools, especially girl students, which worked well. It increased project reach. With JSI DELIVER it has improved FP commodities. Not many stockouts.

The collaboration at the state level is weak, not what I expected. We received training. We also share our PMP and experiences on how we manage M&E. I can remember only 4-5 times when I sat in meetings with LEAD staff to collaborate. The State government is supposed to coordinate these groups. I do know what efforts are ongoing to coordinate not just FSS partners, but other donors as well.

Yes. LEAD strengthened TSHIP through governance, very strong ties. NEI, not so much. There should be better coordination, but the overall partnerships from FSS were good.

I say that they did not. I did not see much cooperation. We could have taken advantage of the opportunity better than we did. It helped us expand/extend coverage. It spread the interventions further.

Being statewide helped. Leverage.

Based on what I have seen I can say that it worked to a certain extent. It could work better. We have no HIV/AIDS component. We could have done more with/through partners. What I would like to see in the future is more deliberate communication and collaboration. LEAD, WASH (some HFs have no water).

We work very well with LEAD project. We share information, plan together. LEAD supports our project at the local level, with government and with gender. It created synergy. We worked together on budgetary allocation at the state level. We defended the budget. At the implementation level we were one. We worked on the "Maternal Death Law" together. With NEI the relationship was not as close.

It made us move to scale in the two states. Every LGA, every Ward. We work with LEAD and NEI. NEI extended TSHIP to audiences it might not have reached as early or as easily. It helped. It gave a guide. NEI, LEAD and TSHIP collaborated from the beginning. LEAD came in especially handy. "They listened and planned." Through LEAD we were able to assess the LGAs on time. It really worked. LEAD gave us access to the legislature. [gave example of maternal mortality notification law]. NEI brought in school-age girls.

Less duplication. Better collaboration.

It was not implemented 100%. LEAD, NEI only worked in limited number of LGAs. In the areas where the three projects were together, it worked and created synergy. BACATMA coordinated some of this. All the projects should be in all the LGAs. We collaborated in adolescent RH with NEI. It has been good. This was an improvement over the usual USAID methodology. "It is better than working in a small space and expecting a bigger picture." It will take longer than five years to see the results. It is a good approach.

We work with DELIVER. Other sectors work more with LEAD. We have tried working with the other implementing partners. We work closely with LEAD. Not so much with NEI. LEAD complements TSHIP well. We work with FISTULA; it has worked. Even when the relationship is not as close, it improves results.

Our collaboration is mostly at Sr. Mgt. but at our level we see LEAD holding meetings and organizing the LGA teams. They also participated in one of our supportive supervision visits. We always invited any of the other projects to meet if they work in the same LGAs that we do.

We move as a team. We move together, so the cooperation is not one after another. There is a lot more collaboration during MCH week.

TSHIP and DELIVER: we have no portfolio for commodities, and need DELIVER to fill that role. TSHIP creates demand, and we must have a means to fill it.

ACQUIRE FISTULA were duplicating services and collaboration fixed this.

Themes: Of the 17 respondents, 11 had a positive view of the Focus States Strategy and the collaboration that it engendered. It produced efficiencies. People mentioned synergy and leverage. Two respondents had a negative impression of it and another three had mixed feelings. One response could not be categorized.

Question 4. If you were writing the follow-on solicitation for this project—what would you change?

Community mobilization. This worked and we should do more. Demand creation is there. Participation. Mobilization. Once this is done right, communities can challenge the government.

Working with the government. HSS We have done much and much more needs to be done.

Service delivery. This is what we are about.

HSS. It's everything. It is governance. It is health. It is finance. More community education in family planning. More outreach services to underserved and hard-to-reach places. More community involvement. More coordination with private sectors. (PMVs) Many PMVs are CHEWs and can be trained to provide FP services.

I would like to see some changes in the structure of the project. I would look at individual programs, not all integrated together. Integration is generally good, but not always. Starting with SO teams. These did not work well. Programs need to think carefully how to align their work with the state programs. State engagement should be done differently. We should be able to follow established protocols and still function. Everything must be channeled through SMOH. Following protocols will remove the influence of individuals. He used the example of getting CBHVs to distribute misoprostol and chlorhexidine. SMOH resisted at first. Better articulated/defined roles among FSS partners. Effective collaboration and coordination. Scheduled meetings among partners.

Better HR in the project. Better match of skills to the tasks in the project.

We need to find ways to empower the staff on the ground. We had to spend a lot of time negotiating for interventions, delaying results.

If TSHIP had been better able to curry the support of government we could have done more.

Right from the pre-implementation stage—get the buy-in from the state. Get the state involved and be sure that they give their total support to the project, from the top. The state should put some of its own money into the project. They should make a monetary commitment. This will establish ownership.

Community org. intervention should have started earlier and the expected outcomes should have been clearer at the beginning.

More midwifery. Community based midwives.

Maintain the "whole-state" strategy. This is necessary. It contributes to Government buy-in.

Focus on targeted interventions. Do not drop any, but focus on some. Training must be there, like it or not.

Focus more on community level interventions, community participation.

Make all child deaths notifiable and investigated. Service delivery through HSS. Building state institutions. Work more on the enabling environment at the policy level.

"USAID is partly to blame. The whole idea was HSS, but most of the PMP indicators are service delivery." They were much more interested in quantitative data. It is not always correct to have health projects managed by physicians. It would be better to use managers. HSS was getting lost under the drive to count immunized children. The PMP should be more policy oriented.

Use PMVs.

When you have consortium partners it can make things bureaucratic.

More men's health programming. Bring men along. Most mistakes are picked up at the midterm evaluation. Hold it earlier. "We wasted time, energy and resources."

I would keep the same mix of interventions. USAID has invested a lot in them and we should see them

through. Engagement of the state government. Get their commitment before the project. "The first three years of this project, this was a big problem. The government was not ready." We went round and round and round. Go beyond a MOU. Counterpart funding is not enough.

More involvement of USAID along the way. More engagement by USAID with the state government.

The project should take on fewer objectives and focus on them more. TSHIP tried to do too much in the first 3 years. Following the refocus from the midterm review, things got better. The initial design was too ambitious.

HSS is still the priority, but choose the specific targets better.

Wealth/income generation. Women empowerment.

Follow-on should maintain all the interventions currently in the mix.

Don't program for the quick win. Some change takes time.

The consortium structure in current project is a struggle. There is a detachment between Abuja and the states. The project needs representation in Abuja. Communication is difficult. This came out in the midterm evaluation. After that things improved.

Get state commitment before starting. Define the state's role from the start.

Project needs a high-level advocacy body.

There is need to support remote areas better. None of the interventions should be dropped.

If there is a follow on, technical staff will still be needed to consolidate quality and solidify gains.

First, involve the state in the design of the project. They should have a say in the design. This will create ownership. Leaving them out creates resentments. If they participate in design they will participate in the project.

Supervision. Regular meetings between USAID and state government.

Better project design. TSHIP started out disorganized and was a bit experimental. Need a better design up front.

If I am to design a project, I would still follow the same pattern, but I would make small changes. I would be more focused on the community, and on the service provider. Get an MOU with the state, but do the work at a lower level, with the clients. Teach that the HF is not government property—it is community property. It is their personal property. They should care for it themselves. Then and there we have the spirit of sustainability

I would improve access to free drugs. There is a lot of poverty here. People go to the hospital and get a prescription but cannot buy drugs. TSHIP cannot pay providers, but they could supply drugs.

Changes brought about from the midterm evaluation made positive changes in how TSHIP worked. institutionalize those changes into a follow on.

Fully involve stakeholders in planning. Must design sustainability into the project. States should sign an MOU, defining their roles.

Community involvement. CBHVs are vital to success of project.

Focus on more deliveries in HF.

Focus behavior change.

Themes: Two themes stand out in the responses above. One is a call for closer collaboration with the states, and earlier, in the design phase. The second is an emphasis on community involvement and community level activities. Another theme emerged that the project was not focused for the first half,

even “experimental.” In the second three years, TSHIP focused a slightly smaller set of activities, more intensely.

Question 5. What were the project’s most successful interventions?

1. Community mobilization
2. CBHVs
3. Governance
4. Polio eradication
5. RI
6. ISS
7. Service delivery integration
8. HSS
9. HREC
10. HMIS

1. Community drug keepers
2. Community mobilization
3. FP champions
4. RI
5. Malaria case management

1. Community mobilization
2. CBHVs
3. Pre-service education
4. HMIS
5. Service delivery integration

1. Misoprostol/chlorhexidine
2. CBHVs
3. 100 Women Group
4. Capacity building

1. Misoprostol/Chlorhexidine
2. CBHVs
3. Malaria case management
4. Polio eradication
5. Kangaroo care

1. HSS
2. Pre-service education
3. Attended deliveries

1. CBHVs
2. Misoprostol/chlorhexidine
3. Capacity building
4. SBMR
5. ISS
6. Evidence-based advocacy
7. Health facility renovation

1. Community mobilization

2. ISS
-
1. RI
 2. CBHVs
 3. Misoprostol/chlorhexidine
 4. Community mobilization
 5. Attended deliveries
 6. Malaria case management
-
1. Misoprostol/chlorhexidine
 2. CBHVs
 3. Task shifting
 4. Malaria case management
 5. HMIS
-
1. MNCH
 2. PPH
 3. ANC
 4. RI
 5. ORT corners
 6. Policy formulation/research
 7. HMIS
-
1. CBHVs
 2. Malaria case management
 3. HMIS
 4. ORT corners
 5. Task shifting
 6. Misoprostol/chlorhexidine
-
1. CBHVs
 2. RI
 3. Capacity building
 4. ANC
 5. Misoprostol/chlorhexidine
-
1. Community mobilization
 2. Misoprostol/chlorhexidine
 3. HF renovation
 4. Malaria case management
 5. FP
 6. Traditional and religious leaders
-
1. Malaria case management
 2. RI
 3. FP
 4. ANC
-
1. Malaria case management
 2. RI
 3. FP
 4. ANC

1. HMIS
2. Misoprostol/chlorhexidine
3. FP
4. RI
5. Attended deliveries
6. Service delivery integration

Themes: A frequency analysis of the responses shows that the two most often mentioned interventions are Community Based Health Volunteers (CBHVs) and community distribution of misoprostol and chlorhexidine at nine each, followed by malaria case management and routine immunization (RI) with 8 apiece. Three interventions were cited six times each, HMIS, community mobilization, and policy formulation. Family planning (FP) and antenatal care (ANC) had four responses each. Four interventions had three mentions, attended deliveries, service integration, capacity building and integrated supportive supervision (ISS). Six interventions were cited twice each: polio eradication, task shifting, pre-service education, evidence-based advocacy, health systems strengthening (HSS), and oral rehydration therapy (ORT) corners. Another 14 interventions had one response apiece.

Question 6. What were the hardest interventions to get the HF/LGA/WDC/SMOH to take ownership of? What were the easiest?

- CBHVs.
- Monthly commodity logistics review meetings.
- WDCs quarterly review meetings
- HREC
- No desire to fund it. The community was more enthusiastic on many activities than the government structures. They took the other structures along.
- FP commodity distribution, currently led by DELIVER and TSHIP. It requires a lot of money to run.
- CBHVs. Again it's the money.
- Supportive supervision: Requires moving people around, hence more costs.
- Staffing. Getting them to hire adequate staff
- Getting government to post women to rural HFs.
- CBHVs
- CBHVs
- Net distribution (because of creating a new budget)
- FP It wasn't the intervention as much as the timing. Get them on board from before the beginning.
- CBHVs
- They are reluctant to take on the community level interventions. But they know that community interventions are popular, so they may have little choice.
- Government is more likely to build new structures than they are to maintain the ones they have.
- Bauchi has two years of misoprostol chlorhexidine in their warehouses. How will they distribute?
- FP logistics

- CBHVs
- FP. They do not want to stick out their necks on this. This is the most difficult for them to take on.
- To take over responsibility for vaccine and other immunization commodities.
- Drugs procurement. We have worked with them to convince them to set up DMMA.
- CBHVs. "They accept that it is a good intervention. They don't want to pay for it." "The new governor supports the idea. We will see."
- Pre-service education. "They've got the schools, but not the students." We need the government to do more to get local midwives, locally trained.
- CBHVs. This is a money issue, not the program.
- They have already taken on the ownership of the policies/policy documents.
- Routine immunization. It was a battle. Requires skilled personnel.
- Cold chain. Resources beyond the Ward/LGA level. We succeeded in getting the state to provide money for this. They thought RI meant only polio. Funding went from 20k to 200K (per month). Now the problem is the release of the before being used for their intended purpose funds.
- Need better monitoring of state funds. They disappear.
- They say that they want all but the funding implications make them hesitate. CBHVs are many, 3230 in Bauchi. Even though they are not high priced, the total is a lot.
- There was no resistance to TSHIPs activities. They are grateful for the renovations and basic equipment.
- CBHVs. The government was slow to take it up. Still is. Project is trying to get WDCs to pressure for uptake.
- Community midwife training program. These are lesser-qualified midwives, not facility based. But they are sustainable and based in the communities where they live. Government did not want to take them.
- Supportive supervision. They have seen the benefits but do not fund it.
- At the LGA level, I do not know the state level, the LGAs think in terms of the financial picture. They love the services, but are reluctant to pay. In a number of cases we advocated for the purchase of drugs. Some LGAs would buy them. Some would not.
- The state gave an allowance for 200,000 N per month for RI. Some LGAs did not use this for RI. Some only gave part.
- The biggest bottleneck is the financial aspect.
- No answer
- CBHVs were the hardest.
- Anything that comes with a price tag.

Themes: Handing over ownership means handing over costs. There is unanimous agreement that paying for programs is the problem, not the programs themselves. CBHVs are very popular across all levels of the SMOH/MLG of both Bauchi and Sokoto, but the cost is a barrier to keeping the program alive. The next biggest area of agreement among respondents is procurement and supply of drugs and vaccines, again because of the costs.

Question 7. What were the three biggest challenges?

- Weak government leadership
 - Budget releases (no funds released)
 - Donor dependency
 - Security
-
- Remoteness/difficult terrain
 - Inadequate staff at HFs
 - Supplies/stockouts
-
- Inadequate staff at health facilities (HFs)
 - Lack of supplies/stockouts
 - Weak collaboration with state partners
-
- Inadequate staff at HFs
 - Weak government
 - Multiple ministries in charge of health facilities
-
- Weak government leadership
 - Security
-
- Weak collaboration with state partners
-
- Inadequate staff at HFs
 - Lack of supplies/stockouts
 - Security
-
- Inadequate staff at HFs
 - Budget releases (no funds released)
-
- Staff turnover in TSHIP
 - SMOH high-level turnover
-
- Inadequate staff at HFs
 - Budget releases (no funds released)
 - TSHIP internal challenges
-
- Inadequate staff in HFs
 - Weak government leadership
-
- Inadequate staff at HFs
 - Weak government leadership
 - Budget releases (no funds released)
-
- Remoteness/difficult terrain
 - Inadequate staff at HFs
 - Weak referral system
-
- Inadequate staff at HFs
 - Weak government leadership
 - Absence of supportive supervision

- Lack of commitment of service providers
- Disruption of services by IPD campaigns
- Inadequate staff at HFs
- Weak government leadership
- Absence of supportive supervision

Themes: There are two clear common threads in these interviews. First is the inadequate numbers of staff in health facilities, which was mentioned by 11 of the respondents. Second is weak government leadership, mentioned by seven. TSHIP staff apparently discuss this among themselves, as the interviewer heard some of the same phrases across interviews and across states. The next most common challenges were budgets not being released, with four mentions, and lack of supplies/stockouts and security issues with three apiece. Three challenges were cited two times each, remoteness/difficult terrain, weak collaboration with state partners and absence of supportive supervision. Nine other challenges were cited once apiece.

Question 8. How do you show gender sensitivity in your program area?

- We advocated to all the six Emirates. We talked to them. We discussed with them.
- We worked on PPP, including a strategic plan but this was dropped in refocusing.
- We groomed advocacy champions for the state. Can be used for any intervention.
- 100 Women Groups.
- Being inclusive.
- Traditional leaders and religious leaders were brought in and given roles in FP.
- Involvement of male service providers in FP worked well
- FP Champions (both men and women but mostly men)
- Fortunately here we have more women than men in the office. The culture creates barriers. There are challenges. If there is anything that hinders women's participation it is the roles they must play outside of work.
- Male champions in FP.
- We don't have that in HMIS.
- Task shifting. Getting male HF staff to perform activities or tasks normally provided by female midwives.
- Male Champions were involved in advocating for services.
- One big problem here is the cultural mindset of men. We assure men that we mean no harm. Otherwise we would be able to do nothing. We had to be accepted to work in the community in program issues that relate to women.
- The hundred women group threatened men. We ensure that the program does not focus only on female workers, but includes males as well. Most staff in my area are female.
- It's an issue in Nigeria. It is partly due to literacy levels.
- The hundred women group.
- CBHVs. They are more welcome. They are knowledgeable. They are change agents.
- Other women's groups such as FOMWAN.
- There is need to do more. Especially education. We need more nurses. More midwives.

- Some of the Policy Implementation Champions are women.
- We make sure that women are represented to the largest extent we can.
- We work to ensure that policies reflect gender equity.
- We are very conscious of creating an enabling environment that reflects gender.
- The worst-case scenario is to have a 40/60 ratio. We have 50/50 in our program area. Women get more mileage in child health. 90% of our volunteers are women.
- "Sometimes I am the only man in some meetings."
- Getting men involved is ANC is important.
- Getting women to be accepted in communities is vital.
- Working with women is not enough. We must work effectively with women.
- Respect.
- Other projects raid our female staff.
- We are gender aware. We are gender sensitive. Look at the CBHVs. The large majority are women, and they can enter homes where men cannot.
- TSHIP staff. We managed the gender balance carefully. The Service Delivery Facilitators (SDF) are all female. The Demand Creators are mainly male, to go after the gatekeepers, who are male. The Demand Creators do not go alone. They pair with an SDF
- By deliberate inclusion in the selection process for services, groups, etc.
- By focusing communication on gender balanced messaging.
- By communicating benefits of FP to men.
- Redefining the male role.
- Male involvement. Male motivators.
- Among the CHEWs that we trained, we have men. "We want to break that jinx." We trained CHEWs to be FP service providers.
- Recruiting. Proactively seeking out female staff.
- Trying to break down communication barriers across gender.
- Increasing female participation in groups and activities in the field.
- Engaging Imams to encourage men to participate in family health decisions.
- In the formation of WDCs and VDCs we made sure that women members were included, and given positions of leadership.
- The 100 women group also.
- There is not a good balance of service providers. This really hurts.
- Sometimes in the facility where there is no woman provider, we had to work with male providers to deal with women. Change their habits and refer if that is all that they can do.
- When conducting trainings we try to recruit female trainees. We encourage women to apply for M&E jobs. But they tend to go for nursing. We even advertise, "Female candidates preferred."

Themes: A frequency analysis of the responses to this question shows that the most frequent response is "proactive inclusion/inclusion of women" with five mentions. The next most frequent responses with four mentions each are: 100 Women Groups, CBHVs, and men and women FP Champions. Three responses received three citations each: use of traditional and religious leaders, male inclusion, and redefining male roles/advocacy to men. Four responses received two mentions apiece: gender inclusive communications/messaging, respect, creating a gender inclusive environment, and task shifting (the

practice of using male service providers in non-traditional tasks for FP). Three responses received one mention each, women as policy champions, crafting gender neutral or gender equitable policies, and involving men in ANC.

Question 9. What health systems changed under the project? How? Which systems resisted change?

- No answer (interrupted).
- Building on existing structures
- Integration.
- Immunization was an entry point for FP
- ORT
- ANC
- Getting CHEWS on board and expanding their roles
- The ORT activity was 45% successful. Sugar and salt are expensive. Replenishment of ORS packets was uneven.
- HMIS.
- Service Delivery (compared to before). There is clear coordination that was not there before.
- Resisted:
- Coordination. Budgetary allocation. Changing mindset to get funding redirected, [vs the past].
- Many policy developments.
- Minimum district health package.
- HR for health policy.
- Health strategic plan development and implementation.
- Immunization coverage improved. Periodic monthly meetings with immunization officers. Monitoring of results. Effective supervision.
- SBMR went well except that it did not reach dispensaries. PHCs and general hospitals used it.
- HMIS
- There is some change in the attitude to work. There is improvement in respect for clients, although there should be more.
- Referrals are better. More patients being referred, with positive outcomes.
- Work planning
- Budgeting
- Governance
- The community component changed. Participation. Demand.
- Health sector financing.
- Provision of health infrastructure.
- HMIS, no doubt.
- The program officers have control of their workplans. Before, any donor or project would show up

and say what they are going to do. State program officers are in control of the state program now and can guide it.

- Facility improvement. It affected systems. If women cannot speak privately, or use the bathroom, they will not come. To deliver a baby there needs to be a place that makes that possible.
- Commodities supply. This has improved in Bauchi. Especially vaccines/RI commodities. ORS zinc.
- Budgeting. Now it involves partners. Now it requires evidence.
- Capacity at the HF and managerial level.
- Technologies (misoprostol and chlorhexidine) and the distribution system.
- Changing the community from “service recipients” to “service participants”
- HMIS.
- Service Delivery. The volume of clients now compels staffing.
- Logistics and commodities security
- Vaccine security
- Facilities rehabilitation
- Research
- HMIS has improved drastically.
- There is integration, but . . . personnel issues drag it down.
- Outreach made a big difference, but cannot say it will continue.
- Facilities based integration will continue.
- FP logistics,
- M&E and data,
- Service delivery
- Health financing. We have tried to influence on multiple levels. Some have worked well.
- Budgeting process is improved, is more reality based.
- Service delivery changed.
- WDCs changed.
- LGAs changed but not as much.
- No answer
- HMIS
- Policies. Last state assembly approved maternal audit.
- HR is resistant to change.
- Release of funds to the health department is resistant to change.

Themes: Frequency analysis of responses to what health systems changed has one clear area of agreement, HMIS at six responses. It is followed by evidence-based budgeting and service delivery integration with four apiece. Commodities supply and logistics was cited three times. Standards-Based Management and Recognition (SBMR), community participation, service provider capacity and work

planning each received two mentions. Eleven other systems each received one response.

Key Informant Interviews with LGA Officials

Dass LGA:

1. What is your experience with how TSHIP engaged the LGA in its project implementation?

- Do you feel the LGA is full equal partner in the implementation? Why
- Very cordial relationship. TSHIP are not doing the work rather they support the LGA to do their work.
- TSHIP have a permanent staff in the LGA who participates in the monthly and quarterly meetings organized by the LGA to plan their activities.
- PHC Director stated that "As much as TSHIP is a partner to the LGA they need to collaborate and work with the LGA if not they would not have received any cooperation from the LGA"

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Capacity Building:
 - o Trained both LGA staffs and Facility level staffs on different areas like infection prevention, management of 3rd stages of labour, HMIS, Nutrition, RH, ORT, MCH, Immunization, vaccine management, FP, Community Mobilization, CLMS, diagnosis and management of malaria, resource mobilization and allocation
 - o Stated that the LGA now have pool of skilled health workers to provide quality service
- Supportive Supervision
 - o Before TSHIP, the LGA was just conducting supervision but with TSHIP intervention, started conducting integrated supportive supervision
 - o Improve on development of plans for supportive supervision.
 - o Improve on the conduct of supportive supervision by including all relevant units in the PHC dept as members of the team. Go together as a team.(reports of supportive supervisions conducted sighted)
- Management
 - o Benefits derived are:
 - good management structure at both the LGA and HF Levels
 - Improve skills of LGA and facility staffs to render quality health services based on trainings received
 - o TSHIP helped to re-activate the PHC management committee. They were trained on leadership and

- government. It's a platform used to discuss issues confronting the health facilities and to find solutions together
- o TSHIP supported the LGA to develop operational health work plans from 2012 to date(Did not see the work plans but sighted the results Matrix which have the baseline, targets and the actual results for the year)
 - o Renovation of health facilities
 - Integrated Services
 - o ANC services are operated on Mondays, Tuesdays and Thursdays in HFs across the LGA
 - o Child welfare services are provided on Wednesdays and Thursdays
 - o Malaria and FP services are provided on daily basis.
 - o They stated that despite having specific days for providing some services, clients are attended to whenever they show up at the HFs irrespective of whether the service was supposed to be rendered on that day or not
 - Applying Standards to improve quality
 - Posters, leaflets, job aids provided by THIP helped the HCWs to remember what they were taught.
 - Collaboration/partnership
 - o Philanthropist constructed Zumbul Maternity in the LGA, the District Head provided generator and curtains, the LGA staffed the HFs and provided mattresses while the Emergency Operation Centre provided Solar refrigerator. TSHIP provided training to the staffs.
 - o TSHIP renovated Town maternity while WOFAN provided toilet facilities and borehole
 - o Other philanthropists also constructed another HF and upgraded one
 - o LGA provided venue for training
 - o All these made health care services easily accessible to the communities
 - Harmonizing community approaches
 - o The different community groups used by TSHIP in the LGA includes:
 - WDCs, CBHVs, Extended Male As Partners (EMAP), Quality Improvement Teams (QITs), Community Direct Intervention (CDIs), Village Development Community (VDCs).
 - o CBHV activities are being appreciated and more clients are using the health facilities based on their work.
 - o The LGA felt that having so many community groups focusing in different health programs is not healthy and suggested that they should be organized to be under one umbrella with a unique name
 - Gender
 - o 100 women group were trained by WODAS one of TSHIP sub grantees who also trained the CBHVs and EMAP
 - o Stated that the gaps experienced in putting women in leadership position is narrowing as the LGA currently have a woman representing it at the state house of assembly a position previously held by a man
 - o It was reported that before:
 - only women go to the health facilities to deliver but now the men are the ones carrying their wives to the health facilities when in labour
 - women need to take permission before they go for ANC but now with sensitization from WDCs and CBHVs, the women have been given standing permission to attend ANC at the facilities without having to seek consent from their husband every time they have to attend the HF

- o TSHIP worked with the community and the LGA to organize emergency transport services with selected motorcycle riders to transport women in labour to the HFs free of charge. They were trained on how to convey women during labour to the health facilities
- Monitoring and Evaluation
 - o Capacity building for Staff –LGA M&E Officer trained on M&E, computer
 - o Provided Laptop, registers, summary forms, internet
 - o With the assistance received from TSHIP, the LGA now have up to date and complete data.
 - o With the trainings received from TSHIP especially computer training, the M&E Officer is now computer literate
- Staffing of health facilities
 - o TSHIP trained Community Based Health Volunteers (CBHV) and gave them some allowance to work with the HFs and community. They serve as the linkage between HF and community
- Policy
 - o None

3. What Policies did you initiate/change as a result of working with TSHIP?

Did changing the policies change the practices?

- None

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals) Examples

- CBHVs do tracking of children and pregnant women in the community and also accompany them to the HFs
- Use of Misoprostol and Chlorhexidine drugs assisted in reducing bleeding in women after delivery and infections in babies. LGA felt that this has greatly increased the chances of the mothers and babies surviving.
- Trained In-charges of HFson referral to higher level, the government provided ambulances for referral all these helped to reduce delays usually encountered when making referrals

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

- What did you do for TSHIP? Cash or Kind
- How much did it cost?
 - o As mentioned in 2 under collaboration/partnership

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral

- Training of the HCWs make them to change their attitude to work, make them to know how to use the various equipment
- Before TSHIP there were no printed registers or other forms in health facilities but with TSHIP all HFs have required registers and forms and data quality changed
- TSHIP renovated Health facilities making them more conducive for client usage

- TSHIP working with MDG and Health Systems Strengthening Development (HSSD) projects helped to strengthen the referral system in the health facilities
- Before TSHIP, there was irregular supply of commodities but with TSHIP now have regular supply of commodities which was made possible through the DDIC system operated by DELIVER Project
- Reported that with TSHIP all households in Dass LGA have a net this was as a result of 39,000 nets distributed in 2010 and a replacement campaign conducted in 2014 with 43,000 nets distributed
- Before TSHIP, malaria treatment was not based on testing but now the HFs are using the RDT to test before prescribing malaria drugs. Also now use ACT instead of chloroquine.
- TSHIP supported outreach services in 8 low performance catchment areas for routine immunization
- In terms of FP, the LGA was mainly distributing pills and injectable but with training received from TSHIP have added IUCD, Implant and Jadelle. Also now have male FP providers and men are also patronizing the HFs to take condoms.

7. Have you been trained by TSHIP?

- Yes

8. What did they train you on?

- As stated in 2 under Capacity building

9. How did you use this training?

- Step down the M&E training to all the HFs staff. After the training, the in-charges now know how to properly complete the HMIS forms
- Provide on the job trainings to HF staffs on all the trainings received from TSHIP

10. What do you do differently now?

- Before was conducting supervision as fault finding activity but now conduct supportive supervision which is helping the staff to improve on what they are doing. Also, go on supportive supervision as a team using the modified supportive supervision checklist
- Use the computer to enter data and transmit it to the next level which has resulted in timely reporting of data. Before TSHIP was using manual method which was not effective

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of data tools, registers, computers, trainings, protocols and job aids

What training do you wish you had that you did not receive?

- None

12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To continue with the monthly meetings of the WDCs which should be supervised by the health educator
- To continue with the training and re-training of WDCs
- To assist the WDCs to get register with Corporate Affairs Commission (CAC) so as to enable them access loan facilities and become economic empowered to support the health situation in their wards

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

Do you think this is a good approach?

- Don't know about it

14. Did TSHIP support you to develop a Costed Health Development Plan?

- They said TSHIP helped them to develop the plan. (Could not cite the copy)
- Also reported that TSHIP helped to develop the health sector workplan(Could not cite the copy)

What is the level of implementation, and how has it improved health care delivery system?

- Was able to sight only the Health Sector Plan results matrix. The Director said that the plans helped them to know where they are and where they want to get to and the DHIS dashboards helps them to know the level of implementation and show the areas that need improvement.

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- Responded Yes. (Could not cite the plan). They said there is a workplan for the WDCs which shows the linkage between the HFs and communities, when to have meetings, etc.

16. How would you describe the linkage between the facility and community?

- The linkages between the community and facility was described as “very encouraging”
- Monthly meetings held between the communities and the health facilities to discuss issues and plan the way forward

Would you say that approaches used were appropriate?

- Stated that the linkages were appropriate

What could they have done differently?

- To have all the different volunteer groups coordinated as one body, to have a unique name for them and all projects to use them for their implementation activities instead of creating new volunteer groups.

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviours?

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

- Yes as stated in 2 above

Are husbands more supportive of their wives going to the health facilities? Explain?

- Yes as stated in 2 above

Are more women being placed in leadership positions? Give examples?

- Yes as stated in 2 above

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community

- No suggestion

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
- NEI
- SIDHAS
- PROACT
- DELIVER & TSHIP

- o Commodity supply to the HFs through the DDIC system
- WHO & UNICEF –
 - o Worked together with TSHIP on routine immunization, community mobilization using WDCs, co-sponsored MCH weeks
- WOFAN
 - o Provided toilet facilities and borehole in Town maternity which was renovated by TSHIP

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? Explain.

Others?

- Most Significant “Improved health seeking behaviour”. This is based on attendance/records at the health facilities (Sighted charts/graphs pasted in DPHC office showing the increase in coverage on different health indices)
- Others are:
 - o Quality improvement in service delivery
 - o Improvement on data quality

20. What are the things TSHIP did in your LGA which you will like to continue doing?

- Monthly review meetings
- Capacity building for staffs of LGA and HFs
- Supportive supervision
- Community mobilization and education
- Infrastructure development - Renovation of HFs
- Supply of drugs

What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

- Renovation of staff quarters which could have enabled HFs to provide 24 hours service
- To provide motorcycles for outreaches
- To build more health facilities to increase access to services
- To supply some essential drugs like analgesics and antibiotics
- To implement development of women power in health i.e. to identify capable women in the LGA for training in School of midwifery and health technology who in turn would come back to the LGA to provide services at the HFs as some of the competent health providers are retiring without any replacement
- DPHC said that if this was done by TSHIP in its 5 years of implementation, then the LGA would have had 25 trained providers to boost their work force

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- Stated that the LGA is currently operating the accountability framework which is holding everybody accountable for his/her duties. He said for example, the M&E Officer is expected to develop Integrated Supportive supervision workplan on quarterly basis and DPHC to supervise its implementation. The M&E would be held accountable for the successful implementation of the plan.
- DPHC said that the logistics/funds required for conducting ISS is already captured in its LGA 2015 budget
- The LGA would continue to work with the WDCs especially the executives at the LGA level.

Giade LGA

1. What is your experience with how TSHIP engaged the LGA in its project implementation?

Do you feel the LGA is full equal partner in the implementation? Why?

- TSHIP came in as partners in progress. Worked together as a team targeting the same goal.
- Was informed that TSHIP have a residential representative in the LGA

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Capacity Building:
 - o Trained both LGA and facility level staffs on different areas like, HMIS, Nutrition, RH, ORT, MCH, Immunization, vaccine management, FP, Community Mobilization, infection prevention, diagnosis and management of malaria, Linking services with the community, how to design workplans, Lot Quality Assessment Survey (LQAS), expanded Male As partners (EMAP) and the 100 women group
 - o LGA now have pool of skilled health workers to provide quality service.
 - o There is increase in the number of delivers, ANC attendance and reduction in mortality and morbidity rates
- Supportive Supervision
 - o Before was conducting traditional type of supervision which was punitive but now conducting integrated supportive supervision with opportunity to offer on-the-job training.
 - o The benefits derived by the LGA include:
 - o Training on ISS, conducting friendly supervision, provision of integrated supportive supervision checklist and transport allowance to conduct supervision
- Management
 - o Benefits derived include receiving training on leadership and governance from TSHIP
 - o TSHIP helped and guided the LGA on how to plan and organize the PHC department. They also guided the LGA in development of job description for staffs and organogram
- Integrated Services
 - o There are no specific days for ANC service but Routine Immunization (IR) services are offered on specific days because of the vaccines.
 - o Family Planning and Malaria activities are conducted on daily basis.
 - o Stated that offering the integrated services have contributed to reduction in morbidity and mortality rates
- Applying Standards to improve quality
 - o Posters, leaflets, job aids provided by THIP helped the HCWs to remember what they were taught. (Sighted the FP Protocol Manual)

- o HCWs are now using the national guidelines for diagnosis and treatment of malaria and other services.
- Collaboration/partnership
 - o LGA provided transportation during ISS and LQAS to ease the movement of staff for supervision.
 - o Provided venue for trainings and other meetings
 - o After TSHIP renovated the GH:
 - WDCs provided pit latrines in both the maternity and male ward
 - Also a philanthropist was reported to have constructed a shed at the ANC unit where health talks take place
- Harmonizing community approaches
 - o The different community groups used by TSHIP in the LGA mentioned include:
 - o WDCs, CBHVs and QITs
 - o Felt that using this different structures have resulted in:
 - increased awareness creation on health issues and utilization of HFs
- Gender
 - o TSHIP trained 65 male volunteers on EMAP – they motivate and counsel their fellow men on health issues specifically as it relates to MCH and FP
 - o CBHVs are all females
 - o HF in-charges are mostly women
 - o Husbands are now involved in the health seeking behaviour of their wives, they now allow them to go to the health facilities to receive service
 - o In WDCs and other community associations, women are given the treasurer position because they are good in keeping money
 - o Men organize the emergency transport system for transporting women in labour to the health facilities
- Monitoring and Evaluation
 - o Capacity building for Staff – Trained LGA M&E Officer on M&E, computer, LQAS
 - o Provided Laptop, registers, summary forms, internet
 - o Provided data tools to all HFs
 - o With the training received from TSHIP especially computer training, the M&E Officer is now computer literate
- Staffing of health facilities
 - o TSHIP trained Community Based Health Volunteers (CBHV) and gave them some allowance to work with the HFs and community. They serve as the linkage between HF and community
 - o With TSHIP intervention, the staffs at HFs are more knowledgeable and motivated.
 - o TSHIP paid advocacy to the LGA and state government to address the issue of shortage of manpower, based on this, the LGA employed 3 staffs for the HFs.
- Policy
 - o None

3. What Policies did you initiate/change as a result of working with TSHIP?

Did changing the policies change the practices?

- None

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals) Examples.

- Having RI conducted on daily basis with outreaches assisted the LGA in increasing the coverage of children protected from the 6 killer diseases from 20% to 89%
- The use of Misoprostol drugs assisted in reducing bleeding in women after delivery
- The establishment of ORS corners and use of zinc and ORS reduced child death associated with diarrhea
- CBHVs do tracking of children and pregnant women in the community and also accompany them to the HFs
- The use of Chlorhexidine has greatly reduced infections in new born babies
- Supplied resuscitation equipment and emergency trolleys to some HFs for MCH activities has assisted in providing quality care to patients
- TSHIP worked with the communities to introduce the emergency transport system use to convey pregnant women to health facility during labour
- TSHIP helped in the distribution of nets to prevent malaria in pregnant women and children under 5.

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

What did you do for TSHIP? Cash or Kind

How much did it cost?

- As mentioned in 2 under collaboration/partnership

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral

- Environment:
 - o Now have burn and bury sites for waste disposal
 - o In terms of infection prevention: reported that before syringes are scattered all over the place in the HFs but now it is disposed properly using the safety boxes
 - o Also have different buckets for high level disinfectants
- Supervision
 - o conduct friendly supervision and also go in teams
- HCWs Capacity:
 - o Have trained and capable HCWs
 - o TSHIP helped to advocate to state and LGA to provide enough staff to the HFs to address issue of manpower shortage
 - o Stated that before, the HF staffs were not wearing their uniforms but with the supportive supervision conducted this has changed
 - o Training of the HCWs make them to change their attitude to work and the clients
- Job aids/Protocols
 - o Available in some HFs before TSHIP intervention, but with TSHIP it is now available in all health

facilities

- Commodities
 - o Before TSHIP use to experience stock out of commodities but with TSHIP there is regular supply of commodities.
- Service Delivery
 - o Before use to have specific days for ANC but now offer ANC on daily basis
 - o Before RI was not conducted in all the 37 HFs in the LGA but with TSHIP intervention stated that all the 37 HFs are offering RI on daily basis in the fix sites and also have outreach activities which is the initiative of TSHIP
 - o Availability of TT injection prevent women from getting infection
 - o More women attending ANC service
 - o Before TSHIP, there were no registers or other forms in health facilities but with TSHIP all HFs have required registers and forms and data quality changed
 - o TSHIP renovated 3Health facilities making them more conducive for client usage
 - o Before TSHIP, HFs don't usually perform malaria test only prescribe drugs but now perform test using the RDT
- Service Utilization:
 - o Stated that less people are patronizing quack doctors and more people are now going to the facilities to receive services
- Referral
 - o In terms of referral, TSHIP reinforced the 2 way referral system and also train the community groups (WDC, CBHVs etc.) on how to refer and proper documentation
- Health Outcomes
 - o Reduction in morbidity and mortality rates to the barest minimum

7. Have you been trained by TSHIP?

- Yes

8. What did they train you on?

- As stated in 2 under Capacity building

9. How did you use this training?

- Step down the M&E training to all the HFs staff. After the training, the in-charges now know how to properly complete the HMIS forms
- Provide on the job trainings for HF staffs on all the trainings conducted by TSHIP

10. What do you do differently now?

- Before GA use to conduct supervision as fault finding activity but now conduct integrated supportive supervision which is not fault finding but helping the staff to improve on what they are doing.
- Use the computer to enter data and transmit it to the next level which has resulted in timely reporting of data. Before was using manual method which was not effective
- Before was not analysing the data collected from HFs but now analysis data producing tables and charts for decision making.
- Establish ORS corners in HFs
- Misoprostol and Chlorhexidine are now administered by CBHVs before it was only HCWs that can administer the drugs

- Using RDT to detect malaria in addition to clinical manifestation

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of data tools, registers, computers, trainings, equipment, commodities and drugs

What training do you wish you had that you did not receive?

- None

12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To support the implementation of the LGA Health development plan by releasing funds to the department for activities

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

Do you think this is a good approach?

- Don't know

14. Did TSHIP support you to develop a Costed Health Development Plan?

What is the level of implementation, and how has it improved health care delivery system?

- Reported that TSHIP helped to develop the health sector annual workplan(Sighted the plans for 2011-2013)
- Stated that much of the activities in the plans were not implemented especially those that required funding

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- Not LEAD LGA

16. How would you describe the linkage between the facility and community?

- The linkages between the community and facility create understanding, interactions and delivery of health messages. They made the clients to understand, accept and put into practice/action what they have been told.

Would you say that approaches used were appropriate?

- Stated that the linkages were appropriate and good

What could they have done differently?

- None.

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviours?

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

- Yes as stated in 2 above

Are husbands more supportive of their wives going to the health facilities? Explain?

- Yes as stated in 2 above

Are more women being placed in leadership positions? Give examples?

- Yes as stated in 2 above

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community?

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
- NEI
- SIDHAS
- PROACT
- DELIVER – Supply of FP commodities, malaria drugs and nets to HFs
- WHO & UNICEF --worked together with TSHIP as follows:
 - o Support RI
 - o Co-sponsor immunization Plus Days

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? explain

- Most Significant “Reduction in child and maternal mortality” said that most people are aware and taking action by attending the health facilities.

Others?

- Capacity building of HCWs in the management of malaria
- Proper documentation and completeness of data

20. What are the things TSHIP did in your LGA which you will like to continue doing?

- To continue all the interventions done by TSHIP Specifically mentioned the following:
 - o Renovation of HFs
 - o Provision of equipment
 - o Conduct Integrated Supportive Supervision
 - o Provision of drugs and commodities
 - o Training and re-training of HCWs
 - o Advocacy to state government to request that they continue where TSHIP stopped.
- Said TSHIP is seen as health “PTF”

What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

- To conduct house numbering as this could help in identifying clients residence for easy follow up and tracking of defaulters
- To initiate Public Private partnership which could have helped in providing some of the basic needs in the HFs

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- No concrete plan in place. However, the LGA chairman said that they will ensure that activities implemented by TSHIP will be sustained by the LGA.
- Also the DDPHC I said that they are waiting for direct funding from the president which will enable them have funds to implement activities

Misau LGA:

1. What is your experience with how TSHIP engaged the LGA in its project implementation? Do you feel the LGA is full equal partner in the implementation? Why

- TSHIP paid advocacy to the LGA Chairman and other management staff to introduce the project's aims and objectives
- Thereafter, stated that TSHIP continued to engage the LGA in its project implementation helping the LGA to develop health strategic plan and monitor its implementation

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Capacity Building:
 - o Trained both LGA and facility level staffs on different areas like, HMIS, Nutrition, RH, ORT, MCH, Immunization, vaccine management, FP, Community Mobilization, infection prevention, diagnosis and management of malaria, Linking services with the community, how to design workplans, Lot Quality Assessment Survey (LQAS), expanded Male As partners (EMAP) and the 100 women group
 - o LGA now have pool of skilled health workers to provide quality service
 - o Community capacity to recognize danger signs improve
- Supportive Supervision
 - o Before was conducting traditional type of supervision which was punitive but now conducting integrated supportive supervision which give opportunity to offer on-the-job training, encourages, motivates and guide the service providers
 - o Benefits includes conducting friendly supervision, revised integrated Supportive Supervision checklist and transport allowance to conduct supervision
- Management
 - o Benefits derived include receiving training on leadership and governance from TSHIP
 - o TSHIP also helped to develop job description for staffs, PHC department Mission, Vision, core-values, objectives and organogram
- Integrated Services
 - o There is no specific days for offering ANC service but the RI services are offered on specific days because of the vaccines.
 - o FP and Malaria activities are conducted on daily basis.
 - o They stated that services are also offered based on client's needs.
- Applying Standards to improve quality
 - o The LGA officers stated that they participated in the pretesting of IEC materials, SOPs etc.
 - o Posters, leaflets, job aids provided by THIP helped the HCWs to remember what they were taught.

- Collaboration/partnership
 - o LGA seconded NYSC members (Medical personnel) to 2 (Zandawa Maternity and Guaram PHC) HFs renovated by TSHIP
 - o LGA provided 10 Solar refrigerators to 10 HFs to boost routine immunization
- Harmonizing community approaches
 - o The different community groups used by TSHIP in the LGA mentioned include:
- WDCs, CBHVs, Community Direct Intervention (CDIs), TBAs
 - o Felt that using these different structures have resulted in:
 - increased awareness creation
 - reduction in maternal mortality
- Gender
 - o TSHIP trained EMAP which are males
 - o Selected CBHVs which are all females
 - o Have the in-charge of facilities all females
 - o Said that if CBHVs are not allowed in an household where their services are needed, they report such issues to the WDCs, EMAP members and traditional leaders who in-turn talk with their men folks to allow the CBHVs to attend to the women
 - o Husbands are now involved in the health seeking behaviour of their wives, they now allow them to go to the health facilities to receive service
- Monitoring and Evaluation
 - o Capacity building for Staff – Trained LGA staff on M&E, computer
 - o Provided Laptop, registers, summary forms, internet
 - o Provided data tools to all HFs both the 2010 and 2013 version
 - o With the training received from TSHIP especially computer training, the M&E Officer is now computer literate
- Staffing of health facilities
 - o TSHIP trained Community Based Health Volunteers (CBHV) and gave them some allowance to work with the HFs and community. They serve as the linkage between HF and community
 - o With TSHIP intervention, the staffs at health facilities are more knowledgeable and motivated.
 - o With TSHIP intervention and advocacy paid to the LGA to address the issue of shortage of staff, the LGA employed 9 staff (4 CHEWs and 5 JCHEWs). This is in addition to posting 2 Youth Corpsers to 2 Health facilities renovated by TSHIP
- Policy
 - o Mentioned Health and safety policy

3. What Policies did you initiate/change as a result of working with TSHIP?

Did changing the policies change the practices?

- Mentioned Health and safety policy which changed the practice of how LGA and HFs staff handles equipment

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals) Examples

- CBHVs do tracking of children and pregnant women in the community and also accompany them to the HFs
- MCH coordinator said that some women attend ANC but when it is time to deliver, they deliver at home and experience bleeding. Said that the use of Misoprostol drugs assisted in reducing bleeding in women after delivery
- Stated that previously they use charcoal, cow ducts, Marcleans, salt, lead etc. to clean the umbilical cords which resulted in infection for babies but with the use of Chlorhexidine thus has greatly reduced infections in new born babies
- Supplied resuscitation equipment and emergency trolleys to some HFs for MCH activities
- TSHIP worked with the communities to introduce the emergency transport system use to convey pregnant women to health facility during labour

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

What did you do for TSHIP? Cash or Kind

How much did it cost? As mentioned in 2 under collaboration/partnership

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral

- More women attending ANC service
- More deliveries by skilled birth attendants
- Improvement in sanitation of the HFs – Dustbins (Colour coded) and sharp boxes are provided for proper waste and sharps disposal. Also the WDCs cleaned the HF premises especially during raining season
- Training of the HCWs make them to change their attitude to work and the clients
- Before TSHIP, there were no registers or other forms in health facilities but with TSHIP all HFs have required registers and forms and data quality changed
- TSHIP renovated 4Health facilities making them more conducive for client usage
- Before TSHIP, use to experience stock out of commodities but with TSHIP there is regular supply of commodities.
- Before TSHIP, HFs don't usually perform malaria test only prescribe drugs but now perform test using the RDT
- In terms of referral, TSHIP reinforced the 2 way referral system and also train the community groups (WDC, CBHVs etc.) on how to refer and proper documentation

7. Have you been trained by TSHIP? Yes

8. What did they train you on? As stated in 2 under Capacity building

9. How did you use this training?

- Step down the M&E training to all the HFs staff. After the training, the in-charges now know how to properly complete the HMIS forms
- Provide on the job trainings for HF staffs on all trainings conducted by TSHIP

10. What do you do differently now?

- Before conduct supervision as fault finding activity but now conduct supportive supervision which is not

fault finding but helping the staff to improve on what they are doing.

- Use the computer to enter data and transmit it to the next level which has resulted in timely reporting of data before was using manual method which was not effective
- Before TSHIP no ORS corners but this was initiate
- Misoprostol and Chlorhexidine are now administered by CBHVs before it was only HCWs that can administer the drugs
- HCWs are now using RDT to detect malaria in addition to clinical manifestation
- Provided services with confidence because of adequate skills and knowledge to perform it

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of data tools, registers, computers, equipment, drugs and trainings

What training do you wish you had that you did not receive?

- None

12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To continue paying for the ISS allowance and transport
- Employ additional supportive staff for the HFs
- To supply portable waters and toilet facilities
- To fence the existing HFs for security purpose
- To provide staff quarters for HCWs as some facility staff are scouting in the facility using rooms in the HF as their living quarters
- To renovate the existing facilities
- To sustain the WDCs and CBHVs through payment of allowances previously paid by TSHIP
- To continue to provide data management tools
- To supply essential drugs
- To conduct re-fresher trainings as the need arises

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

- Said that some staff in 2 HFs (Gawram and Hardawa) were trained on SBMR
- The LGA staff were not trained

Do you think this is a good approach?

14. Did TSHIP support you to develop a Costed Health Development Plan?

What is the level of implementation, and how has it improved health care delivery system?

- Said that the LGA staffs attend the strategic planning meetings held in 2011 and 2013
- They said TSHIP helped them to develop the strategic plan. (Could not cite the copy)
- Also reported that TSHIP helped to develop the health sector annual workplan

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- Don't know

16. How would you describe the linkage between the facility and community?

- The linkages between the community and facility creates understanding, interactions and delivery of health messages. They made the clients to understand, accept and put into practice/action what they have been told.

Would you say that approaches used were appropriate?

- Stated that the linkages were appropriate

What could they have done differently?

- None.

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviours?

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

- Yes as stated in 2 above

Are husbands more supportive of their wives going to the health facilities? Explain?

- Yes as stated in 2 above

Are more women being placed in leadership positions? Give examples?

- Yes as stated in 2 above

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community?

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
- NEI
- SIDHAS
- PROACT
- DELIVER
 - o Supply of FP commodities, malaria drugs and nets to HFs
- WHO & UNICEF – worked together with TSHIP as follows:
 - o Support RI, Disease surveillance
 - o Co-sponsor immunization Plus Days and Child Health Weeks
- BACATMA and TSHIP
 - o stated that they collaborated in the training of HCWs, CDI program, net distribution and RDT

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? explain

- Most Significant "Reduction in child and maternal mortality" said that most people are aware and taking action by attending the health facilities.
- Others?

- o Increase utilization of maternal and child health service.
- o Creating enabling environment for health services
- o HCWs having adequate knowledge and skills to attend to clients
- o Good leadership and governance at the LGA PHC level
- o Good linkages between communities, facilities and LGA
- o Improved data quality – availability of tools and timely reporting
- o Reduction in malaria cases

20. What are the things TSHIP did in your LGA which you will like to continue doing?

- To continue all the interventions done by TSHIP

What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

- To renovate staff quarters instead of only the health facilities as this help to boost 24 hrs service provision
- To train all HF staffs on MCH instead of training few.
- To provide generators and freezers to improve cold chain management which would have an impact on conduct of routine immunization
- To provide modern incinerators for the disposal of waste product as the one in general hospital was not adequate to meet the needs of the LGA. Stated that they have to carry safety boxes to Azare for disposal during campaigns

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- No concrete plan in place. However, the LGA chairman said that they will ensure that activities implemented by TSHIP will be sustained by the LGA.

Shira LGA:

1. What is your experience with how TSHIP engaged the LGA in its project implementation?

Do you feel the LGA is full equal partner in the implementation? Why

- Very cordial relationship.
- TSHIP conducted advocacy to LGA policy makers and the PHC department to introduce the goals and objectives of the project
- Also said that TSHIP conducted a situation analysis of the health situation and worked with the LGA to address the issues identified.

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Capacity Building:
 - o Trained both LGA and facility level staffs on different areas like, HMIS, Nutrition, RH, ORT, MCH, Immunization, vaccine management, FP, Community Mobilization, CLMS, diagnosis and management of malaria, Linking services with the community, how to design workplans, Lot Quality Assessment Survey (LQAS)
 - o LGA now have pool of skilled health workers to provide quality service
- Supportive Supervision
 - o TSHIP organized the LGA to conduct Integrated Supportive Supervision. The reports are produced with recommendations on improvements. Reported that when conducting follow on ISS visits, the extent of implementation of recommendations in previous ISS visit would be done to know the extent of accomplishment.
 - o Before was conducting punitive type of supervision but now conducting supportive supervision which give opportunity to offer on-the-job training
 - o Improve on development of plans for supportive supervision.
 - o Improve on the conduct of supportive supervision by including all relevant units in the PHC dept as members of the team. (reports of supportive supervisions conducted sighted)
- Management
 - o Benefits derived is a good management structure at both the LGA and HFs Levels
 - o Received training on leadership and governance from TSHIP
 - o Before the inception of TSHIP, only the PHC Director know a little about Management but with the training and capacity building activities of TSHP this changed e.g.:
 - There was better management of crisis among staff
 - LGA now know how to prepare organogram, staff schedule of duties and job description. All these have been implemented by the LGA
 - Development of training plans

- Conduct of monthly review meetings
 - TSHIP supported the LGA to develop operational health work plans (Cited the 2014 annual workplan and the results matrix)
 - Improved skills of LGA and facility staffs due to trainings received
 - Renovation of health facilities
- Integrated Services
 - o ANC services are operated on 2 days in a week depending on the days selected by the facility. Also 5 maternity clinics out of the 26 maternity in the LGA are practicing focused ANC
 - o Immunization conducted 4 times in a week i.e. have 2 fixed and 2 outreaches per week
 - o FP and Malaria activities are conducted on daily basis.
 - o They stated that services are also offered based on client's needs.
- Applying Standards to improve quality
 - o Posters, leaflets, job aids provided by THIP helped the HCWs to remember what they were taught.
- Collaboration/partnership
 - o During WDCs meetings LGA provides lunch
 - o LGA distributed the HMIS forms to the HFs after printing by TSHIP
 - o LGA provides fuel for vehicles during supportive supervision activities
 - o LGA provided venue for training
- Harmonizing community approaches
 - o The different community groups used by TSHIP in the LGA mentioned include:
 - WDCs, CBHVs, Community Direct Intervention (CDIs), Village Development Community (VDCs), TBAs, CBO - Alheri_Disina.
 - o Felt that using this different structures have resulted in:
 - increase access to health care services
 - increase patient and client flow at the facilities
 - reduction in maternal mortality
 - improvement in data quality because of the different tools available to track activities of the community groups
- Gender
 - o Said that during training, TSHIP always request for a mixture of male and female participants.
 - o Husbands are now involved in the health seeking behaviour of their wives, they sometimes take them to the health facilities, wait for them to receive service and convey them home afterwards, In other cases they provide transport money for the wife to attend the HFs. Said this was possible because of the awareness created by the different community structures.
 - o Women are given leadership positions in the LGA e.g. the DPHC, MCH Coordinator, TB coordinator, Assistant Director Water and Sanitation, are all women.
 - o In WDCs stated that women are given the positions of Treasurer and Secretary.
- Monitoring and Evaluation
- Capacity building for Staff – Trained LGA staff on M&E, computer
- Provided Laptop, registers, summary forms, internet
- With the training received from TSHIP especially computer training, the M&E Officer is now computer literate

- Staffing of health facilities
 - o TSHIP trained Community Based Health Volunteers (CBHV) and gave them some allowance to work with the HFs and community. They serve as the linkage between HF and community
 - o With TSHIP intervention, the staffs at health facilities are more knowledgeable and motivated.
 - o With TSHIP support, advocacy was paid to the LGA policy makers and MOLG and 52 additional qualified health workers were posted to the LGA to support service provision at the HFs.
- Policy
 - o None

3. What Policies did you initiate/change as a result of working with TSHIP?

Did changing the policies change the practices?

- None

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals) Examples

- CBHVs do tracking of children and pregnant women in the community and also accompany them to the HFs
- Use of Misoprostol and Chlorhexidine drugs assisted in reducing bleeding in women after delivery and infections in babies. LGA felt that this has greatly increase the chances of the mothers and babies surviving.
- Training of in-charge of health facilities for referral to higher facility and the provision of ambulances by government helped to reduce delays usually encountered when making referrals

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

What did you do for TSHIP? Cash or Kind

How much did it cost? As mentioned in 2 under collaboration/partnership

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral

- Training of the HCWs make them to change their attitude to work and the clients
- Before TSHIP there were no registers or other forms in health facilities but with TSHIP all HFs have required registers and forms and data quality changed
- TSHIP renovated 2 Health facilities making them more conducive for client usage
- Delivery of quality health care service e.g. before was not delivery focused ANC
- Supply of equipment like BP Apparatus, weighing scales etc. helped in proper clerking of clients
- Before TSHIP when a woman bleeds after delivery, ergometrin is administered and then the woman is referred but now using of Misoprostol is more effective and stops the bleeding
- Before TSHIP, usually use spirit to clean new born baby umbilical cord but now uses Chlorhexidine. That has reduced the rate of infection in new born babies
- Use of pantograph have helped the midwives in taking deliveries
- Before TSHIP there was no commodities like Misoprostol and Chlorhexidine and also irregular supply of

FP commodities but with TSHIP there is regular supply of commodities.

- In terms of referral, TSHIP conducted training on 2 way referral system, redesign the forms for 2 way referral and institute feedback system. Before TSHIP, the LGA was experiencing difficulties in receiving feedback from the higher level facilities.

7. Have you been trained by TSHIP? Yes

8. What did they train you on? As stated in 2 under Capacity building

9. How did you use this training?

- Step down the M&E training to all the HFs staff. After the training, the in-charges now know how to properly complete the HMIS forms
- Provide on the job trainings for HF staffs in all areas of training conducted by TSHIP

10. What do you do differently now?

- Before conduct supervision as fault finding activity but now conduct supportive supervision which is not fault finding but helping the staff to improve on what they are doing. Also instead of concentrating on one's area of specialization, the officer conducting the supportive supervision can check on other areas with the help of the modified integrated supportive supervision checklist
- Use the computer to enter data and transmit it to the next level which has resulted in timely reporting of data before was using manual method which was not effective
- Before TSHIP ORS corners were grounded but this was resuscitated by TSHIP.
- Misoprostol and Chlorhexidine are now administered by CBHVs before it was only HCWs that administer the drugs
- HCWs are now using RDT to detect malaria in addition to clinical manifestation

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of data tools, registers, computers, equipment, drugs and trainings

What training do you wish you had that you did not receive?

- None

12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To conduct advocacy to policy makers, traditional and religious leaders to solicit for their support to continue where TSHIP stopped
- To embark on resource mobilization from philanthropists and groups.
- To conduct capacity building trainings and re-trainings
- To continue with supportive supervision

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

Do you think this is a good approach?

- L.I.O stated that they were trained twice on SBRM in 2011 and 2012. Not convinced that he knows the SBMR approach

14. Did TSHIP support you to develop a Costed Health Development Plan?

What is the level of implementation, and how has it improved health care delivery system?

- They said TSHIP helped them to develop the strategic plan. (Could not cite the copy)
- Also reported that TSHIP helped to develop the health sector annual workplan(sighted a copy). The implementation is monitored using the Results matrix

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- Don't know

16. How would you describe the linkage between the facility and community?

- The linkages between the community and facility create understanding, interactions and delivery of health messages. They made the clients to understand, accept and put into practice/action what they have been told.

Would you say that approaches used were appropriate?

- Stated that the linkages were appropriate

What could they have done differently?

- None.

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviours?

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

- Yes as stated in 2 above

Are husbands more supportive of their wives going to the health facilities? Explain?

- Yes as stated in 2 above

Are more women being placed in leadership positions? Give examples?

- Yes as stated in 2 above

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community?

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
- NEI
- SIDHAS
- PROACT
- DELIVER
- WHO & UNICEF – worked together with TSHIP as follows:
 - o Provided data tools
 - o Organize seminars and workshops together
 - o Conduct joint supportive supervision with the LGA staff esp. on immunization
 - o Co-sponsor immunization plus days
- WOFAN

- o Provided water in health facilities

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? explain

- Most Significant by L.I.O “Increased utilization of FP service” said that most people are aware and taking action by attending the health facilities
- Most significant by M&E is “Improved quality of Health Care Services” due to the training and re-training received by the HCWs.

Others? :

- Increase utilization of the Routine Immunizations service, said that when there are shortages of vaccine clients go from one facility to the other looking for the vaccines to get for their children which might be as a result of the awareness creation in the communities
- Increased visits to the HFs to receive service because people now prefer to get advice as regards to their health from the HFs rather than rely on the Patent Medicine Vendors (PMVs)

20. What are the things TSHIP did in your LGA which you will like to continue doing?

- Monthly review meetings
- Capacity building for staffs of LGA and HFs
- Supportive supervision
- Community mobilization and education
- Infrastructure development - Renovation of HFs
- Supply of drugs

What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

- To train some of the health facility staff on monitoring of disease surveillance as a way of eradicating Polio incidence in the state
- To provide re-agents and specimen containers to collect samples from the communities
- To monetize the money spent on participants during TSHIP training i.e. instead of lodging the participants in the hotel providing refreshment and lunch, to monetize it and give them the funds and let them find where to stay

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- No concrete plan in place. However, said the LGA chairman will ensure that activities implemented by TSHIP will be sustained by the LGA.

Tafawa Balewa LGA:

1. What is your experience with how TSHIP engaged the LGA in its project implementation?

Do you feel the LGA is full equal partner in the implementation? Why

- TSHIP started working in the LGA around 2011, they first met with stakeholders, conduct analysis of the health situation in the LGA and work together with the LGA to develop annual workplans to address the identified gaps and needs
- Worked with TSHIP like brothers and sisters
- TSHIP relationship with the LGA was very cordial
- LGA and TSHIP rub minds together to implement activities

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Management:
 - o Trained the LGA staff on leadership and management and the following was achieved:
 - Enhanced ability of the LGA staff to work together as a team
 - Developed the PHC Dept Organogram, job descriptions, mission and vision statements
 - File and filing process improved in the PHC dept
 - o Trained the LGA In charges of health facilities on team work
 - o Trained the LGA staff and WDC members on advocacy. Based on this, advocacy visit was conducted to the Care Taker Committee Chairman to introduce the activities of the WDCs and CBHVs to him. This lead to agreement with the chairman who asked the WDCs to state their request which will be incorporated into the LGA budget.
 - o Partnership For Development (PFD) the sub grantee that worked in Tafawa Balewa donated their office furniture, generating set and motorbike that they used in implementing TSHIP project to the PHC Dept
- Capacity Building
 - o TSHIP conducted series of workshops, seminars, trainings and updates for LGA and Health facility staffs. This include training on FP, how to use computer, HMIS, Community Direct Intervention (CDI), case management of malaria, CLMS management, use of MDRT, Infection Prevention (safety precautions), ORT, Basic Emergency Obstetric Care (BEMONC), Integrated Management of Childhood Illnesses (IMCI), EMAP, CAC, Advocacy.
 - o LGA now have pool of trained personnel to provide health services
- Supportive Supervision
 - o Trained LGA staff on supportive supervision
 - o Provide integrated supportive supervision checklist

- o Provide allowances for supportive supervision
- o Supportive supervision now integrated into the LGA systems. The LGA now have yearly supervision plan.
- Integrated Services
 - o The ANC session plan was developed with ANC offered twice weekly. Stated that despite having specific days for ANC whenever a pregnant woman comes to the health facilities she receives service.
 - o RI services offered based on session plans developed with WDCs. About 50% of the HFs conduct 4 fixed and 4 outreach Routine Immunization in a month while some only conduct RI twice in a month.
 - o Malaria and FP are provided on daily basis.
 - o This shows that full integration of services not implemented in the LGA
- Standards to improve quality
 - o TSHIP distribute various protocols, job aids and posters to the health facilities and LGA which include but not limited to:
 - New Treatment guidelines for malaria, diarrhea
 - Standards of Practice (SOP) for FP, data management
 - Standard checklist for ISS
 - o All these provided updated knowledge for the HF staff to help them perform their job well
- Collaboration/Partnership
 - o LGA provided vehicle during supportive supervision and LQAS exercise while TSHIP fund the fuelling of the vehicle
 - o TSHIP and PHC dept. jointly conducted advocacy visit to the LGA executives for repair of damaged ceilings in 2 HFs. Based on the visit, the LGA have completed the repair in 1 HF while the repair of the other one is in progress.
 - o TSHIP conducted joint trainings with SPHDCA and WHO
 - o Worked with BACATMA to train HCWs on malaria, supply of drugs and nets
- Harmonizing Community Approach
 - o Community groups that TSHIP worked with include:
 - WDCs, CBHVs, ISS Teams, QITs and 100 women groups
 - o TSHIP using the various community groups brought the LGA and HFs closer to the community
- Gender Mainstreaming
 - o Increased participation of men in accepting FP
 - o Trained Men as Male As Partner – which is an all men group that sensitize their fellow men on health matters
 - o Trained CBHVs who are mixture of male and female
 - o During dialogue and sensitization activities, men are encouraged to support their wives in their health seeking behaviour
 - o In WDCs, women are usually given the post of treasurer or PRO – there are 4 wards out of the 16 wards where females are part of the executive
 - o TSHIP initiated the emergency transport system (Okada Riders & NURTW) to transport women in labour to the health facilities or to other facilities when referred.
 - o CBHVs created awareness with husbands/in-laws in the family to give their standard permission for their wives to attend the HFs whenever the need arises. They are also sensitized to save money to convey the woman to the HFs when the need arises. TSHIP also provided posters on how husbands

should assist their wives to go to the HFs. This system was reported to be working well and have reduced the denials of husbands for their wives to go to the HFs.

- Monitoring and Evaluation
 - o Capacity building for Staff – Trained LGA staff on M&E, computer, LQAS
 - o Provide Laptop, registers, summary forms, internet
 - o Provide data tools to all HFs
 - o With the trainings received from TSHIP especially computer training, the M&E Officer is now computer literate
- Staffing of HFs
 - o TSHIP worked with the LGA to come up with ward minimum health package
 - o With advocacy from TSHIP and other donors to the state and LGA executives, the PHC department was given approval to employ 46 health workers and have so far been able to employ 28. The LGA also employed 131 security men to guard the HFs.

3. What Policies did you initiate/change as a result of working with TSHIP?

Did changing the policies change the practices?

- None

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals) Examples

- Provision of free ANC drugs, SPs and FP commodities
- Provision of equipment
- Having RI conducted on daily basis with outreaches have really assisted in increasing the coverage of children protected from the 6 killer diseases from 20% to 89%
- The use of Misoprostol drugs assisted in reducing bleeding in women after delivery
- The establishment of ORS corners and use of zinc and ORS reduced child death associated with diarrhoea
- CBHVs do tracking of children and pregnant women in the community and also accompany them to the HFs
- The use of Chlorhexidine has greatly reduced infections in new born babies
- Supplied resuscitation equipment and emergency trolleys to some HFs for MCH activities
- TSHIP worked with the communities to introduce the emergency transport system use to convey pregnant women to health facility during labour
- TSHIP helped in the distribution of nets to prevent malaria in pregnant women and children under 5.
- Immunization status improves as a result of TSHIP supportive supervision

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

What did you do for TSHIP? Cash or Kind

How much did it cost? As mentioned in 2 under collaboration/partnership

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

- Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral
- Environment:
 - o Have burn and bury sites for waste disposal
 - o Provided colour coded dustbins
 - o Have different buckets for high level disinfectants
 - o Not much changes experienced in the availability of functional toilets at HFs
 - o Some HFs in the LGA now have sanitation days when they clean the environment
- Supervision
 - o For supervision, before use to be harsh to the facility staff and did not go as a team but now conduct friendly supervision and also go in teams
- HCWs Capacity:
 - o Have trained and capable HCWs
 - o TSHIP helped to advocate to state and LGA to provide enough staff to the HFs
 - o Training of the HCWs make them to change their attitude to work and the clients
- Job aids/Protocols
 - o Available in some HFs before TSHIP intervention, but with TSHIP it is now available in all health facilities
- Commodities
 - o Before TSHIP use to experience stock out of commodities but with TSHIP there is regular supply of commodities.
- Service Delivery
 - o Improvement in maternal health especially in giving birth.
 - o More women attending ANC service.
 - o Immunization status improved especially as a result of supportive supervision
 - o Before TSHIP there were no registers or other forms in health facilities but with TSHIP all HFs have required registers and forms and data quality changed
 - o TSHIP renovated 3 Health facilities – GH Boto, GH TafawaBalewa and MCH Kardammaking them more conducive for client usage
 - o Established 4 functional ORT corners
 - o Install solars in 2 wards to aid immunization cold chain
 - o Before TSHIP, HFs don't usually perform malaria test only prescribe drugs but now perform test using the RDT
- Service Utilization:
 - o Stated that more people are now going to the facilities to receive services
 - The data available shows that % of HF delivery in 2013 was 8%, it increased to 14% in 2014 and between January and May 2015 have already reached 9% and hopeful that it will be 18% by end of the 2015.
 - In 2013, 1,836 pregnant women attended 1st ANC visit, rose to 4,964 in 2014 and between January and May 2015 have recorded 2,508 visits.
 - For FP visits, there were 213 new acceptors in 2013, rose to 397 in 2014 and have recorded 283 between January and May 2015.

- In the area of immunization, before 2013 immunization coverage was below 50%, in 2013 it was 79%, in 2014 it was 113% and as at May 2015 have achieved 70% coverage
- Referral
 - o In terms of referral, TSHIP reinforced the 2 way referral system and also train the community groups (WDC, CBHVs etc.) on how to refer and proper documentation.
 - o However it was stated that the general hospitals are not providing the required feedback to the lower level; HFs.
- Health Outcomes
 - o Reduction in maternal and child mortality rates

7. Have you been trained by TSHIP? Yes

8. What did they train you on?

- As stated in 2 under Capacity building

9. How did you use this training?

- Step down the M&E training to all the HFs staff. After the training, the in-charges now know how to properly complete the HMIS forms
- Provide on the job trainings for HF staffs

10. What do you do differently now?

- Before conduct supervision as fault finding activity but now conduct supportive supervision which is not fault finding but helping the staff to improve on what they are doing.
- Use the computer to enter data and transmit it to the next level which has resulted in timely reporting of data before was using manual method which was not effective
- Before was not analysing the data collected from HFs but now analysis data producing tables and charts for decision making.
- Before TSHIP no ORS corners but now available
- Misoprostol and Chlorhexidine are now administered by CBHVs before it was only HCWs that administer the drugs
- HCWs are now using RDT to detect malaria in addition to clinical manifestation

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of data tools, registers, computers, trainings, equipment, commodities and drugs

What training do you wish you had that you did not receive?

- Training on PMTCT and syndromic management of STI

12 What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To provide logistics support to conduct day to day activities especially supportive supervision
- To have prompt and regular release of standing imprest for the PHC department
- To intensify capacity building to bridge the knowledge gaps in the LGA
- To have constant supply of essential drugs, Misoprostol and Chlorhexidine
- To support and motivate the WDCs and CBHVs
- To employ additional staff for the health facilities

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

Do you think this is a good approach?

- Don't know

14. Did TSHIP support you to develop a Costed Health Development Plan?

- TSHIP trained HCWs on the development of strategic plans
- Also reported that TSHIP helped to develop the LGA health sector annual workplan

What is the level of implementation, and how has it improved health care delivery system?

- Stated that much is not implemented especially those that required funding except those jointly implemented with other donors and projects. Said that they use the available resources to achieve what can be achieved

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- Not LEAD LGA

16. How would you describe the linkage between the facility and community?

- The linkages between the community and facility create understanding, interactions and delivery of health messages. They made the clients to understand, accept and put into practice/action what they have been told.

Would you say that approaches used were appropriate?

- Said that the linkage is cordial, encouraging and interesting
- Stated that the linkages were appropriate and good

What could they have done differently?

- None.

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviours?

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

- Yes as stated in 2 above

Are husbands more supportive of their wives going to the health facilities? Explain?

- Yes as stated in 2 above

Are more women being placed in leadership positions? Give examples?

- Yes as stated in 2 above

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community?

- TSHIP should have started the EMAP activities earlier at the beginning of the project to be able to achieve more in the area of men supporting their wives to access services in the HFs
- To conduct empowerment trainings for women in the committees
- To use religious leaders to include health issues in their sermons and the role of men because whatever

they say is held in high esteem by the congregation

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
- NEI
- SIDHAS
- PROACT
- DELIVER
 - o Supply of FP commodities, malaria drugs and nets to HFs
- WHO & UNICEF – worked together with TSHIP as follows:
 - o Support RI
 - o Co-sponsor immunization Plus Days and supportive supervision
- DELIVER –

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? Explain.

- Most Significant “Reduction in child and maternal mortality” said that most people are aware and taking action by attending the health facilities.

Others?

- Others are:
 - o Capacity building of HCWs
 - o Proper documentation and completeness of data
 - o Availability of equipment to provide services
 - o Improved quality of services rendered
 - o High utilization of Vitamin A

20. What are the things TSHIP did in your LGA which you will like to continue doing?

- All the areas TSHIP intervened

What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

- To introduce PMTCT in Primary Health Facilities – Training of service providers and setting up the sites
- To introduce the management and prevention of STI in the services rendered in HFs

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- DPHC said that “It is a bond duty that the LGA must do”. Said that the caretaker committee have been informed about the need to sustain the things that TSHIP did in the LGA and is optimistic that once the LGA gets its funds it will address some of the issues.
- For those things that do not require must capital, the following were stated as the plans that the PHC dept have put in place:
 - o The PHC Management Team will continue to support the integrated supportive supervision and already have the 2015 plan in place
 - o To liaise for support from the communities in sustaining the activities of WDCs and CBHVs

- o To engage WDCs and CBHVs in ad-hoc activities of the LGA e.g. IPDs
- o To attach 1 LGA staff to each ward to support the activities of the WDC.

Q1. What is your experience with how TSHIP engaged the LGA in its project implementation?

- LGA staff capacities were built by TSHIP on various management and coordination skills such as in community engagement /mobilization, supervisory monitoring in health facilities, data management and quality procedures etc.
- We also had a very cordial work relationship with TSHIP. The LGA chair meetings held with community groups but supports for the meetings are provided by TSHIP
- Renovation of HFs; training of many HFs personnel in FP, malaria, etc.; holding coordination meetings with the Community-based Health Volunteers (CBHV)
- There is a harmonious work relationship between the LGA and TSHIP. TSHIP provides the commodities and the LGA staff are involved in implementation and monitoring of service provision
- Training of LGA personnel, encouragement of LGA staff in respect of data quality and assessment, improvement of social mobilizations in communities
- The work relation was very cordial, TSHIP sit with the LGA to plan and implement activities together
- The LGA is carried along in all supervision activities
- We appreciate TSHIP, they always come to inform the LGA about what they want to do, whether in training or material distribution etc.
- They conducted advocacy visits to the LGA to engage with Community leaders
- The LGA officials were attached to TSHIP to identify WDC members for reactivation and in the selection of CBHVs in communities
- We plan together with TSHIP on community activities, they create the activities and we work with them for approval and acceptance by communities
- The work relationship is harmonious and cordial. TSHIP always inform us in advance of any program or events or activity they want to carry out
- There is regular contact between the LGA and TSHIP to plan together
- There have been involvement of the LGA, Religious/Traditional leaders in TSHIP programmes
- TSHIP always sent mails to the LGA for cooperation (work together with them) on their assignments
- TSHIP always carry the LGA along by engaging with us and there is mutual relationship and respect between us, we work together as partners
- We partnered with TSHIP, the relationship is cordial, working in the community as partners in progress, TSHIP is here to support us, the LGA is responsible to the pp, they always inform us of their activities
- Strong advocacy with the community & LGA policy makers at the beginning of the project
- Cordial, TSHIP inform the LGA of what they want to do and the LGA give them government, TSHIP is allowed to go on with their work. For example in Ningi West TSHIP inform the LGA of the plan to renovate the Town and Bashi Maternities, LGA official went to these site and give TSHIP the go ahead.
- At the community TSHIP carry along the village communities in what they want to do, involved in decision making
- The work relation I cordial. TSHIP send letter to us inviting us to Bauchi, we go out as teams, we conduct ISS exercise together.
- Whenever they are coming they inform us. If by chance we don't go with them, they give us feedback. Going with them the community respond to them better. Whenever we received commodity from them, the LGA always give in return the acknowledgement letter as a process of documentation
- When there are issues or gaps at the HFs, they come back to the LGA to discuss these and we find solutions to these gaps

- Cordial and harmoniously work relationship
- When TSHIP activities come the LGA allow her staff to work along with TSHIP staff
- LGA staff participated fully in TSHIP activities
- Provision of logistics and guides to the HFs and Community
- We conduct ISS and review meetings together
- TSHIP provide feedback to the LGA on work performance in general

Q2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- We benefitted from TSHIP – training of LGA staff, renovation of health facilities (HFs); provision of equipment to HFs; reactivation and training of WDC members; provision of misoprostol to prevent bleeding by mothers during delivery and chlorhexidine for PPH treatment in children
- Our HFs have poster (job-aids) to help them in their works.
- Benefits from TSHIP includes – training/retraining of LGA officials, HF staff and Community groups; renovation of HFs in the LGA; equipment (stethoscope, weighing-scale etc.); data tools and computers – for DHIS; solar refrigerators, FP commodities (insertion bead and distribution of these commodities); OT materials and equipment; malaria drugs (coatrim and LLIN); support for ANC and RI outreaches; collaboration/partnership and integration of services; organization of baby-show (giving gift e.g. wrappers to encourage service utilization at the HFs.
- Formation of CBHV has improved turn-out of patients at the HFs
- TSHIP promoted gender-equality – Before VDC/WDC were all male but now we have both males and females as members
- They introduced the formation of 100-women group in the LGA for economic empowerment
- TSHIP organized training in gender mainstreaming to promote men/women making decisions together and enhance women to make decisions about herself
- On M&E TSHIP provided computers; data tools and trained on processing of DHIS data, data quality and management
- TSHIP trained HF staff and supported supportive supervision
- On policy TSHIP has facilitated improvement of supply of LGA health data to the State/National health data database
- Training of key LGA staff on all components of ANC; routine immunization, malaria treatment, family planning; female health workers on IUC, LAMP and KMC
- Formation of CBHV workers to mobilize for FP and delivery time services
- Introduction and procurement of misoprostol,
- Renovation of 2 HFs (Saani and Wababe dispensaries)
- Provision of equipment, materials and commodities for ANC, RI, malaria and nutrition services
- Recruitment and payment of house-to-house vitamin A vaccinators
- Provision of supports for follow-up teams
- Recruitment, training and payment of allowance (N2,000) for CBHVs
- Support for ANC and RI outreach activities
- Provision of data tools to HFs
- TSHIP renovated and supply drugs to HFs in the LGA
- TSHIP trained LGA and HF in the LGA
- The project brought community near to government to create awareness about their health

- Trained WDC members for self-service to the community and for ownership
- TSHIP supported the LGA to take RI services to underserved communities especially the Fulani communities
- Provided equipment to preserve drugs
- Provided support for follow-up services
- Supported outreach services by paying service providers
- Before TSHIP there were no data tools or systems to send data, TSHIP provided computers, data tools and training of M&E personnel
- They supported the programme on prevention of maternal and child mortality by providing misoprostol and chlorhexidine
- Formed and trained CBHV workers to mobilize people in the community to increase client flow to the HFs
- Benefitted from TSHIP the knowledge of undertaking standard RI by the LGA personnel
- TSHIP supported a 4-day training in 2013 for NPI Managers
- On gender mainstreaming – None
- On HF staffing - before staff are transferred without consultation and procedure, but TSHIP advised on essence of even distribution of staff
- Staff are nominated by the LGA for training whether qualified or not, but now TSHIP send the name/position of people they want to invite for training
- TSHIP conducted assessment tour to all the health facilities in the LGA
- They identified training needs of all our PHC staff including the LGA team
- Organized training and retraining of PHC staff of all components of PHC
- Provided equipment, materials and apparatus to all PHC facilities for effective management of clients
- Conduct regular supportive supervisions to HFs and bring back feedback to the LGA and also advise for necessary correction for all identified issues
- Reactivated WDCs, in which 5 members in each ward were selected for training to enhance performance
- Assisted the LGA Team and 2 RI personnel from HFs with cash assistance of N2,000 as transport allowances for supervision of outreach services
- Renovated PHCs at Danchadi, Sifawa, and Bodinga General Hospitals
- Supported the LGA in collaboration with Ministry of Local Government and Community Development in the provision of free misoprostol and chlorhexidine to our women for the treatment of postpartum bleeding
- Supported the LGA in selection of 10CBHV workers from the 11 wards for community mobilization on ANC and RI with provision of cash assistance of N2,000 monthly
- Trained the M&E Officer and provided Laptop computer to each M&E Officers across the state as well as provision of cash assistance of N5,000 monthly
- Provided data tools and modem for internet connection for sending data to the State
- Supported the LGA during IPDs with 5 revisit teams in every round
- Supported social mobilization during advocacy and sensitization meetings with traditional and religious leaders during RI and IPDs.
- On Gender – Whenever they want to choose participants for training, gender balance is always considered for example the 5 WDC members chosen for training were ratio of 3men to 2women
- On Staffing at the HFs – Although they were not supposed to recruit staff members, they complement the effort of our staff during implementation of activities

- Rehabilitation of facilities
- Provision of basic equipment, furniture and drugs to HFs
- Built capacities through training of staff of the LGA – Head of Depts. And Sections; HF – In-charge and staff; and the community – this included training of CHEWs & JCHEWs, WDC members, CBHV workers, TBAs, Community/Traditional leaders etc.
- Reactivation of WDCs (before most of them are not functional), they meet monthly and TSHIP supported them with transport fare and snacks
- TSHIP trained and retrained TBAs on basic skills of ANC service delivery
- TSHIP assisted in funding integrated supportive supervision (ISS) to all the HFs. This is done according to a work-plan and itinerary, visiting facilities on the itinerary list
- Supported the Task Force on Immunization (TFI) both morally (i.e. by being there to see things for themselves and supervise) and financially (i.e. providing token amount to community members)
- Supported formation and use of Community Direct Intervention + (CDI+) in the LGA. CDI+ comprised 70% women & 30% men which were formed in 2013. Their specific functions are distribution of malaria drugs and materials, distribution of essential drugs such as chlorhexidine and misoprostol as well as facilitate referral to HFs
- Supported the formation of Community-based Health Volunteer Workers comprised of men and women with a multi-dimensional tasks of facilitating uptake of healthcare services like ANC, RI, FP and referral
- TSHIP has trained all the 20 MCH coordinators on
 - o Orientation and supportive supervision on long active reversible contraception
 - o In-plant and IUC insertion and removal
- Conducted survey on how to support CHEW in FP services
- Trained male SP on how to provide FP services
- TSHIP conducted survey of WDCs (Active & Non-active) across the State with simple random sampling of 7 wards from each LGA
- TSHIP has been providing transportation support for Contraceptive Logistics Management System (CLMS), paying least – N2,000 and highest – N3,000 as well as provision of refreshments
- They have supported monthly review meeting of WDCs, HF In-charges and CDI+ supervised by the LGA paying for transportation the least – N2,000 and highest – N3,000 as well as provision of refreshments
- TSHIP trained all HF's M&E Officers on HMIS data tools (i.e. registers and summary forms) and data collection procedures
- TSHIP provided ORT corner in all the HFs and training on infection control measures
- On malaria programme TSHIP trained HF staff on malaria case management and also provided IEC materials
- TSHIP improved on gender mainstreaming by maintaining equal representative criteria for selection of people to be trained. If for example 6 people are to be trained in the LGA or for CHEW they will insist on 3M & 3F ratio
- They are gender sensitive in project implementation approaches
- The Community Midwifery Scheme for northern states (i.e. Bauchi, Jigawa, Sokoto, Kebbi, Zamfara, etc.) was initiated in 2013 at the National Health Council meeting held in Calabar, where the states were referred to Partners working in the states. TSHIP was for Bauchi and Sokoto states in conjunction with the National Midwifery Council at the training partner
- Management of the LGA was trained on job description, organogram and all Head of Sections were trained on how to assess their subordinates
- On policy, before TSHIP people in the community, does not partake in governance, TSHIP funded Task Force on Immunization (TFI) / LGA management committee, where discussions are held on outbreak alerts,

surveillance, inflow of people during emergence periods (such as during boko haram attacks) at the community level

- Before most HF were in dilapidated condition, TSHIP renovated Garin-Abari Health clinic, Kari PHC and MCH section Model PHC papa, Maternity and Theatre section of General Hospital Darazo
- Capacity building in term id ISS and support with transport allowance for quarterly supervision
- Trained 170 CBHV worker on labour and post-natal and enlightenment of women for ANC and immunization at the HF
- WDC community action cycle – i.e. identify together, planning, implement together; community mobilization, and household education (key hh practices that are not known by some Hh members)
- TSHIP trained all HF SP on malaria, HMIS data tools, labour and life-saving skills
- LGA officials were trained as ToT on community action cycle, extended men as partners in FP, and the training were cascaded down; proposal writing, operational/work-plan development
- Health workers were trained on HMIS tools stepped down the training to LIO, M&E Officer and Cold Chain Officer
- Trained CBHV on use of misoprostol and chlorhexidine
- Health providers were trained on the ORT corner in 10 HFs
- Directors are trained on management skills
- Trained of Health workers on RDT, FP, data management, HMIS tools to the HFs,
- Supply laptops, computers to the M&E Office,
- Supply of equipment, such as furniture (benches, delivery kits, sanitation materials),
- THSIP assist in the formation of Quality Improvement Team (HF staff, community members) in some of the HF (Gen Hospt, Papa Model PHC, Under 5 Clinic and Sadi PHC)
- TSHIP assist in formation of Emergency Transport System in the LGA
- Community
- TSHIP gave grant to 1 WDC (5million) to finance a proposal, on development plans, purchase of drugs and equipment,
- Created awareness in the community (they can identify their problems and know where to go) of ANC services leading to increase in client flow
- Improved reporting from the HF to the LGA on HMIS
- TSHIP strengthened the linkage by inviting CBHV on quarterly basis (submit data on monthly based) to the LGA for review meetings. Linkage strengthen from community leaders to ward leader to LGA administration
- Policy
- TSHIP trained LGA on policy implementation, developed strategic plans, review operational plans,
- Staffing at the HF
- TSHIP advised the LGA to deploy from where there is excess to area of need
- TSHIP upgraded health facility system into a model role
- They empower the community by making them accessible to services (ANC, RI, FP, Sanitation) the healthcare delivery system
- Provided data all the data tools (RI, M&E, MCH tools) and were distributed to the HFs
- TSHIP the LGA health staff in
 - o MNCH
 - o Immunization service delivery

- o Environmental sanitation and
- o Nutrition evaluation
- o Malaria control activities
- o Integrated supervision (Health Dept. staff and some in-charges)
- o Surveillance activities (the LGA team and the focal sites)
- o Supported IPD (send supervisor to supervise) and RI session
- o Supported TFI members through supervision and given them allowances (N6,000 for every TFI member)
- Trained In-charges in
 - o Seeing patients and diagnosis
 - o Provision of diagnosis materials e.g. Ningi Town Maternity (test materials – malaria kits, testing reagents,
- Trained Community members in identifying simple cases and managing it at the community level
- Provided ORT corners
- Reactivated health post in the community
- They empowered WDCs and CBHV through supervision and support IPD teams and
- RI to discuss issues at the community level i.e. community linkage
- Identified some maternities and provided quarterly training managing maternal case (abortion, delivery, malaria in pregnancy, hemorrhage etc.)
- Provided boreholes in the HFs (Gaga Health Clinic, Nasaru MPH, Bura Health Clinic, Bashi Health Clinic and Ningi Town Maternity)
- Prepare breakdown solar fridges in LGA and HFs
- Trained LGA staff on ISS and conduct ISS monthly (State/TSHIP/LGA/HF)

Partnership

- LGA benefitted in terms of service delivery at the HFs
- Renovation of HFs
- Conduct of ISS together
- Support the LGA with allowance every month when they go for ISS
- Provide technical as in service delivery etc.
- Supported 1-4 monitors to supervise during IPDs

Gender Mainstreaming

- In staff training TSHIP invite maternity In-charge that are female and Health Centre In-charges that are male and give them training together
- They incorporated female members in the WDCs

Monitoring & Evaluation

- Monitor and provide on-the-job trainings to SPs (M&E Officers, Surveillance/RI Officer at HF level, the Health focal site etc.)
- They harmonized the data reporting system i.e. Data Verification (DVDM) collected by WHO and the HMIS
- Data analysis at the community level and utilization with the LGA to take informed decisions

Staffing at the Health Facilities

- Advise the LGA on posting of essential staff at both HF and Community levels

- TSHIP send one focal person from the State to each LGA (collect data in all aspects of service) and one another TSHIP staff that collect data on RI

Policy

- Every project in the LGA has a policy and TSHIP assists in the implementation of these policies

LGA

- Built our capacities with several training
- Leadership and management
- ISS (To develop checklist)
- Data management (Data collection and analysis & Computer)
- Budgeting and planning (how to prioritize)
- Lot quality Assurance (LQAS)
- Revive the management meeting
- Maintenance policy
- Data achiever

HF's

- Renovation of HF's (Igila, Baima, Dagu Health Clinics, part of General Hospital)
- TSHIP supply these HF's with benches, equipment, IEC materials
- Built capacities of SPs
- Focus ANC
- FP/RH/RI
- Infection prevention
- Drug management
- Active management of 3rd stage of labour
- Integrated management of Childhood Illness (ILCI)
- Integrated child care management (ICCM)
 - o Newborn Care
 - o Management of pre and post eclasia
 - o Referral system
 - o Establishment of ORT & Zinc corner

Collaboration & Partnership

- In the community some community-based groups were identified such as FOMWAN, 100-Women Groups, WDCs,
- Partnered with State Primary Health Care Development Agency, BACATMA,

Gender Mainstreaming

- Trained 100 Women Group, CBHV (8 Female 2 male), FOMWAN at LGA level
- Trained the Community/Traditional/Religious Leaders to speak to men on FP, RI, attending ANC, Delivery in the facility
- Emergency transport system within the community (Volunteers with each HF having their own team)
- CBO groups were given grants for economic empowerment (100-women group)
- Composition of WDCs with 60% male and 40% female

Monitoring & Evaluation

- HMIS data tools were supplied with the revised 2013 versions
- TSHIP provided computer with modem
- Trained on how to generate, analyse and use data
- TSHIP facilitated compliance with timeline for submission of data
- Trained on data quality

Staffing at HFs

- Trained CBHV on health education, referral and treatment of mild illnesses
- TSHIP advocate to policy-maker on staffing issues for right mix of professionals at the HFs

Policy

- TSHIP use of analysed data to advocate for changes by policy-makers
- TSHIP advocate for supply and replacement of hospital equipment
- TSHIP advocate for health planning & budgeting

Trained/Retraining of LGA Staff

- Management level – development of strategic workplan
- ISS
- LQAS
- Management of malaria cases
- During Maternity & Child Health Week – State government trained Nutrition Focal Person on Nutrition
- Contraceptive Logistic Management System (CLMS)
- Long Acting Contraceptives (Implanor) – MCH Coordinator
- MCH Coordinators on Insertion of IUCD
- On malaria – 2 personnel were trained on malaria management and malaria data tools
- Trained all LGA team on proposal writing
- Training on KMC
- Training of Private Medicine Vendors
- Training on how to use RDTs and dispense drugs
- Training on Focused ANC

Community

- Training of CBHV and WDCs – Male Involvement (EMAP)
- CBHV trained on Misoprostol & Chlorhexidine distribution
- Community mobilization by WDCs and CBHVs
- Early Identification of pregnant women, delivery, immunization and referral
- FP
- ORS
- How to write report
- NHMIS and data management
- 19 HFs in 19 Wards across the LGA on HMIS
- Provision of data tools and collection of reports

- Provision of IEC materials
- Support in ISS (provide some stipends - N 2,000 x 2 x 6 per quarter)
- Provided stipends to WDCs and CBHVs during review meetings (N2000 per person)
- Sponsor part of FP review meetings in terms of transportation
- Renovated maternity section of General Hospital Alkaleri, Duguri Health Clinic
- Formation of ORT corners in 6 HFs
- Provision of healthcare equipment (BP apparatus, beds, delivery kits, Manual Vacuum Aspiration (MVA), weighing scale, suction machines (manual & electrical) to most of the facilities in the LGA
- In immunization TSHIP supplies cold chain equipment (solar refrigerators)
- Maintenance of existing cold chain equipment
- Setup infection prevention corners in labour room

Collaboration/Partnership

- Capacity building for FOMWAN, FBO, CAN on community mobilization during immunization programme where the LGA supervised and collected data

Gender Mainstreaming

- Imams and Pastors were trained to sensitise males in the communities to create awareness among community member to accept service delivery in HFs
- Trained '100 Women Group' and empowerment as women to help the husband at home and play more roles such as in birth preparedness
- Male involvement is under WDCs who oversee the activities, the men work with the CBHV to sensitize the women to seek & access healthcare for their health need even without the husband at home (after permission)

Monitoring & Evaluation

- Training of M&E Officers on
 - o Data management
 - o Data analysis and tabulation
 - o Use of computer

Staffing in the HFs

- TSHIP advocated to the LGA management in terms of staff recruitments
- By training the CBHV who mobilize at the community levels and follow-up to the HFs
- MCH staff trained as ToT to step-down training at HFs and LGA support for the step-down training
- Trained LGA staff as State trainer to train Male CHEW to render FP services in the HFs

Policy

- None

Q3. What Policies did you initiate/change as a result of working with TSHIP?

- Memo to the Council to take-up the RI and MCH programmes in the LGA
- The LGA support for community-driven drug revolving scheme, spraying of every wards to prevent the spread of malaria and promotion of community dialogue
- None

- This is mostly done at the State level, but for M&E domestication of the principle of 3 ones
- No response
- Approval by the State Government (to continue with) of CBHV workers in communities
- Also the selection and training of the 100 women group at the community level
- Change in behaviour and attitude of people e.g.
 - o On behaviour – people's behaviour in respect of open-defecation has reduced
 - o On attitude – Sometimes when there is training, we now have evidence-based approach to attendance of training by staff
- Shortage of security men and TSHIP the LGA to recruit them and these was done
- TSHIP identified roles of the community, SP, LGA, State govts and Partners
- Security situation has improved
- Grass root people are now involved in planning and able do budget tracking
- In general in the quality of the services at the HF level
- Great improvement of ownership of the programme
- No response
- Training of maintenance policy
- Identification of goals and visions
- Before TSHIP supervision is just traditional, but with TSHIP, it is now integrated with supervision and correction, where program officers goes out as a team
- Proper linkage between the SP and the communities
- Improvement in the attitude of Health Workers
- Data collection and reporting originates from the grass-root
- Resource generation by TSHIP encouraging the WDC to mobilize resources from many sources i.e. Politician, Wealthy individuals
- Trained WDC to writing letter seeking for support for advocacy
- Before supervision is done only the section head, with no integration, but now with the TSHIP support it has now transformed into ISS

Q4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals)

- Cases of maternal and child deaths have reduced in the LGA as a result of improvements in the ANC and RI services at the HFs. We know these from the data we get from the HFs
- Provision of LLIN by TSHIP has contributed to reduction in malaria among children and pregnant women in the LGA
- ANC outreach activities has reduced death of pregnant women by creating awareness of seek ANC and delivery services at the HFs
- The use of misoprostol has helped a lot to treat bleeding during delivery, chlorhexidine for cord-care in newborn and the use of coartem (ACT) to prevent malaria has also contributed to reduction in maternal and child mortality in the LGA
- The observation of 'Child Health Week' every three months have been used to promote and sensitize communities to seek healthcare services at HFs which has contributed to increase in service uptake by mothers and children at the HFs and as such reduction in cases of preventable deaths of mothers and children

- TSHIP assisted the LGA through the following activities which led to reduction of maternal and child morbidities and mortalities in the LGA:
 - o advocacy to the LGA and community/religious leaders to solicit support
 - o development of work-plan for social mobilization
 - o Support for outreach activities
 - o Mobilization of the people especially in communities
 - o Use of traditional/religion/women group/TBAs to engage communities
 - o Provision of drugs while the last state government administration provided equipment, stand-by generators and ambulance to the HFs
 - o Training of community groups on resource mobilization for sustainability and ownership of project activities
- MDG provided basic hospital equipment. The DPM is just aware of TSHIP activities in the LGA hence could not say much in this regard
- TSHIP supported RI in the LGA
- Four (4) HFs (Bagarawa PHC, Danchadi PHC, Sifawa Clinic and Dijandi PHC) were provided with Mama-kit and the LGA provided essential drugs
- The distribution of misoprostol and chlorhexidine saved lives of mothers and children respectively in the LGA
- TSHIP in collaboration with the LGA sensitized Community/Religious/Traditional leaders and 3 days later went back to the same communities and immunize the under five children (especially in hard-to-reach locations)
- TSHIP supplemented MDG efforts by bringing the idea of misoprostol and chlorhexidine from Nepal
- Supported PMTCT, to prevent transmission of HIV from mother to their unborn child(ren)
- Provision of infection prevention measures in all HFs
- Provision of ORT corners in all HFs
- Supported/trained on RI
- Training of SPs on active management of 3rd stage of labour and basic BEmOC
- Due to skilled birth attendants trained by TSHIP
- Increase awareness of danger signs by community members and mothers
- Access to misoprostol and chlorhexidine
- On childhood, there immunization coverage has improved because of the awareness
- Management of diarrhea diseases at home using ORT and zinc
- Improvement on malaria treatment due to training and retraining of healthcare providers using ACT and RDT
- During pregnancy if take Sulphurhedine (Fansidar) intermittent malaria prevention prophylaxis drugs to protect mothers and child during pregnancy
- No response
- Capacity building to SP on how to manage bleeding by use of misoprostol and chlorhexidine
- Community member were education on important of HF-base delivery
- Promotion of FP
- Supply of hospital equipment (e.g. weigh-scale, BP apparatus, delivery forcep, mucous extractor, delivery bed, solar panel & batteries for routine immunization) that boosted improved service provision

- Enabling environment in the HFs, resulting in good linkages between the HF and the community thus increasing client flow
- Use of CBHV for community mobilization for ANC, FP and immunization
- Provision of ORT corners has contributed to reduction in child mortality from diarrhoea
- Capacity building of SP, in infection prevention and management of third stage of labour, management of malaria in pregnancy, management of abortion, post abortion care (PAC)
- Formation of WDCs and CBHV worker who server in early detector of complicated cases and referrals
- Supply of delivery kit (e.g. BP apparatus)
- Increased acceptance of FP reduced rate of giving birth and reduced maternal death
- Practices of KMC
- Emergency Obstetric Neo-natal Care – Specific HF trained to render emergency to neo-natal babies hence reduces morbidities and mortalities
- Use of misoprostol and chlorhexidine

Q5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

- The LGA gave TSHIP nothing in terms of cash, but is collaborating with TSHIP to implement project activities
- The State government provided 6 vehicles for the LGA that was distributed to the HFs
- The LGA is supporting (paying salary) of 4 Doctors (1 x-ray and 3 Consultants) working in the HFs
- All sectional heads are supported by the LGA to participate in supportive supervision at the HFs
- The LGA actively dedicated some resources (manpower and vehicles) to create awareness and linkages between TSHIP, community leaders and community organizations
- Through SMOH and SMoLG, payment of N3,000 to RI service providers every month
- Maintenance of cold chain equipment
- Granting authorization to health personnel to go for TSHIP trainings
- The Health Department worked with TSHIP
- Ministry of Local Government employed Health workers and 66 of them were sent to the LGA and they were distributed to the HF, their salaries and allowances were being paid by the LGA in line with the directive from the Local Government Service Commission
- LGA invites Community leaders and pay for their transport during outreach activities
- LGA provide vehicles and allowances for staff during outreach services
- When TSHIP conduct supportive supervisions, findings were discussed with the LGA and they jointly take appropriate actions
- The LGA donated an office space at the LGA to the project
- Sometimes the LGA made available the venue (council chamber) free of charge for TSHIP to hold meetings
- When TSHIP sent notification mail about trainings, the LGA assisted to identify people for such trainings
- Wherever TSHIP wanted to work, the LGA helped TSHIP to locate boundaries and settlements
- LGA provide the platform (HR, discipline, communication etc.) for TSHIP to work in the LGA, - by involving the LGA team which cascade or link it to the community or HF so that it works successful
- LGA is involved in the selection of HF to be renovated
- LGA provided venue and sitting arrangement during training at LGA, Ward and HF levels

- LGA supplemented with some equipment like delivery kits (forcep, stethoscope, furnitures etc.)
- LGA supply some consumable items like drugs, disinfectant, detergents, Jik gloves etc.
- LGA built (Kwarati Dispensary, GakulanGanuwa Dispensary, Gangina Dispensary) and renovated some HF (Gabarin & Lago Health Clinics, Tauya PHCs Jinmin Dispensary)
- Deployment of staff as a result of reports from ISS (identify area of need and supply accordingly)
- LGA provided piece of land, TSHIP constructed "Immunization shade" in Ningi town and Nasaru Model PHC
- Staffing of the HFs based on TSHIP advocacy
- Release of staff for ISS
- When the LGA are invited
- LGA officials provide on-the-job training for HF staff
- LGA provide the basis for community linkages
- LGA in most cases provided training and meeting venues
- At times provision of logistic support for ISS in remote areas
- LGA compile data for TSHIP
- LGA allow staff to participate in TSHIP in activities
- LGA provide logistics during supervision

Q6. How have the HFs changed during TSHIP implementation?

- Turnout of clients increased
- Improvements in data reporting from the LGA to State
- The HFs are very clean
- The CBHVs always mobilize the communities in all activities of the HF in their area
- There are functional ORT corners
- Turnout for MCH has increased tremendously
- Training of HF staff has resulted in better knowledge of how to provide FP services correctly
- Provision of Kangaroo Mother Care (KMC) skill practices before other treatments for newborns with low birth weight
- Ability to provide newborn resuscitation cares
- The LGA did not benefit from the MSS to address shortage of female health workers because it was not in the cluster
- Before TSHIP interventions HFs mostly use demonstration acts to explain health procedures to clients but now we now have many job-aids posters for that purpose and also for constant remainder of various health procedures to clients
- Referral knowledge was poor and almost not practiced before TSHIP. "Even when a client cannot be managed, we still go ahead and manage that patient since we don't know our limitations ... but now TSHIP has improved with more knowledge through training we know how to do it better e.g. for placenta previa ..."
- Before TSHIP interventions, coverage for RI was very low and high incidence of preventable diseases, but with TSHIP support there has been a drastic reduction in unimmunized children and vaccine preventable diseases in the LGA
- We now have reduction in malaria cases amongst pregnant women

- The ways In-charges conduct their roles at the HF has changed. They now observe all rules (following standard procedures) on safety and clinical services
- In-charges have being trained on standards
- There has been improvements quality of data being reported because record officer have been trained
- THSIP provide some job-aids
- The HFs are now more utilize by the people i.e. high turn-out of clients in the HFs
- Before there were no training, purchase of drugs, additional team to support TSHIP but all these are now been done by the LGA
- Before TSHIP our local women in the villages did not know the importance of giving birth in the HFs and other ANC services, RI and FP, but now they know better and are utilizing the services in the HFs
- Before HF staff did not know the importance of working with Community leaders, now they sit and plan activities with them
- We now have Community ownership and linkage with the HFs
- Before pregnant women and women of child bearing age were not going to the HFs to receive TT vaccine, but now this has changed and coverage has increased
- CBHV work with Community leaders who influence husband to contribute positively to the health seeking behaviour of their wives and along become involved themselves
- Before data processing was a challenge but now the capacity to process data has improved very significantly
- There are increase in Client flow at the HFs, due to sustained mobilization and sensitization. Coverage has also increased
- Records are now better kept and updated
- Improved patient-flow at the HFs
- Facility-based deliveries had increased (i.e. shifted from home delivery to facility delivery)
- Increased acceptance of FP services
- Increased demand for immunization services
- Change of attitude to work of healthcare workers as a result of capacity building e.g.
 - o Reduction in rate of absenteeism
 - o Use of ISS to motivate staff
- Considering some performance indicators
- HF-based delivery has increase with skilled birth attendance
- Immunization coverage has improve (increase) Jan 2014 (3%) – Dec. 2014 (81%)
- Knowledge of HF staff has increased using national guideline to offer services to clients
- The community linkage as improved significantly
- Increased availability of commodities and essential drugs
- Increased use of IEC materials at HFs
- Improvement in data utilization and timely reporting
- Improvement in reporting system from the HF to LGA to the national server using SMS technology
- Bedding capacity has improved
- Improved health-worker's skills, now they can handle some complicated cases that they hitherto refer to secondary HFs
- There is reduced number of still-births

- Provision of borehole water reduced incidences of typhoid and diarrhoea
- Provision of quality services at the HFs like:
 - o In the management of severe bleeding during delivery
 - o Use of FP device which has changed the behaviours of the community people
 - o Infection prevention procedure were strictly observed
 - o Increase in use of LLIN as prevention measure
 - o Before chloroquine are used, but now ACT are used for treatment
 - o Conduct of RDT
 - o Haemoglobin testing for pregnant women during ANC by using talquish paper
 - o Use of Intermittent Prevention Treatment (IPT) for prevention of malaria during pregnancy
 - o Implementation of focus ANC
 - o Provision of Iron tablets and delivery kits
- Health Outcomes
 - o Less morbidity amongst children and pregnant mother based on reported/analysed data
 - o Increased in Hospital-based delivery
 - o Increased in immunized children
 - o Change of behaviours by community member
 - o Increase in ANC and HF based deliveries
 - o Greater acceptance and utilization of FP
 - o Increase in RI coverage
 - o HF can now diagnose malaria case through use of RDT
 - o Improvement in diarrhoea at home
 - o Knowledge and general adherence to job description by HF staff
 - o Reduction in referral in respect of abortion, since most HFs can now manage them instead of referral to Gen Hospitals
 - o Bridging of gap between the PHC department and the LGA (success at the HFs) better rapport as a result of
 - o Advised on increase in midwives training in the state

Q7. Have you been trained by TSHIP?

- Yes

Q8. What did they train you on?

- Training of CHEWs on records management
- MCH training on delivery
- RI training on how to give new antigens
- Nutrition trainings on malnutrition issues
- M&E personnel were trained on how to use the computer for processing DHIS data, data management in general and quality of data
- Logistic management for FP

- Demonstration of ORT
- Focus ANC services
- Malaria management
- 'Jadel' insertion
- Community sensitization
- Training on DHIS and HMIS
- Kangaroo Mother Care
- Newborn care
- Management of third stage of labour
- Training of key LGA staff on all components of:
 - o ANC
 - o Routine immunization
 - o Malaria treatment
 - o Family planning
- Female health workers on:
 - o IUC
 - o LAMP and
 - o KMC
- LGA/HF/Community groups received training on the following:
 - o Documentation
 - o Malaria in pregnancy
 - o ORT
 - o Data management
 - o Community resource mobilization
 - o RI
 - o Disease surveillance
 - o FP
 - o ANC/MCH
- All trainings as mentioned in Q2
 - o TSHIP trained and retrained TBAs on basic skills of ANC service delivery
 - o Built capacities through training of staff of the LGA – Head of Depts. And Sections; HF – In-charge and staff; and the community – this included training of CHEWs & JCHEWs, WDC members, CBHV workers, TBAs, Community/Traditional leaders etc.
 - o TSHIP trained and retrained TBAs on basic skills of ANC service delivery
 - o TSHIP has trained all the 20 MCH coordinators on
 - Orientation and supportive supervision on long active reversible contraception
 - In-plant and IUC insertion and removal
- Trained male SP on how to provide FP services
- TSHIP trained all HF's M&E Officers on ICT, HMIS data tools (i.e. registers and summary forms) and data collection procedures

- Management of the LGA was trained on job description, organogram and all Head of Sections were trained on how to assess their subordinates

In addition to the trainings mentioned in Q2 above

- Trained/Retrained on HMIS on 2103 version
- Training of the LGA team, Ward focal persons, and Distribution Point (DP) personnel on the use of LLIN
- MCH
- Immunization
- Environmental sanitation
- Training of 5 CHEWs in each LGA for the insertion/removal of implants
- Counselling and testing on HIV for pregnant mothers during ANC
- Roles and responsibilities on each staff in the HFs
- Trained on DQA
- ToT on Community Direct Intervention (CDI) on malaria
- Long Active Reversible Contraceptive (LARC)
- Leadership and Management System
- TSHIP trained on Bauchi State Ward Minimum Healthcare Package
- Training on AMSTL, Emergency Neo-natal care (ENC)
- ToT for Village Health Workers (VHW)

Q9. How did you use this training?

- To improve the way we perform our duties
- Better ORT services are now being provided at the HFs
- No response
- The trainings have been used to improve service provision and also stepped down to junior staff in the departments
- Things are now being done in standard ways for example the training in RI – before vaccine injections were given on intramuscular (buttocks) part of the body, but now we use the outer part of the thigh, this has encouraged more turnout for immunization
- The trainings were done in clusters where LGA staff were invited to Yago for training
- Training on insertion provided the required knowledge and enhanced skillful application of the FP method
- Before computers were not used to send repots to the State by now after the training we have started processing and submitting report through the computer
- We now perform supportive supervisory visits with the required skills
- After the training on infection control, there are now better use of safety boxes and sanitary equipment at the HFs
- The ORT corners are fully utilized now
- After training on surveillance, report on disease surveillance are now much quickly and timely submitted
- Before it was manual/paper reporting but now I use the computer to input data and send it to the server
- Use the operational plan to know when and where activities will be conducted
- Being trained as ToT's trainings are cascaded down to lower level of personnel
- Using ISS findings, issues are addressed at the health facilities and corrections are made on the spot promptly

- Data are now more utilized for decision making at the HF and LGA levels as they can perform simple analysis
- Ability to perform self-assessment (i.e. internal DQA) on reported data
- Ability to produce and update the immunization monitoring charts
- We now conduct ISS
- Improved performance on the part of SP
- Provision of quality services
- Resulted in integrated work environment, working together , with greater input and better results

Q10. What do you do differently now?

- Before MCH services are provided anyhow, but now it is done by appointment
- FP are done blindly before but it is now done with better knowledge
- Before data are sent manually but since TSHIP provided computers and training M&E officers , we now send DHIS data electronically to the State
- Before ...'I do it as I like, but after TSHIP trainings, it is done the way it is supposed to be done'
- Before TSHIP, there was low coverage, but with their support there has been a reduction of unimmunized children
- Before TSHIP there was high incidences of vaccine preventable diseases, which has now reduced with the use of vaccines
- We now have reduction in malaria cases among women
- The use of misoprostol has reduced incidences of hemorrhage during delivery, hence more clients are taking up ANC services
- Use of FP services has increased in service demand
- Before many M&E Officers don't know how to operate the computer, but now they can do so and send data to the State without using the service of a Cyber-cafe
- Before HF could not do analysis to diagnose malaria, but now all the HFs are now using RTDs for malaria diagnosis before treatment
- There are major improvements in data/records/document keeping at the LGA/HF/Communities
- Before the selection of IPD workers were done without the WDCs, but now the WDCs are involved
- Before TSHIP every reports were in hard copies, but now we have soft-copies which makes sharing of data/information to be faster as well as able to back-up documents in a more efficient manner
- Before we go for supervision without work-plans, but now we develop a work-plan before going for any supervisory visit
- Promotion of team work among the LGA team and the HF staff
- ISS was initially fault-finding mission, but now it is more of supporting and corrective for HF staff by LGA personnel
- Before items like drugs, furniture materials, etc. were being distributed without requisition, but now the process as change to making requisition first, request being scrutinized and decision to supply (if available)
- Initial in supervision of HF a programme officer can supervise only he/her programme, but now it is integrated such that individual can supervise beyond the area of profession
- Initially checklist are kept with the facilities, but now a copy is being given to them after each visit
- Our reporting system has been harmonized (DVDMT and HMIS)
- Delivery and malaria control since the HFs can now diagnose and treat malaria
- LGA official are able to form goals, vision, mission and priorities

- On maintenance policy, staff can now maintain equipment, more security conscious,
- On ISS – now HFs and LGA can identify gaps and proffer solutions to them
- After data training, quality data (rather suspicious data) are now reported
- LGA officials now work in team with good team spirit leading to increase in productivity
- We now use data for planning
- Train on misoprostol and chlorhexidine as led to increase in coverage and demand from village not initially included in the coverage area
- FP training – there is high coverage of the services – before they give different reason for not wanting the services but now they are the one demanding for the services
- On RI training – SP now know how to administer and apply correct antigen, how to record information, how to plan for the year, know target percentage, as well as how to dispose wastes generated during the session
- Before in HFs infection prevention is not observed but there is high level disinfection for infection prevention
- Before in the HF staff does not know or work with any job description but now they work with documented job description
- Before HF does not have workplan but now they have workplan
- HF now have service protocols to guide their practices
- In RI before staff cannot track defaulters but now CBHV are now able to track defaulter
- Before we use ordinary book to capture data but we now use standard recording and reporting tools
- B4 we capture data annually, but we now use computer
- Before now proper documentation (e.g. meeting minutes) but we have proper documentation
- There is feedback from TSHIP to the LGA, HFs & community thro graph, charts etc.
- Now after ISS, we develop monthly executive summary that is submitted to the LGA management
- B4 chlorhexidine, the TBA normally apply cow-dung, maclean, salt etc. on umbilical cord, but now it is the chlorhexidine
- B4 miso women are left to die if there is no remedy or were given local herbs
- B4 no practice of active management 3rd stage of labour and they give egometrin, but now they use miso or oxytocin or miso in the HFs
- B4 nature of reporting is not tracked (zero, late, earl reporting), but now we chat reporting status
- We now have organograms
- B4 aborting id referral but now most Hf can now do MVA to treat incomplete abortions
- B4 LARC (jadelimplanol) was done by Doctors and midwives, but now CHEW are now allowed to do it
- B4 care of premature babies was crude but KMC is now practiced
- B4 Private Medicine Vendor but now they use RDT before managing it and also at the HFs
- B4 pp do not want to use ACT drug, but due to training ACT are now being used
- B4 children are dying due to diarrhoea but ORT at hoe has stopped this
- B4 we don't know how to implement the 5-years strategic plan, but TSHIP taught us how to update and extract annual workplan
- B4 women refused practice of EBF, but with TSHIP more women are now practicing EBF
- Now ISS is performed using prepared work-plan as against random pick of HFs before
- B4 there are several appointment for ANC, but now it is maximum of 4 visits

Q11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Through the trainings we received and supportive supervisory visits to the HFs
- No response
- Yes in many ways such as the trainings, ISS, linkage of the communities with the HFs etc.
- Training on ANC services led to reduction in maternal and child deaths and after the training the LGA provided fund for mobilization in the community
- No response
- The various trainings has enhanced the capacities to do our jobs more efficiently, we now conduct ISS to the HFs as mentors rather than bosses who was look for faults with improved coverage (before a HF may not be visited for a year, but now most HFs are visited regularly i.e. monthly)

YES

MNCH

- Through training on life-saving skill (LSS), FP, Operational plan development
- Before HFs don't know management of 3rd stage of labour but now during supervision it is done practically
- Before no management of preclasia but now it is being managed at the health facilities by use of magnesium sulphate

FP/RH

- Selected In-charges of dispensaries were trained on FP
- Provision of data tool for FP

RI

- Provided immunization registers, tally sheets and monthly summary sheets
- Capacity built on Sub Immunization Activities (SIA) / RI reports
- TSHIP funded outreach activities in some selected HF (e.g. Diggri Dispensary, Gakulan-Ganuwa Dispensary, Indabo Dispensary etc.)

YES

- Through supportive supervision of service delivery
- On-the-job training of SP

YES

MCH

- Before HF does not know how to maintain equipment, but now maintain some of our equipment (such as delivery equipment)
- Before HFs does not do growth monitoring and promotion, but it is now being done
- Before HFs does traditional ANC, but now they do focused ANC

FP

- Training HFs staff
- Receive of commodities on bi-monthly basis
- Before HFs does not do implants but now they can do implants
- The use CBHV to mobilize the community for family planning

- Provision of FP commodities to client free of charge

RI

- Provision of on-the-job trains to RI provides
- Provision of antigens
- Monthly meeting of RI providers and provision of transport support
- Some HFs were provided with solar refrigerators for vaccine storage
- Planning of fixed sessions in the HFs and outreaches to communities that are at least 5km a far
- Conduct of ISS to the RI providers
- Support through community mobilizations when there are poor turn-outs

MCH/FP

- Better performance of duties e.g. AMSTL, conducting FP review meetings and supervising CBHV monthly review meetings
- Stock and restock FP commodities very well
- Able now to insert IUCD, implanol, LARM
- Trained as ToT (State trainer)
- Performance of on-the-job training to other HF staff

RI

- Able to collect and collate RI data
- Analyse data for actions
- Based on analysis be able to prioritize area to give supervision
- Conduct of monthly review meetings with RI providers in HFs that bring about quality services

Q12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- No response
- For MNCH continuous training, FP/RH/RI – training, supply of commodities related to the services , strengthening of supervision and continuous provision of incentives
- Advocacy to the LGA management for support after outline of all results of TSHIP
- MCH - Conduct of more training and retraining on quarterly/annual basis to consolidate on improved capacities
- FP – Create more awareness through a committee to progressively mobilize in the community
- Provision of more trainings to the LGA staff and Service providers
- Assist in vaccine distribution
- The LGA should continue training and retraining of health personnel
- At the service delivery points, the LGA should provide incentives to motive workers
- LGA should sustain ISS
- LGA should ensure availability of data tools
- LGA should provide continuously functional vehicles to conduct ISS and visits to communities
- The LGA should continue to support WDCs and TFI committees
- LGA should continue to make provision for essential drugs
- To continue all what TSHIP has done (i.e. on FP, MCH, RI, ISS etc.) in the LGA health sector

- In respect of linkage between the LGA and the Community, the LGA should support quarterly meeting with the community groups (WDCs, etc.)
- To recognize HF that are working according to standards through word of mouth, recommendation letters, gift , certificates etc.
- More priority for renovation of HFs (most of the HFs are dilapidated)
- Provide equipment and personnel

MCH

- Support for monthly review meetings with HFs
- Provision of health equipment for HFs that are yet to be provided with equipment like the 3 MDG HFs with no equipment but were just staffed
- The LGA should support MCH to have volunteers in areas where there are no volunteers yet
- Support for HFs with no delivery bed and examination bed

FP

- All HFs should be trained on how to provide insertions (Note only 5 female in-charges were trained) as there are 26 maternities with only 5 providing insertions
- Strengthening of FP at ward and community level by the involvement religious/community leaders

RI

- Provision of solar-powered refrigerators to all HFs (only HF out of 38 HFs has now)
- Provision of cold store in the LGA, currently offices are being used
- Provision of two more deep freezer in the LGA and a stand-by generator that carry 3 freezers

MCH

- LGA should sustain training and retraining of SP to maintain achievements
- LGA should continue to procure and supply misoprostol and chlorhexidine
- LGA should provide logistic supports to the WDCs and CBHV to continue with their activities
- LGA should identify and sponsor female indigenes to go for midwifery/CHW training
- LGA should supply basic working equipment (delivery beds, BP apparatus etc.) to the HFs
- LGA should motivate best performing staff

FP

- LGA should support the WDC to continue to create awareness in the communities on acceptance of FP

RI

- LGA should start logistic support (e.g. functional vehicle for vaccine distribution to HFs providing RI services throughout the LGA) to LGA team on ISS
- LGA should take up the maintenance of cold chain equipment
- LGA should provide standby generator in the LGA cold store for vaccine storage

Q13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

- No idea of SBMR
- We have had no training in SBMR
- No response
- SBMR is practiced in the HF

- No idea
- TSHIP set-up model PHCs
- There was training on standard best practices where so many issues were discussed such as about essential drug management etc.
- Use of checklist during ISS to check whether HFs are working according to available SOPs
- HF are commended on working according to standards
- Creation of ORT corners helped in managing diarrhoea cases better
- Quarterly training of labour/maternity In-charges on managing complications has yielded positive results
- Provision of guidelines to some HFs on integrated management of childhood illness
- Use of checklist on infection prevention in the HFs
- Use of checklists on Active Management of Third Stage of Labour (AMSTAL)
- Examination of clients and all pregnant women with RDTs
- Use of checklist for implanon insertion
- Use of guideline booklet and checklist on surveillances, and writing of action steps and allocation of responsibilities for identified gaps
- Guidelines on waste management of routine immunization sessions
- The use of SBMR HFs can perform better, they now refer to (consult) the SBMR for guide on cases that are complicated e.g.
 - o In the treatment IMCI they refer to the SBMR for guidance
- Treatment of malaria, focused ANC, immunization, infection prevention etc.

Q14. Did TSHIP support you to develop a Costed Health Development Plan?

- No
- No
- No, we only use the State health Development Strategic Plan
- Yes, they compiled the costed health development plan and sent them to the MoLG for approval and uniform implementation
- No
- YES (but was not sighted)
- YES (yet to be sighted)
- How the plan have being implemented by extraction from the health development plan to develop annual work-plans
- What has changed
 - o Staff have being trained to fill gaps in HR shortage
 - o Before (2013) only 40 HF are trained to use the national guideline on malaria, but now all have been trained and are now using the guideline
- YES – In collaboration with the state govt. Last development plan developed in 2015, but not implemented yet
- YES (but not sighted)
 - o Annual work-plan are derived from the HDP (Electronic Sample for 2012, 2014 & 2015 collected)
- YES (sighted and photographed)

Q15. Did LEAD work with you to produce a Community Based Development Plan?

- The LGA is not a LEAD LGA
- LEAD did not work in the LGA
- YES (but not sighted)
- LEAD did not work in the LGA
- Confirm from Officer in charge of LEAD
- LEAD did not work in the LGA
- LEAD did not work in the LGA
- LEAD did not work in the LGA
- LEAD did not work in the LGA
- LEAD did not work in the LGA

Q16. How would you describe the linkage between the facility and community?

- Before the HFs and the community people are not close, but now the WDCs work with the HFs and there is more transparency. Also the LGA work closely with the WDCs which work with the HFs
- Very effective for example, the use of 'town criers' during RI activities, implementation of 'Drug revolving schemes' in HFs in 4 out of 11 wards in the LGA, the introduction of CBHV workers, the reactivation and engagement of the WDCs all contributed to collaborations between HFs and their communities
- (What could they have done differently -) New innovation/methodologies should be introduced by THIP through trainings
- No response
- TSHIP used the resuscitated WDC to establish linkage between communities and their HFs which benefitted both sides
- TSHIP suggested a shift from wards level interventions to settlement level, they tried but this could not be sustained
- HF In-charges are members of WDCs or VDCs, where monthly meetings are held to discuss the needs of HFs and priorities of communities
- These meetings promotes sharing of information between HFs and the communities
- There were conduct of house-to-house community mobilization activities to encourage service uptake in the HFs
- It has improved due to CBHV workers going from house to house to create healthcare services
- Before 51 HF are conducting RI but now all (55) are conducting RI
- All WDCs are functional, hence awareness and utilization has increased for ANC, FP, RI services
- The environment at the HFs are now more client-friendly

What could have been done differently?

- No response
- TSHIP reactivated/created WDCs, which enhanced the relationship between the community and the HFs
- TSHIP provided funds specifically for social mobilization activities
- Cordial relationship, using the WDCs to mobilize influential religious/community leaders to
- WDCs hold meeting and share information with SP, CBHV and LGA officials

- WDCs helped in dissemination of information on RI
- Towards ownership, Chairmen and Secretaries are signatories to funds received from Bill & Melinda and Dangote foundations
- WDCs mobilize resources for HFs
- Provide support for referral systems
- The WDCs operate drug revolving funds through a committee to sustain drug supply to the HFs

Could have been done differently:

- TSHIP should have created knowledge, skills and capacity to claim ownership
- TSHIP should have explored avenues to make influential people to attend meetings
- Provide feedback mechanism for people trained in the HFs and the Communities
- It is cordial
- Conduct of monthly meeting between WDCs and SP at the HFs
- RI outreach services has enhanced the linkage of health services between the community and the HFs
- The use of CBHVs who report their activities to the SPs and collect commodities (misoprostol & chlorhexidine) from their supervisions (CHEW, midwives etc.)
- Training given to the FBO has strengthened the linkage between the community and SP
- Linkage has given the community sense of ownership of the healthcare services
- Collaboration with RT workers (Okada) used as emergency transport system for pregnant women
- Done differently
- TSHIP sometime just sent letter to HFs staff for training, TSHIP should consult with the LGA in the selection of trainees

Q17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviors?

- Working as a team with the women in the LGA
- TSHIP has mobilized women in the community to go to the HFs for healthcare services
- Through the FP services, such as in counselling. Before TSHIP, women alone were being provided with FP services, but since TSHIP intervention, she is requested to come together with her husband so that FP services are explained to both of them and data has shown increase in male involvement
- TSHIP formed the 100-Women Groups
- The women members of CBHV going from house to house to mobilize the community for service uptake at the HFs
- Meeting with Village heads and Religious leaders and ownership of the HF in the community with active involvement of women
- The formation of the 100-women Group and provision of economic empowerment supports for them so that they will not always be dependent on their husbands
- Before women do not attend ANC but now through sensitization women go with their husbands to know the importance of the service
- There was a motivating scheme of a free net for a woman who collect all 5 doses of vaccines
- CBHVs conduct compound meetings involving wives, husbands, and household members with MCH coordinators as facilitator to promote male involvement in their wives health status. Community leaders prevail on husbands to attend such meetings.
- Male and female workers are given equal opportunities

- Female clients are treated with respect and dignity at the HFs
- We don't know but TSHIP has been working with women group in the LGA (100 Women group – 170 members) in the community
- Generally men and women are paid the same in respect of salary and allowances
- HF environment is more client-friendly especially in integrating services for women
- Involvement of WDCs and VDCs mobilized/sensitized men. This has changed the norms greatly. Husbands are now more supportive
- The Director PHC is a woman, the Chairperson of the LGA WDC's forum is also a female
- Women need to be empowered to go for western education; more women should be involved in VDCs
- TSHIP's focus was under 5 children and women of child bearing age, and considering their population it translates to 22% (Women) and 10% (Under 5), hence it will take longer time before the coverage. Men are only involved when there are issues such as for FP service uptake by women
- There high change of health attitude/behaviours for example in:
 - o Post-natal care
 - o RI
 - o ANC attendance in very high now because they now know the importance of delivery in the facilities and care of excess bleeding, neonatal tetanus, sepsis etc.
- Husbands are invited to discuss wife's complication during ANC and to use the HF for delivery
- Husbands go for counselling with their wives on FP services especially for barrier methods, such as male condoms
-)

What TSHIP could have done better to reduce issues of gender norm

- TSHIP should have established a centre for men and women where health issues only are discuss
- On culture – when female issues are to be discuss men shy away, hence couple should be invited at the same time
- The number of CBHV should be increase by say 50% in all wards
- TSHIP should have come closer (provide retraining) to the TBA (although they were trained almost 3 years ago in the LGA) to improve their services
- The MCH Coordinator (a female) of the LGA has always been selected for ToT assignment at both LGA and State levels, this is an instance in which the LGA promote gender equality for opportunities at a workplace
- Involvement of FOMWAN in immunization exercise to allow children to be immunized
- Gender balance should be considered when selecting WDC membership
- TSHIP has trained health educators on male involvement who have stepped down this training to Traditional/Religious/Community leaders and who use for a like the Jumat/Church services, festival period, community meetings etc. to disseminate information to husbands to allow their wives to seek healthcare services and other health behaviour supports
- Women are now coming out by themselves to seek healthcare services at the HFs
- Although gender equity is desirable, required qualifications should not be sacrificed for promotion of gender balance, hence TSHIP should have supported strategies that encourages more women to seek better education and become qualified for positions in the LGA

Q18. How has TSHIP collaborated with other organizations and projects in your LGA?

- TSHIP has not collaborated with any project in the LGA

- TSHIP collaborated with WHO on RI in the LGA, in the process TSHIP provided support for outreach services, while WHO was in charge of updated micro-plan and regular supervision
- There is the LGA Coordinating Team which comprise of LGA Director PHC, DD PHC, LIO, Health Educator, Disease Surveillance Officer, M&E, Cold-Chain Office, RBM, Nutrition Officer, Environmental Health Officer, HIV Coordinator and All Partners (TSHIP, WHO, UNICEF etc.)
- TSHIP is broad and cut across all programme areas
- In immunization TSHIP provided and repair solar refrigerators, an
- NEI & TSHIP collaborated in educating the less privileged people in the community about 2 years ago
- WHO & TSHIP jointly conducted planning for RI and SI (supplementary immunization) events, resulting in the existence of only one plan (harmonization of several plans) which was implemented and supervised by relevant stakeholders
- WHO & TSHIP
- WHO trained LGA staff for IPDs and TSHIP support with 5 revisit teams to resolve non-compliance challenges
- TSHIP also support TBAs during IPDs

UNICEF & TSHIP

- During child/maternal week UNICEF provide vaccine, trained LGA and State staff while TSHIP support with 2 Teams each to conduct outreach services with vitamin
- During RI and IPDs UNICEF generally provide N50,000 for social mobilization in every round (either monthly or 'n' times in a year) while TSHIP assist in advocacy, sensitization and community dialogue
- UNICEF and TSHIP jointly conduct supportive supervisions to HFs and the communities during IPDs and RI
- TSHIP & LEAD collaborated on community mobilization and high level advocacy
- TSHIP & DELIVER collaborated on supplies of FP commodities and training of SP on Contraceptives Logistic Management System (CLMS)
- TSHIP & WHO collaborated on immunization programme trainings

TSHIP/SIDHAS

- We don't know if there has been a collaboration between SIDHAS and TSHIP
- TSHIP collaborated with UNICEF WHO and CDC

TSHIP/DELIVER

- Provision of RDT, Zinc, ORS and ACTs by TSHIP and DELIVER supported with distribution
- TSHIP provided FP commodities and DELIVER distributed to HFs and conducts review meetings with them
- TSHIP provide misoprostol and chlorhexidine and DELIVER distributed to ward supervisors

TSHIP/WHO

- WHO provided solar panel and batteries and TSHIP supported with repairs and maintenance

TSHIP/UNICEF/BACATMA

- During maternal and child health week TSHIP and UNICEF jointly provided vitamin A supplement and BACATMA provided ORS and ACT

TSHIP & DELIVER

- On provision of FP commodities, TSHIP & DELIVER jointly support with payment of N3,000 stipends to SP
- The bi-monthly review meetings of SP are jointly supported by TSHIP & DELIVER, paying N3,000 to each participant for transport and refreshment
- The quarterly review meetings of MCH coordinators are jointly supported by TSHIP & DELIVER, paying

N3,000 to each participant for transport and refreshment

- TSHIP & WHO
- On immunization, TSHIP maintain and repair cold stores, solar power source and recruits independent monitors while WHO provides logistic supports

TSHIP & UNICEF

- During Immunization Plus Days (IPD), TSHIP & UNICEF jointly recruit and support community mobilizers
- TSHIP provides IEC materials

Q19. What is the most significant health change you observed in your LGA due to TSHIP intervention? explain

- Increased turnout for MCH services due to mobilization at the communities
- Capacity building of service provider for RI

Others

- Acceptance of FP by the community
- Community awareness and linkage to the HFs
- Renovation of HFs and training of personnel
- Improved hospital deliveries resulting in reduction in maternal mortality
- Creating community participation and ownership
- Strengthening RI
- Strengthening the healthcare delivery services
- Training and retraining of staff
- Creating awareness within the local population and encouraging them to utilize the HFs
- Prevention of maternal and child deaths by using misoprostol and chlorhexidine
- Training of personnel in respect of standard immunization services
- Selection of 110 CBHV women in the communities for outreach activities
- Provision of misoprostol and chlorhexidine
- Improvement in skill and knowledge of healthcare workers
- Others
 - o Capacity building at LGA, HF and community levels
 - o Increased turnout of women for FP services
 - o Effective use of ORT corners
 - o Identification and recruitment of the 170 (10 per ward) of CBHV worker bringing healthcare services to the household doorstep is the most significant process change
- Others
 - o Reduction of maternal mortality rate as can be confirmed from the data analysis conducted in the LGA
 - o Hospitals renovation and provision of equipment and commodities. This has led to reduced maternal and infant mortality
- Others
 - o Provision of data tools
 - o Behavioural change in healthcare seeking attitude

- o Improvement in capacity building for the LGA staff (because most LGA staff capacities have been built over the years of TSHIP implementation)
- Other
 - o Ownership of HF and the services by the community
 - o Tremendous reduction in PPH cases at the LGA
 - o Updated skills of the SPs

Q20. What are the things TSHIP did in your LGA which you will like to continue doing?

- Presentation of a proposal to the LGA to continue the MCH and RI programmes from where TSHIP will stop
- TSHIP has agreed with the LGA that the LGA will continue to supply the cold-chain materials to maintain the antigens, however it is difficult to make commitments because it involved money, which we (those interviewed) do have final say
- Recommendation to the State Government for support for full participation of communities on Healthcare delivery
- Training and retraining of personnel
- Promoting ANC services by conducting ANC outreach services to underserved communities
- We can only suggest, hence we want the LGA to
- Continue with those activities mentioned in Q19 above
- The LGA to continue with revisit team for outreach activities
- Provide N5,000 to buy recharge card to send data to the cloud
- Continue support for ISS
- Use of misoprostol and chlorhexidine and all that was mentioned in Q19 above (for the LGA)
- The ISS activity to the HF
- The LGA will be willing to continue with the CBHV workers scheme
- Continue on training and retraining HR at LGA/HF/Community level
- Provision of essential drugs and FP commodities
- With availability of funds, the LGA will like to continue all the intervention

Given the new administration, the LGA hope that there will be enough resources provided to continue with the following:

- Maintenance of the WDCs and CBHV workers
- Development of health planning and budgeting as well as annual work-plan at the LGA level
- Continuity of ISS
- Renovation and maintenance of HFs in the LGA
- Continuation with the community linkage
- Continuity of emergency transport system
- Support provision of data tools
- Generation of quality data and onward submission to state and partners

What TSHIP could have done differently?

- TSHIP could have done more renovation of HFs

- TSHIP could have trained more HF staff on insertion
- TSHIP should have engaged more volunteers
- TSHIP could have provided more ORT corner, only 5 were provide and they are not functional i.e. non-supply of material and replacement of equipment
- Most TSHIP staff are from the Agencies like SPHCDA, BACATMA and very very few from the LGA, more LGA personnel should be engage as project staff due to their wealth of experience working with the communities
- Since decision on what to continue rests with the policy-makers and management of the LGA, 'what TSHIP activities, the LGA is willing to continue' would rather be considered as 'what TSHIP activities, the LGA is supposed to continue'
- The LGA is supposed to continue:
 - o With the community structures put in place by TSHIP (i.e. WDCs, CBHV, 100-Women Group etc.)
 - o Procurement of basic healthcare equipment
- What TSHIP could have done differently in the LGA
 - o TSHIP could have increase coverage for some of the interventions like ORT corner to all the HFs in the LGA
 - o As a motivational measures, TSHIP could have certificated the well trained HF staff
 - o Officials trained as ToT's should have mostly be from the LGA instead of State MDA staff, because often when those trained as ToT's are stepping down trainings at the LGA, LGA participant usually correct them ...
 - o Retraining on data management for NHMIS would have enhanced better data flow

Q21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service?

- The LGA can only take up and continue with some of what TSHIP has done such as in the ANC and immunization
- Expectation that another project will continue where TSHIP stop
- No response
- MCH/RI – More staff has been recruited and this will continue after TSHIP
- Also the LGA has sponsor female indigenes to train as midwives so that they can come back and serve in the LGA
- FP - None
- None, but the LGA is ready to continue with TSHIP activities within the limited resources available to it
- Posted healthcare personnel to the HFs
- Recruited skill healthcare workers
- Provision of furniture to the HFs

MCH

- LGA has purchased and supply the HF with delivery equipment, delivery beds, consumables etc.

FP

- LGA has sent male health workers to continue providing FP services in the community
- The community structures like the WDCs are working indirectly in the community to create awareness on the FP services

RI

- The LGA is giving an impress of N10,000 for maintenance of cold chain equipment,
- The State provided satellite cold chain equipment and the LGA have provided manpower (i.e. payment of salaries and allowances of the CCOs)
- Lack of funds is a serious constraint for sustainability

MCH

- Staffing such Community midwives, Ordinary midwives, Pharmacies, Lab, Technicians
- Participation in ISS
- Community involvement in health service activities
- Collection and collation of data that are transmitted to the State

FP-RH

- Participation in ISS
- RI
- Staffing of RI Providers the LGA trained and paying their salary and allowances
- Participation in ISS
- Maintenance of cold chain equipment by the LGA

MCH/FP_RH/RI

- Funding of step-draw training by the LGA
- Support of the LGA team with functional vehicle to go for ISS

Gwadabawa LGA:

1. What is your experience with how TSHIP engaged the LGA in its project implementation?

Do you feel the LGA is full equal partner in the implementation? Why?

- Whatever TSHIP does they do with the government

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Capacity Building:
 - o Trained both LGA staff and Facility level staff on different areas like Nutrition, RH, ORT, MCH, Immunization, FP, Community Mobilization
 - o Trained drug keepers and also monitor their activities
- Supportive Supervision
 - o Before TSHIP, the LGA was conducting individual supervision by thematic areas. TSHIP taught the LGA to have integrated supervision and also provided the checklist.
 - o Said immunization coverage increased due to the supportive supervisions conducted.
- Management
 - o PHC Dept. staff trained on how to work together as a team
 - o Encouraged the LGA on how to sustain what they do
 - o Renovated the health facilities
 - o Provided instruments, drugs, FP commodities, Nets
- Integrated Services
 - o Before TSHIP there are different days for provision of services at the HFs but with TSHIP interventions, the communities and HFs agreed to have MCH and RI services together on certain days in the facilities while FP is provided everyday
- Applying Standards to improve quality
 - o The participants are not aware of the SOPs, job aids etc. so could not talk about the benefits to the LGA
- Collaboration/partnership
 - o State Government provided 10 ambulances and MDG provided 2 to referral HFs to use in transporting clients referred from lower facility to the referral facility. This has assisted in increasing access to services for clients
- Harmonizing community approaches
 - o Communities are able to sensitize the people to attend the HFs
 - o National Union of Road Transport workers (NURTW) are working with WDCs and VDCs. They provided

transportation for clients especially those in need of emergency and obstetric care from the community to the health facilities.

- o They also helped to move mosquito nets at subsidised price which helped in protecting pregnant women and children from malaria.
- Gender
 - o TSHIP worked with traditional leaders to advice the households to carry their children to the health facilities
 - o Dialogue with district and village heads has made more men aware of the activities of the health facilities and are allowing their wives to attend the health facilities
 - o Trained on male as partners
- Monitoring and Evaluation
 - o Capacity building for Staff – Trained LGA staff on M&E
 - o Provided Laptop, registers, summary forms, internet
 - o LGA participate in monthly meetings conducted by TSHIP with M&E Officers
 - o With the assistance received from TSHIP, the LGA now have up to date and complete data. In 2011 the reporting rate was “0” but with TSHIP LGA now have 100% reporting rate
 - o Quote “Before, the M&E officers were analogue officers but now are digital officers”
 - o With the training received from TSHIP especially computer training, the M&E Officer stepped it down to 3 other staffs in the LGA
- Staffing of health facilities
 - o TSHIP trained Community Based Health Volunteers (CBHV) and gave them some allowance to work with the HFs and community. They serve as the linkage between HF and community
 - o TSHIP trained Ward Polio monitor and CHEWS that supported the health facilities. TSHIP pays them some stipends
- Policy
 - o No policy change during TSHIP implementation
 - o But with TSHIP intervention deadlines are set for reporting of data from the HFs to the LGA and from LGA to the state which is being adhered to by both HFs and LGA.

3. What Policies did you initiate/change as a result of working with TSHIP?

Did changing the policies change the practices?

- None

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals)? Examples

- CBHV do tracking of children and pregnant women in the community and also accompany them to the HFs
- Use of Misoprostol and Chlorhexidine drugs assisted in reducing child and maternal mortality
- Quotes: “when women gets to the facility and the Misoprostol and Chlorhexidine drugs are not available they felt like crying”
- Supply of nets reduce the problem of malaria in pregnancy
- Training of in-charge of health facility for referral to higher facility and the provision of ambulances by govt help to reduce delays usually encountered when making referrals

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

What did you do for TSHIP? Cash or Kind

How much did it cost?

- Manpower – LGA and Health Facility staffs
- Materials and equipment for services
- Drugs Misoprostol and Chlorhexidine which are provided by govt
- Venue for training – conference hall, school classrooms
- No funds provided, rather TSHIP provides the funds

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral

- Training of the HCWs make them to change their attitude to work, make them to know how to use the various equipment
- Before TSHIP there were no registers or other forms but with TSHIP all health facilities have required registers and forms and data quality changed
- TSHIP renovated HFs and also in some cases staff quarters this has resulted in some facilities providing 24hrs service. E.g Mammande Dispensary and Salame dispensary
- Huchi PHC and Salame Dispensary were not having labour room before TSHIP intervention but now have Labour rooms to provide safe place for women to deliver
- ORT corners set up which is being used to train women on how to prepare ORT. This has equipped the community members with the knowledge required for home treatment of diarrhea

7. Have you been trained by TSHIP? Yes

8. What did they train you on?

- LGA and HF staffs were trained on Leadership Management, FP, Nutrition, malaria, data collection, reporting etc.

9. How did you use this training?

- Step down the M&E training to 3 additional staff. They are now computer literate
- Completion of tools and registers properly
- Timely transmission of data to next level
- Ensure completeness of data

10. What do you do differently now?

- Use the computer to enter data and transmit it to the next level which has resulted in timely reporting of data before use to be manual

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of data tools and registers

What training do you wish you had that you did not receive?

- None

12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To sustain the capacity building process by training and re-training of staff
- LGA to take up the payment of CBHVs allowance and to also include lunch allowance
- To provide all essential routine drugs, commodities and equipment
- To sustain the provision of data tool
- To open drug revolving centres in the health facilities

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

Do you think this is a good approach?

- Not much known about this in the LGA

14. Did TSHIP support you to develop a Costed Health Development Plan?

What is the level of implementation, and how has it improved health care delivery system?

- After much explanation, the respondents said they were supported to develop the plans but don't know where the copy is and don't know the level of implementation

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- LEAD did not work in the LGA

16. How would you describe the linkage between the facility and community?

- The linkages between the community and facility were described as "very encouraging", "very appreciated".
- Said that there is good relationship between the health facilities and the communities e.g. chairman of the Village Development Committee (VDC) is the traditional leader while the secretary is the Officer in charge of the health facility
- Monthly meetings held between the communities and the health facilities to discuss issues and plan the way forward

Would you say that approaches used were appropriate?

- Said the approach is appropriate

What could they have done differently?

- To encourage the communities to institute community drug revolving funds for health facilities (thru contribution from community members)

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviours?

- Yes as stated in 2 above

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

Are husbands more supportive of their wives going to the health facilities? Explain?

Are more women being placed in leadership positions? Give examples?

- Could not deduce that this is done from their response

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community

- All the things they did are good to continue doing them

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
 - o LEAD did not work in the LGA
- NEI
- LEAD
 - o LEAD did not work in the LGA
- SIDHAS
- PROACT
- DELIVER
 - o They did not know DELIVER project
- WHO, UNICEF etc.
 - o WHO – worked together to train the personnel for Immunization Plus days
 - o UNICEF – worked together to mobilize the communities to attend the health facilities and advocacy to religious leaders
- CDC
 - o Worked together in providing immunization services to the nomadic population especially the missed children i.e. working together to reach the hard to reach population
- Roll Back Malaria
 - o TSHIP worked with the team to fill the gaps in the net distribution as they helped to move some of the nets to the health facilities
- PPFN
 - o Was a sub grantee under TSHIP. They organize the monthly review meetings and train the CBHVs

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? explain

- Most Significant “Reduction of maternal and child mortality”. This is because of the introduction of the Misoprostol and Chlorhexidine drugs and improvement in the referral system
- Others?
 - o Increased attendance for ANC service at health facilities due to the outreach services
 - o Improved quality of health data
 - o Increased coverage of different services
 - o Increased utilization of services
 - o Health care workers attitudinal change
 - o Health care workers more knowledgeable and skilled in the provision of service
 - o Case management of clients changed i.e. is now different

- o Increased in target coverage
- o Quality of referral changed – before use to have 1 way referral system now have 2 way referral system which include feedback

20. What are the things TSHIP did in your LGA which you will like to continue doing? What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

- Capacity building for staffs of LGA and HFs
- Supply of drugs and nets
- Renovation of HFs
- M&E officers training
- To provide the stipends for CBHVs including transportation and lunch because they sometimes work late into the evening time

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- Advocacy was paid to the LGA sole administrator by WDCs, HF staffs and the CBHVs. The administrators have made some promises to continue some of TSHIP activities e.g. continue the payment of stipends to CBHVs but all the promises are dependent on availability of funds
- The LGA hoped that the supply of Misoprostol and Chlorhexidine drugs will continue
- The M&E is hoping that the Ministry of Local Government will continue providing the M&E tools.

Rabah LGA:

1. What is your experience with how TSHIP engaged the LGA in its project implementation?

Do you feel the LGA is full equal partner in the implementation? Why

- Very cordial relationship, very friendly and do things together
- During Planning meetings, TSHIP invites PHC Directors, ask about the needs of the LGAs and incorporate those that are within the scope of the project in the plans developed

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Capacity Building:
 - o Trained both LGA staff and Facility level staff on different areas like Nutrition, RH, ORT, MCH, Immunization, FP, Community Mobilization, Community Action Cycle (CAC), management of Labour, exclusive breastfeeding, data tools
 - o LGA now have pool of skilled health workers to provide quality service
- Supportive Supervision
 - o Improved on the checklist incorporating all the various needs of TSHIP and other donors on the checklist
 - o Improved on development of plans for supportive supervision.
 - o Improved on the conduct of supportive supervision by including all relevant units in the PHC dept as members of the team
- Management
 - o Re-activated all WDCs
 - o Improved skills of LGA and facility staff due to trainings received
 - o Renovation of health facilities
- Integrated Services
 - o MCH Coordinator said when a woman comes for ANC she has opportunity to go for HIV/AIDS test, malaria test and also receive counselling on ORT, FP and post natal care
 - o After probing they said that they have different days for providing ANC (Once a week in PHC and twice in General Hospital) and 2 times in a week for routine immunization while FP is provided on daily basis. This is against the concept of integration
- Applying Standards to improve quality
 - o Posters, leaflets, job aids provided by THIP helped the HCWs to remember what they were taught. E.g. it was reported that during supportive supervision it was observed that the HCWs are adhering to the protocol of explaining the use and side effects of contraceptive pills to clients using all available job aids a thing that was not done before.

- Collaboration/partnership
 - o Reported that after TSHIP renovated 5 health facilities in the LGA (Gawakuke PHC, Tursa dispensary, Gandhi PHC, Rabah General Hospital and Yartsakuwa PHC) the LGA provided overhead water tanks and generators in Gawakuke PHC and Tursa dispensary.
 - o The LGA are providing SP drugs that are given to pregnant women as IPT. The LGA also provide Paracetamol syrup for children which are branded with the picture of the chairman so that it would not be sold by the HCWs
 - o Reported that the LGA provided 1 ambulance in Rarah PHC as a result of feedback from supportive supervision and advice from TSHIP. Reported there are some part of the LGA that are cut off during raining season and the ambulance is used to transfer clients from those areas to referral centres.
 - o M&E quantify this by saying that before 2 lives are lost in a week but with the provision of the ambulances it has reduced and referral made easy. However this could not be verified.
 - o State Government provided 10 ambulances and MDG provided 1 to referral HFs to use in transporting clients referred from lower facility to the referral facility. This has assisted in increasing access to services for clients
 - o The LGA donated 11 motorcycles to each ward to be used during the outreach services at the rate of 1 per ward. This donation was done based on feedback from supportive supervision and service data from the field. The motorcycles are under the care of the WDC who provide fuel and maintenance for the motorcycles
 - o WDCs contribute money and use it to procure drugs that are provided to the clients at subsidized rates
 - o Local government employed 55 TBAs that are paid monthly allowance by the LGA
- Harmonizing community approaches
 - o CBHVs and WDCs are able to sensitize the people to attend the HFs
 - o CBHV activities are being appreciated and more clients are using the health facilities.
 - o The TBAs employed by the LGAs are also complimenting the work of the CBHVs, WDCs
 - o TBAs are working with the HFs to ensure that complicated cases are promptly referred to the health facilities where there are skilled staff to attend to the client
- Gender
 - o TSHIP worked with traditional leaders to advice the households to carry their children to the health facilities
 - o 100 women group were trained by Life Helper Initiative one of TSHIP sub grantees
 - o WDCs tried to put women in leadership position, they are the secretary, some are vice chairmen and others are Assistant Treasurer
 - o TSHIP oriented the communities on the need to send their female children to go to school based on this 5 girls were sponsored by the LGA to school of nursing, 3 have graduated and they have been employed and working in HFs in their ward – Gwaddodi, Gandhi and Tofa wards. This is to help the LGA meet its demand needs for female skilled health providers
 - o Respondents said sometimes sensitization of community members on health issues are carried out in the District head house or the mosque
 - o Respondents said husbands are now taking their wives to the health facilities to receive service. They not only take them but also wait for them to finish and then carry them home, In some hard to reach areas where the roads are not motor able it was reported that the husbands even use donkeys to take their wives to the health facilities.
 - o Quote: "If you take the count of vehicles or motorcycles in health facilities they are more than the number of health facility staff this is to show that the men are taking their wives to the health facilities."

- o At the LGA level before TSHIP, only MCH Coordinator was female staff in charge of a unit but now have 3-4 sectional heads that are female and 4 assistant sectional heads that are female.
- o Most in-charge of health facilities were males but this is changing
- o Quote: "Before the culture says female should be behind males but now they have the chance to hold key management positions"
- o FP data reviewed for March 2015 shows that 3 and 15 males picked up condoms from Gawakuke and Yartsakuwa PHCs respectively. Further probe reveal that there are sex workers in the wards where the HFs are sited and the men are using the condoms as means of protection against STI(Source: HMIS Monthly Report – March 2015)
- Monitoring and Evaluation
 - o Capacity building for Staff – Trained LGA staff on M&E, computer
- Quote "Before, the M&E officers were analogue officers but now are digital officers"
 - o Provided Laptop, registers, summary forms, internet
 - o LGA participated in monthly meetings conducted by TSHIP with M&E Officers
 - o With the assistance received from TSHIP, the LGA now have up to date and complete data.
 - o With the training received from TSHIP especially computer training, the M&E Officer stepped it down to 3 other staffs in the LGA
- Staffing of health facilities
 - o TSHIP trained Community Based Health Volunteers (CBHV) and gave them some allowance to work with the HFs and community. They serve as the linkage between HF and community
 - o LGA sponsored 5 girls in the LGA to school of nursing, 3 have graduated and they are already working in HFs in the LGA
- Policy

What Policies did you initiate/change as a result of working with TSHIP?

- No policy change during TSHIP implementation
- But with TSHIP intervention deadlines are set for reporting of data from the HFs to the LGA and from LGA to the state which is being adhered to by both HFs and LGA. Also SOP for data collection, was given to the LGA and facilities (SOP sighted)

Did changing the policies change the practices?

- None

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals) Examples

- CBHVs do tracking of children and pregnant women in the community and also accompany them to the HFs
- Use of Misoprostol and Chlorhexidine drugs assisted in reducing child and maternal mortality
- Quotes: "when women gets to the facility and the Misoprostol and Chlorhexidine drugs are not available they felt like crying"
- Supply of drugs like Phansiderreduce the problem of malaria in pregnancy and Paracetamol syrup help to reduce temperature in children
- Training of in-charge of health facility for referral to higher facility and the provision of ambulances by government helped to reduce delays usually encountered when making referrals

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

What did you do for TSHIP? Cash or Kind

How much did it cost?

- In addition to those mentioned above it includes:
 - o Venue for training – conference hall, school classrooms

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral

- Training of the HCWs make them to change their attitude to work, make them to know how to use the various equipment
- Before TSHIP there were no registers or other forms in health facilities but with TSHIP all HFs have required registers and forms and data quality changed
- TSHIP renovated HFs and also in some cases staff quarters this has resulted in increase in HFs providing 24hrs service from 2 to 5.
- Before TSHIP ,most health workers were not using uniforms they dress in house cloths but with TSHIP observation and advice HCWs are now using uniforms
- Before TSHIP, clients always complain about HCWs in the facility saying they want them removed but this have changed as a result of changing attitude to clients
- HCWs are now living up to their responsibilities. Before TSHIP intervention the OICs are not always in the hospital and usually arrives late i.e. sometimes resuming work at 10 am but with TSHIP intervention and advice to the LGA most of them resume at the normal working hours. It was explained that the Local Government chairman sometimes pay unscheduled/unannounced visits to the health facilities.
- Also TSHP trained the LGA and HCWs on how to prepare duty rooster and preparation of reports. The LGA have adapted this initiative and are using it. They reported that they print out copies and give each staff a copy.

7. Have you been trained by TSHIP? Yes

8. What did they train you on?

- LGA and HF staffs were trained on FP, Nutrition, malaria, data collection, reporting etc.

9. How did you use this training?

- Step down the M&E training to all the HFs staff. This has resulted in the LGA having 100% reporting rate.
- Timely transmission of data to next level
- Ensure completeness of data through the monthly review meeting

10. What do you do differently now?

- Currently testing the use of mobile application on the DHIS for transmission of data to the next level with 3 HFs.
- Use the computer to enter data and transmit it to the next level which has resulted in timely reporting of data before was using manual method which was not effective

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of data tools and registers

What training do you wish you had that you did not receive?

- None

12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To participate in the health Facility assessment planed by Ministry of Local Government
- LGA to integrated the CBHVs into the LGA and take up the payment of their allowance
- To continue to provide all essential routine drugs, commodities and equipment
- To sustain the provision of data tool

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

- Director PHC and M&E officer attended the training organized by TSHIP on SBMR approach.
- Based on this, a plan of action was developed and discussed with the Local Government Chairman
- Data from HFs were analysed and presented to management for decision making
- Reactivated the Health Development committee

Do you think this is a good approach?

- It was rated a good approach as they viewed it as a process that helped the LGA to prioritize their spending. This greatly have impact on health budgeting and release of funds

14. Did TSHIP support you to develop a Costed Health Development Plan?

What is the level of implementation, and how has it improved health care delivery system?

- After much explanation, the respondents said they were supported to develop the plans but could not state the level of implementation. (Could not cite the copy)

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- Respond Yes. Stated that the last plan was developed 3 weeks ago (Could not cite the plan)

16. How would you describe the linkage between the facility and community?

- The linkages between the community and facility were described as "very encouraging", "very appreciated".
- Said that there is good relationship between the health facilities and the communities e.g. chairman of the Village Development Committee (VDC) is the traditional leader while the secretary is the Officer in charge of the health facility
- Monthly meetings held between the communities and the health facilities to discuss issues and plan the way forward

Would you say that approaches used were appropriate?

- Said the approach is appropriate

What could they have done differently?

- To encourage the communities to institute community drug revolving funds for health facilities (thru contribution from community members)

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these

roles affect health care seeking behaviours?

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

- Yes as stated in 2 above

Are husbands more supportive of their wives going to the health facilities? Explain?

- Yes as stated in 2 above

Are more women being placed in leadership positions? Give examples?

- Yes as stated in 2 above

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community?

- Would have love to have women in political position e.g. like councillor

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
 - o conduct meetings together and participate in supportive supervision
- NEI
- SIDHAS
- PROACT
- DELIVER
 - o worked in 10 facilities delivering nets, malaria drugs and FP commodities
- WHO & UNICEF etc.
 - o TSHIP supported local immunization monitor consultants are used for community mobilization and routine immunization at FP and during Supplemental Immunization Plus Days
- WOFAN
 - o TSHIP advice the LGA to collaborate with WOFAN to improve the sanitary conditions in the LGA. Based on this an agreement was signed with WOFAN that in 3 months' time there would be no faeces littering the environment as all houses would have toilets. 3 wards (Rabah, Tofa and Trusa) are being used as pilot project. Learned that the WDCs have started constructing the toilets in front of their houses. Also learnt that 3 departments in the LGA (Works, Social welfare and PHC) are collaborating to achieve this clean environment

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? Explain

- "Reduction of maternal mortality". This is because of the introduction of the Misoprostol drugs and improvement in the referral system
- Others?
 - o Improved coverage in eradication of polio
 - o Increased attendance for ANC service at health facilities due to the outreach services
 - o Increased attendance for labour and delivery services at the health facilities
 - o Improved sanitation
 - o Increased FP uptake
 - o Reduction in malaria incidence among under 5

- o Reduction in nutrition
- o Increased use of data for decision making

20. What are the things TSHIP did in your LGA which you will like to continue doing? What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

- Capacity building for staffs of LGA and HFs
- Supply of drugs and nets
- Renovation of HFs
- M&E officers raining
- To provide CBHVs allowance

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- Reported that the Chairman told the CBHVs to continue providing community services after the end of TSHIP project
- The LGA is planning to conduct an assessment of the current CBHV personnel to know who to retain and who to let go based on their performance
- Then the CBHVs would be integrated into the TBA scheme already supported by the LGA.
- The payment of the allowances would be continued by the LGA
- Learnt that the previous week the PHC Director and WDCs discussed how they will continue to get the Misoprostol and Chlorhexidine drugs.
- Reported that the Ministry of Local Government posted staff to the LGA to serve as zonal inspector. The posting was mirrored after TSHIP organization. It is newly created and expected to continue where TSHIP stopped. They are to supervise health activities in their zones and provide feedback and recommendations to the MOLG
- The chairman of the LGA was met and he promised and gave his word to continue most of the activities implemented by TSHIP. He stated that he needed data to make informed decisions.

Sokoto South LGA:

1. What is your experience with how TSHIP engaged the LGA in its project implementation?

- Before SHIP, there were staff in the LGA but TSHIP helped to revive supportive supervision.

Do you feel the LGA is full equal partner in the implementation? Why

- TSHIP planned together with the LGA and they implement together. Use to have meetings with TSHIP which are organized by TSHIP.
- Said that TSHIP review LGA plan, see where the LGA cannot meet their needs and TSHIP was asked to support the LGA in that area especially as it relates to training of staff

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Capacity Building:
 - o Trained both LGA and Facility level staffs on different areas like Nutrition, RH, ORT, MCH, Immunization, FP, Community Mobilization, How to prepare Jik Solution and CBHV.
- Supportive Supervision
 - o Before TSHIP, the LGA was conducting unplanned supervision. TSHIP taught the LGA to use a plan and checklist (With TSHIP there is a guidance of what to supervise by the supervisor) for supportive supervision. Have district coordinators with a number of facilities assigned to them that they supervise on regular basis(copy of the memo assigning them to the LGA collected)
 - Quote: "TSHIP make you to realize what the LGA is, what the LGA is supposed to be doing and push the LGA into doing it"
- Management
 - o Trained the DPHC on leadership management at Administrative Staff College of Nigeria (ASCON)
 - o Renovated the health facilities
 - o Provide instruments, drugs, FP commodities, hand gloves
 - o Quotes:
 - "View TSHIP as a dying man on Hospital Bed"
 - " Don't Want TSHIP to go because thy help the LGA a lot"
 - "TSHIP is not like the other IPs that just give money to the LGA and leave the LGA to use the money rather they provide the fund, plan and implement together the activities with the LGA"
- Integrated Services
 - o Before TSHIP, there are different days for provision of services at the HFs but with TSHIP interventions MCH/FP are integrated with routine immunization in all FP in the LGA. (this could not be verified)
- Applying Standards to improve quality
- TSHIP provides checklist for supportive supervision

- Guidelines for ANC and New born
- General checklist
- Availability of the checklists improve documentation and in correcting the HCWs
- Quote: Before TSHIP it was like a blind man going around with a stick but with TSHIP it is like a man going around with a guide who sees and show him the way”}
- Collaboration/partnership
 - o Could not talk more on collaboration and partnership except as stated in 1 above
- Harmonizing community approaches
 - o Communities are able to sensitize the people to attend the HFs
- Gender
 - o Deputy Director PHC in the LGA is a female
 - o 2 Female Assistant Directors in the Dept of PHC in the LGA
 - o Have both Male and Female as In-charge of Health facilities and the men also provide FP services
- Monitoring and Evaluation
 - o Capacity building for Staff – Trained on staff on M&E
 - o Provide Laptop, registers, summary forms, calendars for checking and booking appointments, drawers to keep client folders for safe keeping
 - o LGA participate in monthly meetings conducted by TSHIP with M&E Officers
 - o With the assistance received from TSHIP, the LGA now have up to date data, was able to incorporate private clinic to provide their service data to the LGA and able to trace communicable diseases like wild polio virus
- Staffing of health facilities
 - o SHIP trained Community Based Health Volunteers (CBHV) and gave them some allowance to work with the HFs and community. They serve as the linkage between HF and community
- Policy
 - o No policy change during TSHIP implementation
 - o TSHIP only brought innovations like supportive supervision, outreach services too hard to reach communities

3. What Policies did you initiate/change as a result of working with TSHIP?

Did changing the policies change the practices?

- None

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals) Examples

- Thru TSHIP activities of creating awareness, training of staff, equipping the health facility, renovation, supply of drugs and consumables there are more women now delivering in health facilities compared to before TSHIP intervention, more are coming for post natal visits, more getting their routine supplements and post abortion care provided.
- DD PHC concluded by saying “Healthier children and mothers”

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

What did you do for TSHIP? Cash or Kind

How much did it cost?

- None except getting the corporation, attention, appreciation and occasionally providing space for training.
- "In most cases, it is TSHIP that brings things to the LGA not the LGA giving TSHIP things"

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral

- Now have ORT corners,
- materials for providing the services are available
- commodity and drugs available
- Provision of mama kits have made delivery easier especially for mothers who do not have basis delivery kits and reduce incidence of infection. (DPHC not sure if it would be sustained by the LGA, planned to put it on the next costed health plan)
- More people are now using the services requesting for FP, ANC and immunization
- Before TSHIP. there were no registers or other forms but with TSHIP all health facilities have required registers and forms

7. Have you been trained by TSHIP? Yes

8. What did they train you on?

- DPHC – On Leadership Management, DDPHC on FP, Nutrition etc., M&E Officer on M&E, data collection, reporting etc.

9. How did you use this training?

- During supportive supervision to mentor the HCWs
- In arranging the department to ensure that all staff in the department are performing according to their job schedule
- Completion of tools and registers properly
- Timely transmission of data to next level
- Ensure completeness of data

10. What do you do differently now?

- Use the computer to enter data and transmit it to the next level which has resulted in timely reporting of data before use to be manual
- Conduct supportive supervision (Participants Not sure if the activity will continue after TSHIP)
- Provide technical assistance to the HFs on service provision and M&E

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of checklist for supportive supervision

What training do you wish you had that you did not receive?

- To train more HCWs on Implant

12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To employ the CBHVs
- Take responsibility for hosting the monthly meetings with service providers (Funding)
- To provide all essential routine drugs, commodities and equipment
- Renovation of HFs to be a continuous process within the LGA
- Toilet and water to be made available in the facilities

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

Do you think this is a good approach?

- Not much known about this in the LGA

14. Did TSHIP support you to develop a Costed Health Development Plan?

- TSHIP assisted the LGAs to highlight some activities/program that the LGA is supposed to be doing
- TSHIP did this indirectly.

What is the level of implementation, and how has it improved health care delivery system?

- When LGA is convinced about the activity they put it on the LGA plan. (Annual Budget)
- The LGA administrators are not cooperative or supportive of TSHIP project

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- Could not have much information on this from the participants

16. How would you describe the linkage between the facility and community?

Would you say that approaches used were appropriate?

- The approach is okay

What could they have done differently?

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviours? What specific activities do you know they carried out in your LGA that relates to gender? Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

- Inclusion of women in WDC
- Establish the 100 women groups
- During ANC some women have their husband accompany them to HFs
- ANC registers shows that men are supporting their wives during delivery and ANC (could not verify this)
- Men are supportive in the area of FP
- TSHIP did all they could to make men know the importance of the need for men to allow their wives to go to the HFs

- Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?
- Yes, as stated in 2 above.

Are husbands more supportive of their wives going to the health facilities? Explain?

Are more women being placed in leadership positions? Give examples?

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community

- All the things they did are good and should be continued

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
- NEI
- SIDHAS
- PROACT
- DELIVER
- WHO, UNICEF etc.
 - o TSHIP and other projects use to attend meetings together
 - o They contribute in the area of supervision e.g. WHO
 - o Did not know of collaboration with NEI project

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? Explain

- Most Significant "Documentation and up to date data" because it is now timely and complete
- Others?
 - o Change in HCWs attitude to clients
 - o M&E office functioning well
 - o More women visiting the HFs for ANC, Delivery and FP services
 - o Inclusion of counselling and testing for HIV
 - o Conducive environments in HFs

20. What are the things TSHIP did in your LGA which you will like to continue doing?

- ALL is good and should continue
- "TSHIP opened the way and show the LGA the way to go"

What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- "Not sure of any concrete plan by the LGA to sustain what TSHIP has done"
- Health department is praying that the project will be sustained
- "will miss financial and technical assistance from TSHIP" as anything that has financial implication cannot be met by the LGA
- M&E wants TSHIP to work more on the issue of sustainability

- DPHC stated that one of the sustainability plan that the LGA, TSHIP and WDCs are working on is to have LGA staff forum and WDC s forum that will serve as advocacy team advocating for support from the LGA and state levels for the HFs and provision of quality health service.

Wamakko LGA:

1. What is your experience with how TSHIP engaged the LGA in its project implementation?

Do you feel the LGA is full equal partner in the implementation? Why

- Very cordial relationship. The DPHC said that initially the LGA felt that TSHIP was about to take over their work or checkmate them, but when they held meeting with TSHIP they were able to plan together and implement activities together

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Capacity Building:
 - o Trained both LGA staff and facility level staff on different areas like Nutrition, RH, ORT, MCH, Immunization, FP, Community Mobilization, Community Action Cycle (CAC), management of Labour, exclusive breastfeeding, data tools
 - o The DPHC was sent to Administrative Staff College of Nigeria (ASCON) to participate in Leadership training. Stated that the 1weekk they spent at the training was like 3months because it was an intensive training
 - o The LGA gained much in terms of training for all cadre of staff
- Supportive Supervision
 - o Supportive supervision checklist was provided to the LGA
 - o Improvement on the way supportive supervision was conduct - LGA and TSHIP staff go together
 - o TSHIP helped the LGA to conduct supportive supervision to hard-to-reach areas because of the availability of their 4 wheel drive vehicles.
 - o The LGA plan to continue the supportive supervision to easy- to- reach facilities until the Ministry of Local Government (MOLG) is able to provide 4 wheel drive vehicles to the LGA to use in reaching the hard-to-reach areas. The LGA said they have made the request to the MOLG for vehicles which they have promised.
- Management
 - o DPHC said all WDCs in the LGA were re-activated. Said that the WDCs now have selected executives at Ward, LGA and state levels. Felt that the WDCs have now be institutionalized in the state as they now have voice at the State level.
 - o Capacity building – training of all cadres of staff
 - o Renovation of 4health facilities
 - o Provision of equipment and drugs especially Misoprostol, Chlorhexidine and SP for ANC, Delivery and care of ne born
 - o Outreach services conducted by CBHVs to mobilize clients to go to the clinic for services
- Integrated Services

- o MCH Coordinator stated that:-
 - ANC services not provided on daily basis in the HFs in the LGA but it is conducted on the same day with malaria service
 - FP is conducted on daily basis
 - 2 days used for Immunization service -1 day at health facility and 1 day for outreach
- o She said that if client shows up at the facility for any of the services even on days services not earmarked to be provided they will receive service.
- o From the explanations it shows that services are not well integrated in the LGA
- Applying Standards to improve quality
 - o Posters, leaflets, job aids provided by THIP helped the HCWs to remember what they were taught
- Collaboration/partnership
 - o LGA provided drugs , generators and freezers to the renovated health facilities
 - o LGA provided venues for training.
 - o The collaboration and partnership have resulted in great changes in the health facilities in terms of service provision and discipline of staff
- Harmonizing community approaches
 - o CBHVs, WDCs, VDCs and TBAs are able to sensitize the people to attend the HFs
 - o CBHV activities are being appreciated and more clients are using the health facilities.
 - o Using the approach of the WDCs now provides avenue for the communities and the HFs to look at issues affecting the HFs together and jointly solve the problem
 - o Using the CBHVs approach enable more communities and households to be reached with health information and more people to be convinced to attend the health facility. The DPHC recalled an instance when he was at a HF and the HCW was informed that a woman was in labour but refused to come to the HF to deliver. The neighbour of the woman then informed the CBHV who followed the neighbour to see the woman and at the end of the day was able to convince the woman to change her initial decision and got the woman to the facility. He said the woman deliver her baby 30 minutes after getting to the HF.
- Gender
 - o Traditional leaders are Chairmen of WDCs
 - o Drug keepers are males
 - o Male service providers rendering services in the health facilities
 - o Awareness creation at mosques and other meeting place. This was reported to have contributed to the success of men allowing their wives to go the health facilities
- Monitoring and Evaluation
 - o Capacity building for Staff – Trained LGA staff on M&E, DHIS, computer and GIS, Use of data. M&E Officer said he was not computer literate before TSHIP training. The M&E officer have also trained his assistant on computer
 - o TSHIP provided Laptop, registers, summary forms, internet and monthly allowance of N5,000. Before TSHIP intervention registers and HMIS forms were not available in the LGA.
 - o LGA participate in monthly review meetings conducted by TSHIP with M&E Officers
 - o With the assistance received from TSHIP, the LGA now have data to report to the state and even the federal level
 - o With the training received from TSHIP M&E officer was able to step it down to the HCWs and also provide on-the-job training as needed.

- Staffing of health facilities
 - o TSHIP trained Community Based Health Volunteers (CBHV) and gave them some allowance to work with the HFs and community. They serve as the linkage between HF and community
- Policy
 - o Nothing on policy

3. What Policies did you initiate/change as a result of working with TSHIP?

Did changing the policies change the practices?

- None

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals) Examples

- Capacity building for staff especially on modified life saving skills
- CBHVs do tracking of children and pregnant women in the community and also accompany them to the HFs
- Use of Misoprostol and Chlorhexidine drugs assisted in reducing maternal and child mortality
- Training of in-charge of HFs for referral to higher facility and the provision of ambulances by government helped to reduce delays usually encountered when making referrals
- Availability of FP commodities, SP and ACTs. Before the LGA use to experience stock out of the drugs but now it is available and free
- Setting up of ORT corners and provision of ORT

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

What did you do for TSHIP? Cash or Kind

How much did it cost?

- As mentioned in 2 above under collaboration and partnership
- Could not quantify in cash the cost

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral

- Training of the HCWs make them more knowledge able and skilled in the provision of services
- Before TSHIP there were no registers or other forms but with TSHIP all health facilities have required registers and forms and data quality changed
- TSHIP renovated 4 HFs
- Environmental sanitation has improved. Most HFs have environmental officers and they practice burning and burying of wastes.
- The mobilization activities of CBHVs have resulted in more people attending the health facilities
- The provision of ambulances have made referral easy – The DPHC said the frequency that you see the ambulances going up and down shows that the referral system is working
- HCWs were trained on referral i.e. telling them when to refer and how to refer.

- Also TSHIP helped the LGA to institute 2 way referral system before have 1 way referral system
- Conducting supportive supervision help to identify issues and ways of addressing them.

7. Have you been trained by TSHIP?

- Yes (more responses from M&E and MCH)

8. What did they train you on?

- LGA and HF staffs were trained on FP, Nutrition, malaria, data collection, reporting, lifesaving skills, strategic counselling method, immunization, ORT, CLMS, computer etc.

9. How did you use this training?

- Step down the M&E training to all the HFs staff.
- Trained Assistant M&E on the computer
- Stepped down the MCH trainings to HCWs and CBHVs
- Organize review meetings with HCWs and CBHVs to discuss issues, review their documentations and discuss way forward

10. What do you do differently now?

- Use the computer to enter data and transmit it to the next level. This has resulted in timely reporting of data. Before TSHIP intervention, data submission was done manually and majority of the HFs were not reporting
- Insertion of implant and Jadelle not done before
- In terms of ANC – now conduct several tests including urine test, blood grouping test, HIV test and RDT test for clients
- For Delivery _ Now use Misoprostol and Chlorhexidine
- For malaria – Now test for malaria using RDT instead of just giving malaria drugs without testing
- Giving ACT to treat malaria instead of using chloroquine

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of data tools and registers, different trainings

What training do you wish you had that you did not receive?

- None just to continue re-training

12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To continue to fund the RI outreach services which was stopped in 2013
- To support supervision with means of transportation (4 Wheel drive).
- To make available all registers and forms use for documentation
- To organize quarterly or bi-annual re-training of HCWs on all the trainings conducted by TSHIP
- To fund the quarterly M&E meetings
- To continue to provide all essential routine drugs and other drugs like Misoprostol and Chlorhexidine, ACT, RDT, SP, commodities, nets and equipment
- To build toilets in health facilities

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

Do you think this is a good approach?

- Participants don't seem to know approach. Not sure what it means

14. Did TSHIP support you to develop a Costed Health Development Plan?

What is the level of implementation, and how has it improved health care delivery system?

- Respondents not sure. DPHC said if there is one it was not implemented

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- Not sure

16. How would you describe the linkage between the facility and community?

- The linkages between the community and facility was described as cordial, good relationship
- The following community groups were listed as used by TSHIP to link the communities with facilities – WDCs, VDCs, CBHVs and TBA.

Would you say that approaches used were appropriate?

- Said the approach used was appropriate as evidenced by the turnout at the health facilities

What could they have done differently?

- Nothing

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviours?

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community? Are husbands more supportive of their wives going to the health facilities? Explain?

- As stated in 2 above under gender
- As stated in 2 above
- As stated in 2 above

Are more women being placed in leadership positions? Give examples?

- The respondents don't think that women are being placed in leadership positions

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community?

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
 - o DPHC said he attended a seminar organized by both TSHIP and LEAD in Katsina: Said TSHIP paid for some participants while LEAD paid for other participants
- NEI
- SIDHAS
- PROACT
- DELIVER

- o Worked together to conduct FP review meetings and in the supply of FP commodities
- WHO, & UNICEF
 - o Collaborated with TSHIP In the area of immunization, disease surveillance, training and supervision

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? Explain

- Most Significant “Increase utilization of ANC services”. This is as a result of awareness creation in the communities (outreach services)
- Others?
 - o Increase acceptance of FP services
 - o Timely reporting of facility data to the LGA
 - o Reduction in malaria incidence because of net distribution and malaria drugs

20. What are the things TSHIP did in your LGA which you will like to continue doing?

- Everything done by TSHIP was perfect. Respondents pray that the LGA will continue where TSHIP stopped

What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

- Felt the TSHIP should be extended for another 5 years because there are some programs which the respondents said that government might not be able to support now. They mentioned – Supply of drugs, data tools and equipment

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- Respondents could not state categorically what the LGA is doing to sustain the TSHIP program but said that the LGA might need to pay advocacy to the Ministry of Local Government and state government to advocate for their support

Yabo LGA:

1. What is your experience with how TSHIP engaged the LGA in its project implementation?

Do you feel the LGA is full equal partner in the implementation? Why

- Very cordial relationship. The TSHIP encourage people in the local government. They came to help us.

2. Overall, how has your LGA benefitted from the TSHIP Project? Please explain

- Management
- Capacity Building – Training, Supportive supervision
- Integrated Services
- Applying standards to improve quality
- Collaboration/partnership
- Harmonizing community approaches
- Gender mainstreaming
- Monitoring and Evaluation
- Staffing of health facilities
- Policy
- Capacity Building:
 - o Trained both LGA staff and facility level staff on different areas like Nutrition, RH, ORT, MCH, Immunization, FP, Community Mobilization, Community Action Cycle (CAC), management of Labour, exclusive breastfeeding, data tools
 - o The LGA gained much in terms of training
- Supportive Supervision
 - o Checklist was provided to the LGA
 - o Improve on the conduct of supportive supervision
 - o The LGA plan to continue based on availability of funds
- Management
 - o Re-activated all WDCs
 - o Capacity building
 - o Renovation of 5 health facilities as follows:
 - Yabo general Hospital – renovated HF and staff quarters, provided solar for maternity room, lying in ward and laboratory, Air Conditioners
 - WCWC PHC – renovated the HF, put beds and AC. Before the labour room was not conducive for the clients but now they are very conducive for clients
 - Dagawa PHC
 - Kilibari PHC
 - Gudure Dispensary – HF and staff quarter renovated
 - Stated that the renovated facilities provided conducive environment for both the client and the service providers and increased utilization of service in the HFs
 - Provision of equipment and drugs especially Misoprostol and Chlorhexidine. Said “Very Good achievement” that whenever there is stock out people will continue to ask for the drugs. Also said that even if a client is 10km from the health facility they have access to the drugs through the CBHVs and WDCs
 - Outreach services conducted by CBHVs helped to mobilize clients to the HFs

- Integrated Services
 - o MCH Coordinator stated that before they have specific days when services were offered but with TSHIP intervention services are provided on daily basis - ANC, ORT, FP, malaria but the Routine Immunization depends on the cold chain system in the facility.
 - o She said that having the services on daily basis is better because some women may have only that opportunity to be at the health facility and if all services are not rendered on the day of visit she might miss out and not have another opportunity
- Applying Standards to improve quality
 - o Posters, leaflets, job aids provided by THIP helped the HCWs to remember what they were taught. E.g. MCH coordinator said that the rate at which ANC clients visit the health facility during their pregnancy period is reducing from 10 to 4 (for clients without complications) because the health care workers have started using the standards for booking appointments for ANC clients as contained in the guidelines. Also this has greatly reduced the workload of the HCWs
- Collaboration/partnership
 - o LGA provided drugs and staffing
 - o Reported that after TSHIP renovated 5 health facilities in the LGA the LGA provided generators.
 - o WDC in Dagawa ward purchased motor vehicle for referral purpose
- Harmonizing community approaches
 - o Communities are able to sensitize the people to attend the HFs
 - o CBHV activities are being appreciated and more clients are using the health facilities.
- Gender
 - o 100 women group were trained on skills development like making soap etc. – L.I.O and the MCH Coordinator mentioned 2 people that benefitted from the scheme and are doing better in taking care of their family and health needs
 - o WDCs tried to put women in leadership position, stated that apart from the Chairman, women can hold any key position in the WDC
 - o Training on male involvement conducted in the LGA
 - o Male service providers rendering services in the health facilities including delivery
 - o Husbands supporting their wives in health seeking behaviour, stated that sometimes it is the men who first visit the health facilities to seek for information after which they encouraged their wives to attend the health facility. Also reported that sometimes they transport their wives to the health facility, follow them and even take the children to the health facility for routine immunization.
 - Quote: "Village heads as champions are key to acceptance of project by men "
 - o FP data reviewed for January and February 2015 shows that men are visiting the health facilities to pick up condoms (12 men in January and 11 in February)(Source: HMIS Monthly Report – January and February 2015)
- Monitoring and Evaluation
 - o Capacity building for Staff – Trained LGA staff on M&E and computer. Before the M&E officer was not computer literate
 - o Provided Laptop, registers, summary forms, internet. Before TSHIP intervention registers and HMIS forms were not available in the LGA.
 - o LGA participate in monthly meetings conducted by TSHIP with M&E Officers
 - o With the assistance received from TSHIP, the LGA now have data to report to the state and even the federal level

- With the training received from TSHIP M&E officer was able to step it down to the HCWs and also provide on-the-job training as needed.
- Staffing of health facilities
 - TSHIP trained Community Based Health Volunteers (CBHV) and gave them some allowance to work with the HFs and community. They serve as the linkage between HF and community
 - LGA provide staff for the renovated facilities
- Policy
 - No policy change during TSHIP implementation
 - But with TSHIP intervention deadlines are set for reporting of data from the HFs to the LGA and from LGA to the state which is being adhered to by both HFs and LGA.

3. What Policies did you initiate/change as a result of working with TSHIP?

Did changing the policies change the practices?

- None

4. To what extent did TSHIP implementation of activities assist the LGA in addressing issues related to reducing Child and Maternal Mortality (MDGs 4&5 goals) Examples

- CBHVs do tracking of children and pregnant women in the community and also accompany them to the HFs
- Use of Misoprostol and Chlorhexidine drugs assisted in reducing child and maternal mortality
- Training of in-charge of health facility for referral to higher facility and the provision of ambulances by govt help to reduce delays usually encountered when making referrals
- Food demonstration in the HF facilities helped women with under nourish children to know type of food to give to them to make them healthy. It was noted that the food stuff has finished and the HFs are looking up to the WDCs to replenish them
- Teaching women how to prepare ORT helped in arresting diarrhea in children

5. What particular resource(s) of the LGA have been leveraged on the TSHIP project(s)? Explain

What did you do for TSHIP? Cash or Kind

How much did it cost?

- In addition to those mentioned above:
 - o The LGA provided solar power in all facilities that have capacity to conduct delivery except in 1 facility

6. How have the HFs changed during TSHIP implementation?

Status before and after implementation?

Environment, HWs capacity, Staffing, Service delivery, Availability of job aids & SOPs, commodities, health outcomes, facility utilization, referral

- Training of the HCWs make them more knowledgeable and skilled in the provision of services
- Before TSHIP there were no registers or other forms but with TSHIP all health facilities have required registers and forms and data quality changed
- TSHIP renovated HFs and also in some cases staff quarters. The renovated health facilities are neat and very conducive for clients e.g. having the Air conditioner installed in the health facility.

- The mobilization activities of CBHVs have resulted in more people attending the health facilities
- The provision of ambulances have made referral easy – before women in labour are sometimes carried on local beds to the facility but now having the ambulances makes transportation of the women in labour much easier
- Conducting supportive supervision help to identify issues and ways of addressing them.

7. Have you been trained by TSHIP? Yes (more response from M&E and MCH)

8. What did they train you on?

- LGA and HF staffs were trained on FP, Nutrition, malaria, data collection, reporting, lifesaving skills, strategic counselling method, immunization, ORT, CLMS, computer, etc.

9. How did you use this training?

- Step down the M&E training to all the HFs staff.
- Stepped down the MCH trainings to HCWs and CBHVs
- Conduct –on-the-job training to HCWs whenever there is a new staff at the facility
- Organize review meetings with HCWs and CBHVs to discuss issues, review their documentations and discuss way forward

10. What do you do differently now?

- Use the computer to enter data and transmit it to the next level which has resulted in timely reporting of data before use to be manual process
- Conducting DQA
- Conducting supportive supervision

11. Has the project strengthened your capacity to support MNCH/FP/RH for your LGA? How?

- Yes through provision of data tools and registers, different trainings

What training do you wish you had that you did not receive?

- HIV/AIDS Training
- Life Saving Skills training for Male health workers

12. What recommendations do you have for your LGA to improve its capacity in supporting MNCH/FP/RH?

- To provide water for the health facilities. Most health facilities don't have water
- To continue the midwifery scheme
- To support Routine Immunization more instead of concentrating on campaigns.
- LGA to integrate the CBHVs into the LGA and take up the payment of their allowance and also increase their number. To also base the number of CBHVs on the population (coverage area) of the ward
- To continue to provide all essential routine drugs, commodities and equipment especially during child health week. Noted that the community members are mobilized during the week but when they get to the health facilities the drugs etc. promised during the campaigns are not usually available

13. What is the level of implementation of the Standard Based Management and Recognition (SBMR) approach to improve quality of performance in HFs in your LGAs?

Do you think this is a good approach?

- The respondents do not know the approach. They are not sure what it means

14. Did TSHIP support you to develop a Costed Health Development Plan?

What is the level of implementation, and how has it improved health care delivery system?

- Respondents not sure. The PHC Director left before we got to the question

15. Did LEAD work with you to produce a Community Based Development Plan? How is the plan used? Have you used the Community Based Development Plan within the TSHIP project?

- Not LEAD LGA

16. How would you describe the linkage between the facility and community?

- The linkages between the community and facility was described as cordial, good relationship
- Said that there is good relationship between the health facilities and the communities. E.g., the HCW is free to go to the WDC chairman to ask for support, mobilization of clients to the facility and the requests are granted.
- The use of CBHVs was describe as the best approach to link the community to the facility

Would you say that approaches used were appropriate?

- Said the approach was appropriate

What could they have done differently?

- Nothing

17. How has the TSHIP project addressed the perceived roles of men versus women in your LGA, and how these roles affect health care seeking behaviours?

What specific activities do you know they carried out in your LGA that relates to gender?

Do you think the activities were adequate to minimize the issue of gender norms challenges in your community?

Are husbands more supportive of their wives going to the health facilities? Explain?

Are more women being placed in leadership positions? Give examples?

- By training, using the village heads, sensitization and mobilizing the men to support their wives and children to go to the health facility to receive service
- Yes as stated in 2 above
- Yes as stated in 2 above

What do you think TSHIP could have done better to reduce the issue of gender norm challenges in your community?

- Nothing

18. How has TSHIP collaborated with other organizations and projects in your LGA?

- LEAD
 - o Not LEAD LGA
- NEI
- SIDHAS
- PROACT
- DELIVER
 - o Could not state categorically what they did together
- WHO & UNICEF etc.

- o W and implement together on immunization especially IPDs conduct trainings together

19. What is the most significant health change you observed in your LGA due to TSHIP intervention? Explain

- Most Significant “Increased utilization of ANC services”. This is as a result of awareness creation in the communities (outreach services)
- Others?
 - o Increased acceptance of FP services – clients are even calling HCWs at home and in the night to ask for service. Men are also picking up condoms from HFs
 - o Increased delivery at health facilities
 - o Increased general attendance at the health facilities
 - o Reduction in malaria incidence because of net distribution and malaria drugs
- Respondents felt that no significant change occurred in immunization because of problems encountered in transporting Routine Immunization drugs too hard to reach communities who finds it difficult to come to the HF

20. What are the things TSHIP did in your LGA which you will like to continue doing?

What are the things that you feel TSHIP could have done better in your LGA which could have increased coverage and accessibility of services?

- Use of CBHVs for community mobilization
- Supply of drugs and nets
- Supply of SP
- Support HCWs for Routine Immunization outreach
- Conduct refresher training on life saving skills, FP, focused antenatal
- To continue supply of Misoprostol and Chlorhexidine drugs
- To renovate more facilities

21. What actions have your LGA taken to sustain what TSHIP has done on MNCH/FP/RH service? Examples

- The DPHC said that the LGA will retain some of the activities implemented by TSHIP.
- It was noted from the interview that the LGA don't have any concrete plan on ground to sustain what TSHIP did in the LGA.

d) Focus Group Discussions Notes

Focus Group Discussions with TSHIP Sub-grantees

1. How did you use your grant? Give examples, what is the most significant health outcome you achieved?

- We abided by the community health development plan and adhered to budgets.
- We worked on social mobilization.
- We supported all the health programs under TSHIP.
- As stakeholders we centered our work on community interventions for mother child health.
- We worked for MNCH outcomes. We worked to build the capacity of the community to create demand for services. We achieved this through review meetings with the community and LGA to plan activities and implement them.
- We encouraged the WDC to come up with support.
- We worked to build capacity.
- The drivers of the work were the community volunteers, CBHVs. They did the work. We supported the CBHVs by capacity building and tools. We monitored them to measure the outcome of activities and report back to TSHIP.
- We specifically strengthened community based organizations, 100 Women Group, EMAPs, CBHVs, etc. using TSHIP tools.
- We trained healthcare providers and updated trainings.
- We trained EMAPS (expanded male as partner). We performed social mobilization.
- We were the eyes and ears, and the hands and feet of the TSHIP project at the community level. Every day.
- Theme
 - Post partum hemorrhage
- Community mobilization
- Newborn and child mortality
- Awareness raising and education
- Increasing utilization of health facility services
- Nutrition (IYCF, ORT, breastfeeding, supplementary food introduction/preparation)

Significant outcomes:

- Reductions in maternal and newborn mortality
- More engaged communities
- More active communities
- Better HF attendance, especially ANC
- Healthier babies
- Community ownership of health.

2. Overall, how has your organization benefitted from the TSHIP Project? Please explain

- We were there before TSHIP came, so we were not new to this.
- TSHIP organized trainings for the grantees, giving knowledge and skills to carry out work.

- They provided funding, and capacity building.
- They provided supportive supervision. "We were not just left to work on our own." They corrected the course when necessary.
- They gave us equipment to use for the work. We were supported for procuring IEC materials.
- We were given training in misoprostol and chlorhexidine.
- TSHIP worked on the project objectives, but also helped us.
- TSHIP taught us planning, budgeting, management.
- They strengthened our systems.
 - It has streamlined our focus. We identified our strengths and became better at what we do.
 - Training, new skills, new information
 - Reviewed internal systems and made them stronger
 - Learned how to gather, report and use data
 - Staff perform better

3. What do you do differently now as a result of TSHIP intervention?

- We now have operational plans.
- We learned about gender and incorporated it into our work.
- We practice gender mainstreaming.
- HR changed, improved and became more organized and professional.
- Our policies are more developed.
- We have increased involvement of our board of trustees. Before we had vague rules. TSHIP had a workshop targeting our board of trustees. We created a manual that defined governing structures, rules and roles.
- Mentorship. We were mentored. Now we mentor others.
- We have been taking steps to make sure implementation follows the plan.
- Fund raising. We have learned much about revenue.
- Community participation.
- We learned how to use advocacy as a tool, to get government and non-state actors to participate.
- Data gathering/record keeping.
- Male involvement in health. Engage community to engage the HF.
- We work with structures more now, not try to do everything ourselves.
- We learned to change, improve and grow.

4. What approach (if any) have you used to integrated gender into your programming?

- Gender is critical for working in our society.
- We have sensitized communities to give a chance to women to participate in their own activities. Men have long dominated here. We had to break barriers.
- Gender approach after training we learned we had to go beyond male and female.
- The project focused on women. We must be sure to carry men along.
- Men needed a bigger role in this project [note: enthusiastic agreement from all on this point.]
- EMAP (expanded male as partner).

- In recruitment: the volunteers [CBHVs] made a huge difference because they have access. They have access because they are women.
- The activity determines the role of gender in the implementation.
- Consult the community first.
- At the design stage, there should be active participation of both genders.

[How many women do you have in leadership position?]

- Depends on the activity, and the organization
- [Three out of the four sub-grantees said male education.
- Changing the role of men by educating them on the basics of ANC/RH/FP but also a sort of moral education on the role of men in supporting wives and daughters.
- Getting men to support ANC and HF attendance.
- Used locally accepted TBAs to advocate with both men and women for ANC attendance.
- Used religious leaders to tell men to support their wives.
- "Men respond well to new information. We always had men-specific messages."

[How many women do you have in leadership position?]

Two of the four sub-grantees interviewed are headed by women.

5. How accountable is TSHIP to stakeholders?

- Very accountable.
- TSHIP has CMOs (community mobilization officers).
- Our budget is a monthly event. It must be approved, and sometimes revised. Retirement of accounts is also procedural. They work through the LGAs.
- Every activity must have a profile, with expected outcome. These guide the budget.
- They were accountable to us. They took us along every step. They responded when we had problems. They assisted when we had challenges.
- Compared to other donors, "The professionalism in TSHIP was exceptional."
- They were always involved. They were always there to support us.
- They gave good feedback. They were prompt.
- They responded to reports. They really read them.
- The first misoprostol/chlorhexidine birth, sadly, the child died. TSHIP's response was superb.
- Very.
- They give good feedback.
- We discuss issues and challenges.
- There is mutual problem solving. We are also learning that learning is more than two ways. We learn from communities. We learn from TSHIP. They learn from us.
- Working with TSHIP is a big opportunity.
- We wish we could have learned more.

6. How easy and transparent was the grant process?

- It was really hard. Negotiate and renegotiate. We went to a workshop and then did it again.
- It took about 2 or 3 years.
- Towards the end of this project we realized how much time we lost. [enthusiastic unanimity on this]
- This process must improve. It must be made simpler and more efficient.
 - There is no reason for this process to take more than a year! [Two sub-grantees obtained grants through a competitive process and two were sole sourced.]
 - They two who competed said that the process was difficult and made them perform (apply) at a higher level than they would have otherwise. They were happy they did it, but laughed and said that they did not think so as much at the time.
 - The other two were sole sourced, and said that the process was very bureaucratic. One respondent said she worried that good groups/people could be left behind because they were not sophisticated in the competitive process or with working with donor funded projects.

7. Do you have suggestions on how to improve the grant management process?

- The current systems work. It was the development stage.
- "There are grey areas"
- The level of awareness in the communities is very low. Producing receipts can be difficult. In another project where we work we use vouchers, which makes this easier.
- "These people do not understand banks."
- Remoteness contributes to difficulties. Some people do not use signatures.
- TSHIP needs to adapt procedures to the context of remote, semiliterate societies. [much emphasis and agreement on this!]
- Adapt to context.
- Start earlier
- Glitches in payment can create hardship in remote areas. [No money, no ATM].
- TSHIP should spend more time seeking solutions when these problems arise.
- In early 2013 there was an issue about values. This was a turning point. It was decided [by TSHIP] to reassess and change. All subgrantees participated in the process. It could have been more open.
- [They all agreed on this turning point and thought that it marked a major change, but were not clear on what all changed. Ed.]
- The project was very large. It could be broken apart into its components.
- There is always room for improvement.
- Need to develop simpler process for retiring expenses. The complexity causes delays.

8. Will you continue your activities after TSHIP? Where will you seek funds?

- "We will sustain the situation Inshallah."
- Some activities will not continue.
- "We use other grants now."
- [They described different ways of financing themselves. Government. Others. Banks. Charities. Small enterprises. They have obviously spent some time and thought on this. They argued. They were animated.]
- "Where is SPHCDA? Isn't it their job to sustain PHC?"

- CBHVs want to continue. They work without pay. This is sustainability. The WDCs want them to stay.
- • “We were doing this before TSHIP came. We will do it after they leave.” • Yes. With or without TSHIP we will continue activities.
- We can sell ourselves.
- We may lose funding but we will not lose what we have learned.
- We have taken the TSHIP templates to other states and other donors.
- I worry about the CBHVs [without TSHIP support].
- We put pressure on LGAs to continue this work.
- “I do not worry about the money. I worry about losing the level of access that TSHIP provided. TSHIP broke hard ground.”

Other comments

[Highlights of TSHIP;]

- The focus on MNCH. Getting people aware of it.
- Community participation.
- They linked communities with the government.
- Introducing new initiatives in the state, misoprostol and chlorhexidine. New innovations. Research. [compared TSHIP to UNICEF, saying UNICEF was never there, not involved in their problems]
- Gender. TSHIP really invested in gender.
- Political involvement. Got the state to support the interventions.
- Communities were very happy to be involved.

[weaknesses:]

- Uneven application/enforcement of policies. [This refers to the difference between competitive and sole sourced grants.] Created bad feeling, a two-tiered structure.
- We could have used a severance payment.
- It is good that THIP worked with existing structures, state, LGA, WDC. But they shouldn't have restricted themselves to just those.
- USAID should, when closing out, ask, “How will this project replicate itself?” This did not happen.
- We wanted more M&E.
- We would like to be more involved with JSI.
- We would have liked a capacity building plan with goals, objectives and benchmarks.
- TSHIP should have worked harder on getting providers, especially in hospitals, to treat women better, more respect, fewer delays.

Focus Group Discussions with Ward Development Committees

Bauchi State

Alkaleri LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

- Yes (all participants)
- We received initial training on interpersonal communication and basics of MNCH to be able to effectively sensitize the community on health care delivery; our annual ANC attendance is now more than 3,000 in each HF; delivery at the hospital has increased; in some HFs about 10 FP registers have been filled up as a result of mobilizing the community.
- "With the reactivation of the WDC and the capacity building, we can now sustain ourselves."
- TSHIP requested us to identify 7 females and 3 males as volunteers, who will sensitize the community on ANC, and completion of immunization; the use of misoprostol has reduced maternal mortality.
- Previously, community mobilization was limited to urban areas, but now it has been extended to remote areas, which as a result we have seen about 95% reduction in maternal mortality; immunization also reduced infant mortality.
- The emergency transport system has greatly saved lives of women in labor.

2. Has your group been trained by TSHIP? How do you use this training?

Yes (all participants)

- We were trained on interpersonal communication; community mobilization on ANC and immunization; we were provided with counseling book, referral card, which led to community's acceptance of the services.
- Previously, mothers did not appreciate the importance of personal hygiene, immunization, ANC, diseases prevention measures, family planning -- until the coming of TSHIP.
- The training on 'extended males as partners' (involvement of traditional and religious leaders, youths organizations) sensitized the community (which even enhanced HIV prevention interventions); husbands have been sensitized to allow their wives to be taken to hospital in their absence.
- The community action cycle training taught us how to identify, prioritize and solve local problems with local solutions/resources.
- We were taught on how to mobilize resources, not to rely on government.

3. Did the use of this training change anything? What do you do differently?

(See 2 above)

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

- "Previously, community members report the service providers to the LGA, and without proper investigation the LGA takes punitive measures. But now we learned that the service providers are part of us, they are working for us."
- Service providers now pay special attention to patients we take to them.
- The formation of the quality improvement team opened ways for sharing the community's misperception with the service providers for correction.

5. How do you think the health facility benefit from your contributions? Please give examples.

- We funded the repair of laboratory instruments; we introduced the drugs revolving funds (commenced with N10,000 now we have more than N200,000) -- we sell the drugs at affordable rates.
- We provided electricity to one of our HFs; we carry out repairs of benches and beds; we fuel the motorcycles to go for community mobilization.
- We renovated the staff quarters; repaired the roofing, and conduct environmental sanitation.
- We constructed burn/bury pit for waste disposal

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

- We work with the herbalists association; youths self-help groups; traditional birth attendants' association; local barbers' association; Bazar Kowa; Fadi Sonka; and motorcyclists association.

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

- We lobbied for the rehabilitation of one of our HFs but was not done
- The LGA upgraded our dispensary to a PHC
- LGA supported to provision of electricity to one of our HFs, we lobbied the LGA to pay the 11-months outstanding salary of the community midwives, and was settled.
- The LGA provided solar powered refrigerator to one of our HFs.

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

- The mix of female and male volunteers yields result, we sensitize mothers while the male volunteers sensitize their fellow men.
- Now some husbands request us to sensitize/counsel their wives against inflating the cost of accessing health care service (ANC).
- "Previously we believed immunization makes children stubborn, unborn babies become big if the mother takes ANC drugs thereby killing the mother during delivery. But with enlightenment, all the superstitions now become a history. We counsel husbands that "if you don't sacrifice N500 for your wife's pregnancy, you may spend thousands if there is complication or if she dies."
- Some husbands rely on herbal medicines, we had to sponsor their wives' treatment to convince them; now they give their wives permission to borrow money to go to the hospital when the need arises.
- The emergency transport system convinced many husbands to allow their wives to access health care services.
- Participation of religious leaders helped convinced husbands from religious perspective, some husbands feared ANC could be a cover for FP, we enlightened them on the socio-economic consequences of un-spaced children.
- Some husbands thought eclampsia was caused by the spirits; previously some people felt hospital delivery was an embarrassment.

10. Has the participation of women increased in your group? What's the evidence?

- We have women in all our WDCs: 16/30; 17/36; 11/38; 13/25; 18/35

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

- LGA should:
 - o Sustain the CBHVs; continue the quarterly review meetings with the WDCs; and continue to monitor the activities of the WDCs.

Other:

- Most utilized services:
 - o ANC; immunization; malaria treatment; hospital delivery
- Less utilized services:
 - o Use of LLINs; FP

Bauchi LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

- Yes (all participants)
- We were trained on the use of misoprostol and chlorohexidine, and this has reduced maternal mortality in our community.
- As a result of the awareness created by TSHIP, we provided water to two communities, we clean hospital environment, and constructed a burn/bury pit for waste disposal.
- Clients issued with referral cards by the community-based health volunteers have better access to services at the health facilities.
- "I have been working on mobilizing people but never seen a better approach than that of TSHIP (it covers not only health but other socioeconomic issues).
- TSHIP introduced the extended males as partners and trained them to sensitize fellow men on the importance of ANC, they encourage husbands to begin making savings immediately their wives get pregnant; TSHIP facilitated the formation of village development committees to ensure greater coverage on mobilization.

2. Has your group been trained by TSHIP? How do you use this training?

- Yes (all participants)
- We were trained on advocacy, sensitization, resource mobilization, community action, which helped us identified problems of service providers' not going to work and lack of equipments. We visited all the health facilities in our ward and we give feedback to the service providers on our observations during the visit. We developed quality improvement plan; we use the counseling cards to convince mothers; we established the drugs revolving funds and the essential transport system to cater for referral cases.
- A group of 100 women were trained on entrepreneurship
- More women attended some of TSHIP training and volunteered to pass the information across (e.g. on the need to stop stigmatizing people living with HIV).

3. Did the use of this training change anything? What do you do differently?

(See 2 above)

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

- "The Petroleum Trust Fund program attempted to create similar structures as the WDCs, but that time the service providers were skeptical of engaging with WDC members. When TSHIP came, it harmonized the two groups, we now feel like brothers."
- We mobilize people house-to-house, while the service providers counsel clients and endeavor to improve the quality of service (e.g. conducting health talk and home visit once a week).

5. How do you think the health facility benefit from your contributions? Please give examples.

- We mobilized the community to construct drainage (the hospital provided the blocks and we provided the mason).
- We constructed burn/bury pit for waste incineration
- We constructed a FP unit at Yelwa Domiciliary clinic (amounting to over N800,000); we constructed a security

office (amounting to over N150,000); the WDC chairman's car is used to convey patients when referred to the specialists hospital.

- We constructed a two-bedroom flat for our service providers; constructed a burn/bury pit for waste incineration; we provided curtains to the hospital; we conduct environmental sanitation; we employed a hospital attendants and involved them in polio eradication activities (to get some stipends); and provided some apparatus (BP and stethoscope).

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

- We work with the association of local barbers; motorcyclists association; and women's group

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

- We lobbied for assistance from the LGA but we never got it.

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

- Involvement of the extended males as partners in sensitizing husbands led to a breakthrough (previously we usually give up). We involve the traditional and religious leaders in sensitizing men (sometimes one-on-one especially during the immunization campaigns); we identify defaulters using the immunization coverage; we reach out to the men's mothers to resolve difficult non-compliance cases.

10. Has the participation of women increased in your group? What's the evidence?

- We have women in all our WDCs: 35/100; 8/18; 2/14; 6/24

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

- We need moral support from the LGA; an officer should be attached to each WDC to supervise their activities; a desk officer should be appointed to coordinate all WDCs activities at the LG level
- LGA should sustain the supply of misoprostol and chlorhexidine, as well as ACTs
- TSHIP should educate the LGA on the capabilities and progress made by the WDCs; LGA should sustain the payment of allowances, organize seminars, workshops, and quarterly review meetings
- "If TSHIP goes, and the LGA does not sustain the activities, there is going to be a catastrophe (especially involvement of the community-based health volunteers)."

Other:

- Most utilized services:
 - o ANC; hospital delivery; immunization; malaria treatment;
- Less utilized services:

Use of LLINs; FP

Darazo LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

- Yes (all participants)
- TSHIP supported areas beyond the health sector, including peaceful coexistence, self-help, and enlightened us on the importance of MNCH "unskilled persons can now administer the misoprostol and chlorohexidine;" women go house-to-house to mobilize mothers to attend ANC; now we conduct activities with proper planning (we develop work plans).
- Previously mothers only deliver at hospital if there is complication; TSHIP taught us what ANC entails (we can sustain the activities even without TSHIP); mothers now make some little savings in preparation for delivery.

2. Has your group been trained by TSHIP? How do you use this training?

- Yes (all participants)
- We were trained on community action cycle, now we conduct activities strategically; the training taught us how to tackle public health issues like malaria during the rainy season (we spray used engine oil on areas where mosquitoes breed).
- We were trained on interpersonal communication; the use of misoprostol and CHX; use of LLINs (we sensitize mothers on the effect of malaria); the importance of FP (which increased acceptance); we have seen increased immunization coverage
- We were trained on diarrhea management (we educated mothers on personal hygiene as a preventive measure); we were trained on preparation of ORT and the need to rush the patient to the hospital; we were trained on malaria prevention/treatment (recognition of symptoms and rushing the patient to the hospital)
- We formed the quality improvement team
- TSHIP trained the extended males as partners (previously mothers felt shy or thought FP commodities were for sale); we educated mothers on the need for birth spacing (which led to reduced infant mortality)
- We introduced the emergency transport system (use of motorcycles, cars to convey patients to the hospital)

3. Did the use of this training change anything? What do you do differently?

(See 2 above)

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

- We are now like colleagues, we work harmoniously; we recognized the need to work on the health sector as a result of TSHIP.
- "Previously our only business with the service providers is when we fall ill, now the WDC has access to health facilities; whenever there are issues concerning service delivery (e.g. non-compliance to immunization) the service providers informs the WDC."

5. How do you think the health facility benefit from your contributions? Please give examples.

- We repaired the hospital roofing; we are currently expanding the immunization section; we sponsor mothers on labor; we constructed a store, provided drugs and a drum for collecting water
- We completed the staff accommodation; and constructed burn/bury waste incineration pit
- We established the drugs revolving funds to ensure availability and affordability of essential drugs; and provided water (currently not functional) to one of our HFs.

- We constructed the Kuka biyu dispensary (LGA provided doors, windows); we conducted some minor repairs at two HFs; we repaired the gate of another HF.
- We repaired the roofing and constructed pit latrine at one of our HFs; we involve the community health volunteers in supervisory visit to HFs
- We constructed drainage at the maternity hospital, and provide some consumables

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

- We work with the association of butchers; motorcyclists association; traders' association; Myetti Allah; Jama'atun Nasril Islam (in cleaning HFs); union of road transport workers; and other craftsmen

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

- We reach out to our traditional leaders and other philanthropist but not the LGA; the LG representative at the state House of Assembly repaired the generator at our HF; another philanthropist provided mattress to the HF; our WDC lobbied for the LGA to allow the service provider to remain at the ward; LGA also provided a permanent female service provider

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

- We prepare the grounds for paying hospital bills by reaching out to husbands first to counsel them, before meeting the mothers. Where the husbands are not cooperative, we inform the WDC; husbands are now sensitized to allow their children to be immunized (even before the naming ceremony)
- We enlighten both the husbands/wives on the importance of hospital delivery over the expenses for the baby's naming ceremony. We tell the husbands "if you do not tackle a small problem while your wives are pregnant, you will end up spending a lot e.g. blood transfusion or conducting CS)
- Husbands now take their wives to hospital after home delivery

10. Has the participation of women increased in your group? What's the evidence?

- We have women in all our WDCs: 16/33; 17/35; 8/32; 16/40; 9/39; 9/21; 16/42/ 18/53; 9/35

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

- ANC drugs should be available
- LGA should continue the WDC forum, and sustain the community volunteers

Other:

- Most utilized services: ANC; immunization; malaria treatment;
- Less utilized services: FP

Dass LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP.

The respondents indicated that the things that happen different are positive changes in the health system of their communities due to the TSHIP project. And all of the respondents said that they and their communities benefitted from the TSHIP program. In the course of the discussion, the respondents indicated the following benefits they and their communities received from TSHIP:-

1. The respondents indicated that TSHIP project has unified the people in the LGA to fight a common problem – i.e. poor maternal and child health. They said now the WDC and the Health Care Providers work together to ensure healthy mother and baby. Service Providers and the WDCs meet discuss and make solutions to their maternal and child health.
2. Reactivation of the WDCs. Prior to TSHIP project the WDCs were virtually none existent, but TSHIP has activated the WDCs and now they perform many functions in the communities.
3. The respondents said TSHIP has enlightened the communities in appreciating the importance of patronizing Health Facilities. According to them, such enlightenment has increased the community utilization of antenatal, delivery and postnatal services. Also, more women and men avail themselves for HIV counseling and testing,
4. TSHIP supply of drugs such as Chlorhexidine and Misoprostol; which help in reduction of newborn infections and bleeding in women during childbirth are another benefits. They also learnt to prepare ORT solution for diarrheal diseases.
5. More drugs are available in Health Facilities courtesy of STHIP program. These drugs, according to the respondents include; anti-malarial (ACT), Misoprostol, Chlorhexidine, and family planning commodities
6. Activities of the CDI+ members assist women in the communities. According to the respondents, pregnant and women in labor are assisted by the CDI+ members whenever the former are having complications. Even in the night, the CDI+ members are call upon to attend to the women and their newborn babies.
7. TSHIP training of the WDCs and the CDI+ members help the WDCs/ CDI+ to perform community services much better with good outcome. The CDI+ members cited the use of Misoprostol and Chlorhexidine as one of the best benefits to the communities and the practicing CDI+ members. According to them the CDI+ members, they are now more accepted by the community members than the untrained Traditional Birth Attendants (TBA).
8. TSHIP Hygiene training helps the communities to be cleaner and healthier. According to the respondents, they teach the households to be clean and eat balanced diet, and occasionally, the CDI+ members assist some household by sweeping the house, and ensuring the family members wash their hands before eating.
9. TSHIP community sensitization has created awareness among men, such that men are now more responsive to their wives' and children's health.
10. The respondents also indicated that Maternal and Child Mortalities and Morbidities have reduced drastically in their communities as a result of the TSHIP project.

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. All the respondents said they were trained at one time or another. The trainings were on leadership managements, advocacy, hygiene, community sensitization, and family planning. In addition, the female respondents also said they were trained on the use of essential drugs (Chlorhexidine, Misoprostol).

The respondents indicated that the trainings help them to improve in working as follows:

1. Monthly meeting is now conducted and problems are discussed and solutions provided. Without TSHIP training such meeting could not have been successful.
2. They use the knowledge in Advocacy for recourses mobilization.
3. Participating better in their community sensitization and mobilization for increased utilization of Health care services.

4. The trainings sensitized them to help their communities. For example, WDCs, as a group and sometimes individuals, raise money to buy drugs and give to the patient. Recently the WDCS of Bununu central ward raised up funds worth N20, 000 for the Caesarean Section of a young mother who could not deliver because of obstructed labour.

Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many positive changes.

They indicated that the following are the things they now do differently and have seen positive changes

1. That now they work as a team. The Health Care Providers, the WDCs, the CDI+ and the traditional/religious leaders work hand-in-hand. They help themselves and also help the Health Facilities. They meet monthly and review the health situations and proper solutions.

2. They conduct lectures, meetings and dialogues to create awareness among the people of their communities. The awareness creation has made the WDCs to be accepted by their community members.. These community sensitization activities have made their communities to accept Exclusive Breast Feeding (EBF) and Family Planning (FP).

3. Now WDC members take more roles managing their Health Facilities. They assist in providing financial assistance to the Health Facilities to buy drugs and also sometimes assist poor patients financially.

4. CDI+ members, who are Traditional Birth Attendants (TBAs), now use Misoprostol for the prevention of bleeding during childbirth and Chlorhexidine for prevention of neonatal infection.

5. CDI+ members prevent the use of cow dugs and other dirty materials for managing umbilical cords of newborn babies. Discourage the use of water to the newborn babies; but encourage the practice of Exclusive Breast Feeding.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited many examples of areas of collaboration between the WDCs/CBHV and the Health Facilities which can be group into:

a) Increasing utilization of MNCH/FP/RH services. This is achieved by increased community awareness, accompanying the sick woman to the Health Facility. This relationship between the CDI+ members and the HF encourage the CDI+ members, improve their community mobilization and ease logistics and hence increase utilization of the services.

b) Increasing community awareness. These are done through organizing public lectures or dialogue and a Health Facility staff is invited to give lectures or to moderate dialogue. The monthly meetings of the WDCs include Health Facility staffs, and that provide an avenue for discussing health issues of the communities and together developing strategies for handling such issues.

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in the TSHIP project.

They gave examples of how the Health Facilities benefited from their contributions as:

1. The WDCs contribute in repairs of Health Facilities structures, for example the WDCs contributed money and through direct labour repaired the toilets of Durr PHC. They also advocated for the repairs of Borehole within the same facility. They also indicated that they built a laboratory and made other repairs at Gwantukurwa Dispensary. And they also ensure that the clinic environments are clean always.

2. The WDCs contributed in community enlightenment and sensitization; which increase community patronage to Health Facilities. And the CBHVs sensitized women in their houses to also utilize the Health Facilities.

3. The WDC's sensitization encouraged husbands to not only support their wives, but also accompany the

women to the hospital for ANC and FP.

Q6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

A6. They indicated that their group collaborates with members of NURTW in getting transport for the patients. Also they cited other local CBOs that they collaborate with – including Zumunta Social Club and Durr II Young Famers Club, both addressing manual developmental issues such as construction of drainage, making access roads and repairs of Chairs and other carpentry or bricklaying works.

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. The WDC's members said after discussing a problem and determining their needs they first make efforts before going to the Chairman through the appropriate Director (e.g. Director for PHC for health issues). However, they have not succeeded by such advocacy.

But if direct consultation fails, they meet the rich indigenes of the local government area and make their complaint and it can be done. An example is the repair of Bundot PHC Borehole.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that occasionally, they make contributions to buy some basic drugs and give to CDI+ members as well as the Health Facilities. They assist in maintaining access roads into some Health facilities. There was a time when wind blew the roofing of Bununu Central dispensary and they made contribution and bought nails, timber and others items and repair it through direct labour.

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are now more supportive to their wives in utilizing the Health Facilities. That the husbands now, more than before, accompany their wives to the Hospital.

They also said the husbands are now more accepting immunization and use of drugs (e.g. Misoprostol) to their wives.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. Most of the respondents said the participation of women in their wards has increased considerably. They indicated that the position of treasurer of WDC is reserved for the female members.

And more female community members are involved in their activities when the need arises.

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LGA counsel to:

a) All the respondents recommended the employment of more CDI+ members and the LG to take the responsibility of paying the monthly N2, 000:00, and providing them with drugs. They also indicated the need for re-training of these CDI+ members on a regular basis.

b) The LG to maintain the present TSHIP activities and infrastructures put in place in many Wards.

c) They also recommended that the monthly meeting of the WDCs be sponsored by LGC.

Giade LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP.

The respondents indicated that the things that happen different are positive changes in the health system. And all of the respondents said that they and their communities benefitted from the TSHIP program. In the course of the discussion, the respondents indicated the following benefits they and their communities received from TSHIP:-

1. TSHIP provided them with drugs in their Health Facilities and to the CDI+ volunteers. Such drugs include Chlorhexidine, Misoprostol, and contraceptives. Also they are taught how to make Sugar Salt Solution for the management of diarrhea.
2. Renovation of many health facilities and providing the Facilities with drugs and equipments.
3. The respondents said TSHIP has enlightened and sensitized the communities on appreciating the importance of patronizing health facilities. According to them, such enlightenment and sensitization has increased the community's utilization of Health Care Services.
4. Capacity building of WDC members and some health personnel.
5. Introduction of environmental sanitation and hygiene, which enhances well being and reduces ill-health.
6. Receiving the sum of N2, 000:00 monthly by the WDC members.
7. Introduction of Monthly meeting where WDCs and Health Care Providers meet and discuss the community's health problems and seek solutions to the problems.
8. They said there is now remarkable increase in Health care services utilization and a decrease in Maternal and Children mortalities and morbidities

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. All the respondents indicated that they were trained. The trainings were on leadership, advocacy, sanitation, and family planning.

The respondents indicated that the training helps them to improve in working as follows:

1. That they did step-down training to other WDC members and some people in their wards. This, according to them, created awareness and shared the knowledge acquired during the training.
2. Because of the capacity building they received from TSHIP, they developed work plan which guide them in working.
3. They now contribute money from which they buy drugs for the Health Facilities and the CDI+ Volunteers. They also assist the poor members of the community to access Health Care Services.
4. That the WDCs now keep their environment clean and people maintain their personal hygiene.
5. That they now prepare and give Sugar Salt Solution to children, as First-Aid, before taking them to health facilities.
6. They have created a drug revolving fund (DRF) from which they provide drugs in some of their health facilities as well as generate money for other activities.
7. The WDCs counsel and teach women how to prepare balanced diet.

Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many positive changes.

They indicated that the following are the things they now do differently and have seen changes

1. Creating awareness in the communities leading to increase services utilization.
2. The CDI+ Volunteers now enter houses for community enlightenments on Health issues such as family

planning, immunization, and danger signs of pregnancy.

3. Self-esteem; that they now contribute and solve their problems without the contribution of the LG.

4. The WDCs have more collaboration with the Health Care Providers and the traditional leaders. WDCs contribute in environmental sanitation and hygiene. Now they ensure that their Health Facilities are clean, drugs available and monitor the activities of the Health Care Providers

5. The WDCs now assist the Health Facilities in infrastructural repairs such as repairs of roofing when wind blew it up, repairs of seats and toilets.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited many examples of areas of collaboration between the community/group and the health Facilities which can be group into:

a) Increasing utilization of MNCH/FP/RH services. This is done by providing means of transportation to Health facilities (using Village Development Committee (VDC)), financial assistance to families that cannot afford buying their drugs or operation fees, accompanying the sick woman to the Health Facility to ease logistic issues, and helping to make the Health Facilities more clients friendly.

b) Increasing community awareness. These are done through organizing public lectures and a Health Facility staff is invited to give lectures, information sharing, and through distribution of IEC materials.

c) Regular visits to the Health Facilities by the WDC officials to see and know what are happening so that they can assist. These visits improve the quality of services in the Health Care Facilities. They also buy drugs and give the Health Facilities, thus minimizing the 'out-of-stalk' syndrome

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in TSHIP project.

They gave examples of how the Health Facilities benefitted from their contributions as:

1. The WDCs contributed in community enlightenment and sensitization; which increase community patronage of services. They also settle any misunderstanding between the Health Care Providers and the patients or patients' relatives. They also enlighten and encourage women and their husbands to avail themselves for Health care services, especially ANC, Delivery and Family Planning services. This, according to them, is manifested in the increased turn-out of women attending ANC clinic, Facility deliveries, Family planning, and immunization services.

2. They gave various instances where they contributed in maintaining or providing infrastructure in many Health centers. They said WDCs built toilets at Kurba Dispensary, repaired access road to Faguji MCH, also Doguwa MCH has Well from the activities of WDCs. In Isawa Clinic, WDCs repaired Toilets and the Roof of the clinic; which was destroyed by heavy Wind.

Q6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

A6. They indicated that they collaborate with NURTW and 'Achaba Union' in transporting patients. Others that they collaborate with in development activities that improve MNCH include 'Kungiyar Wanzamai', Doguwa Shooting Stars, Giade Youth Association, and Isawa Foundation.

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. The respondents indicated that they lobby for resources from the LGA by initially conducting advocacy visit to the District Head; who assist them in intimating the Local Government officials. Then they go to the Chairman with their request. Through that faguji MCHC got their well constructed.

But if that fail, they go through the other key stakeholders such as the Philanthropists within the communities.

Sometimes they tax themselves to get money for their projects.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that they created a DRF from their financial contributions. Occasionally, they make contribution to buy some basic drugs. And they also execute some projects through direct labour; examples are mentioned in question 5(2).

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are more supportive to their wives in utilizing the Health Facilities. They gave many examples of Husbands accompanying their spouses to the hospital when the wives are sick or attending ANC clinics.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. The participation of women in their group has increased considerably. The respondents indicated the establishment of WDC women's wing as a manifestation of the increase. Also, the integration of CDI+ Volunteers into the WDC has increased the number of WDC membership..

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LGA counsel to:

- a) At least continue with the financial assistance given to the CDI+ Volunteers, their drugs, and other working materials to be provided by the LG on a regular basis.
- b) The LG to sponsor and ensure the WDC's monthly meetings continue uninterrupted. To also continue the pay of N2, 000:00 to the WDC members; which are paid by TSHIP after each monthly meeting.
- c) The LG to maintain the present TSHIP activities and infrastructures put in place in the LGA.

Misau LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP.

The respondents indicated that the things that happen different are positive changes in the health system. And all of the respondents said that they and their communities benefitted from the TSHIP program. In the course of the discussion, the respondents indicated the following benefits they and their communities received from TSHIP:-

1. They said that deliveries are now much easier, with fewer complications.
2. Activation of WDCs, especially the establishment of collaboration between the WDCs and the Health facilities. This facilitated many achievements in the health sector of the LGA.
3. The respondents said TSHIP has enlightened and sensitized the communities on appreciating the importance of patronizing health facilities. The women are also informed on danger signs and symptoms in pregnancy. The CDI+ Volunteers were also trained on management of baby's umbilical cord to prevent infections. According to them, such enlightenment and sensitization has increased the community's utilization of Health Care Services.
4. TSHIP provided them with drugs in their Health Facilities and to the CDI+ volunteers. Such drugs include Chlorhexidine, Misoprostol, and contraceptives. Also they are taught how to make Sugar Salt Solution for the management of diarrhea.
5. Renovation of many health facilities.
6. Capacity building of WDC members and some health personnel.
7. Introduction of Monthly meeting where WDCs and Health Care Providers meet and discuss the community's health problems and seek solutions to the problems.
8. They said there is now remarkable increase in health care services utilization, and a decrease in Maternal and Children mortalities and morbidities
9. Introduction of environmental sanitation and hygiene, which enhances well being and reduces ill-health.
10. Receiving the sum of N2, 000:00 monthly by the WDC members.

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. All the respondents indicated that they were trained, except the WDC Chairman of Tofu ward. According to him, he was not available when the training took place. The trainings were on leadership, advocacy, sanitation, and family planning..

The respondents indicated that the training helps them to improve in working as follows:

1. That the Health Service Providers were trained on quality of care; which they now use in the management of diseases in the Health Facilities.
2. That they now prepare and give Sugar Salt Solution to children, as First-Aid, before taking them to health facilities.
3. That they did step-down training to other WDC members and some people in their wards. This, according to them, created awareness and shared the knowledge acquired during the training.
4. That they now conduct advocacy to key stakeholders in their communities on health issues and other community development issues.
5. They now contribute money from which they buy drugs for the Health Facilities and the CDI+ volunteers. They also assist the poor members of the community to access Health Care Services.
6. The WDC members now are involved in dispensing Misoprostol and Misoprostol at the community levels, and contraceptives in the Health Facilities.

Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many positive changes.

They indicated that the following are the things they now do differently and have seen changes

1. They now contribute money and buy drugs or even assist women to settle their medical bills.
2. The WDCs have more collaboration with the Health Care Providers and the traditional leaders.
3. Self-esteem; that they now contribute and solve their problems without the contribution of the LG.
4. The CDI+ volunteers now enter houses for community enlightenments on Health issues such as family planning, immunization, and danger signs of pregnancy..
5. The CDI+ volunteers now have different attitudes towards conduct of delivery; they use clean and hygienic instruments in conducting deliveries and give drugs to control bleeding after delivery.
6. WDCs contribute in environmental sanitation and hygiene. .
7. Now they ensure that their Health Facilities are clean, drugs available and monitor the activities of the Health Care Providers
8. The WDCs now assist the Health Facilities in infrastructural repairs such as repairs of roofing when wind blew it up, repairs of seats and toilets.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited many examples of areas of collaboration between the community/group and the health Facilities which can be group into:

- a) Increasing utilization of MNCH/FP/RH services. This is done by providing financial assistance to families that cannot afford buying their drugs or operation fees, accompanying the sick women to the Health Facility to ease logistic issues, and helping to make the Health Facilities more clients friendly.
- b) Increasing community awareness. These are done through organizing public lectures and a Health Facility staff is invited to give lectures, and through distribution of IEC materials.
- c) Regular visits to the Health Facilities by the WDC officials to see and know what are happening so that they can assist. These visits improve the quality of services in the Health Care Facilities. They also buy drugs and give the Health Facilities, thus minimizing the 'out-of-stalk' syndrome

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in TSHIP project.

They gave examples of how the Health Facilities benefited from their contributions as:

1. The WDCs contributed in community enlightenment and sensitization; which increase community patronage. They also settle any misunderstanding between the Health Care Providers and the patients or patients' relatives. They also enlighten and encourage women and their husbands to avail themselves for Health care services, especially ANC, Delivery and Family Planning services. This according to them is manifested in the increased turn-out of women attending ANC clinic, Facility deliveries, Family planning, and immunization services.
2. They gave various instances where they contributed in maintaining or providing infrastructure in many Health centers. They said WDCs bought drugs to the Antenatal clinic of General Hospital Misau, repaired main gate of Tofu MCH, and provision of Sand and Drainage system at Kukadi Maternity center
3. The WDCs also make appeal .for funds to assist the Health Care Providers; especially when the staff is newly employed.

Q6. Does your committee or group collaborate with other community organizations to support local

MNCH/FP/RH activities?

A6. They indicated that they collaborate with NURTW and 'Achaba Union' in transporting patients, FOMWAN and Jama'atu Nasril Islam in creating awareness and financial assistance.

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. The respondents indicated that they lobby for resources from the LGC by initially conducting advocacy visit to the District Head; who assist them in intimating the local government officials. Then they go to the Chairman with their request.

But if that fail, they go through the other key stakeholders such as the Philanthropists within the communities. Sometimes they tax themselves to get money for their projects.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that occasionally, they make contribution to buy some basic drugs. And they also execute some projects through direct labour; examples are mentioned in question 5(2).

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are more supportive to their wives in utilizing the Health Facilities. They gave many examples of Husbands accompanying their spouses to the hospital when the wives are sick or attending ANC clinics.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. The participation of women in their group has increased considerably. The respondents indicated the establishment of WDC women's wing as a manifestation of the increase. Also, the integration of CDI+ Volunteers into the WDC has increased the number of WDC membership. That occasionally, women are the majority in their meetings.

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LGA counsel to:

a) Employ or at least continue with the financial assistance given to the CDI+ Volunteers. And their drugs and other working materials to be provided by the LG on a regular basis.

b) The LG to sponsor and ensure the WDC's monthly meetings continue uninterrupted. To also continue the pay of N2, 000:00 to the WDC members; which are paid by TSHIP after each monthly meeting.

c) The LG to maintain the present TSHIP activities and infrastructures put in place within the LGA.

Ningi LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

Yes (all participants)

The community has been sensitized on ANC and immunization; TSHIP provided benches, misoprostol and chlorohexidine to our HFs

"TSHIP's achievement speaks volume, previously mothers don't go for ANC and immunization; we were not self-reliant (now we don't rely on government to maintain/repair the infrastructure like water pumps)."

We have been trained on how to sensitize and relate with our people better; WDCs were reactivated; with the communication action cycle training we now handle issues beyond the health sectors

2. Has your group been trained by TSHIP? How do you use this training?

Yes (all participants)

"Formerly it was a taboo for women to go for ANC and delivery, but with TSHIP's training on interpersonal communication, things have changed. Previously we did not take emergency cases seriously, but now we introduced the emergency transport system."

As a result of TSHIP's communication action cycle training, we employed volunteer TBAs, cleaners and security guards in our HFs.

We have been trained on advocacy (previously we did not bother to go, we were not persistent, now we know how to conduct effective advocacy).

We ensured 10 females from our community were enrolled into the community midwives scheme

We have been trained on how to identify danger signs during pregnancy

We were trained on community action cycle, we stepped-down the training to the village development committee members, we identified priority issues, proffered solution (e.g. transporting mothers during labor, we repaired the roads for ease of access).

We conduct environmental sanitation; we counsel mothers on personal hygiene (hanging of clothes, causing mosquitoes to breed thereby causing malaria); we have seen reduced cases of diarrhea

We learned from the training on exclusive breastfeeding that breast milk contains water, with sensitization, mothers are now adopting it.

3. Did the use of this training change anything? What do you do differently?

(See 2 above)

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

We had no business with the HFs previously, but now we know we have the right to monitor the performance of service delivery; we now jointly conduct hospital sanitation, and hold periodic meetings together.

"Initially the service providers felt we were rivals, with the coming of TSHIP, we created the quality improvement team, which improved the relationship between WDC and the health workers, we don't conduct anything without each other's knowledge."

5. How do you think the health facility benefit from your contributions? Please give examples.

We used to buy water to provide to our HF, eventually we constructed a borehole at the midwives service scheme compound, we provide fuel for the generators; we settle the bills of accident victims from the drugs revolving funds; we constructed burn/bury incineration pit; we conduct minor repairs; we employed a security guard since 2005

We collaborated with FOMWAN to construct toilet blocks (we provided 30% of the cost); we permanently attached 2 to 3 members to each HF in case of emergency cases.

We repaired the solar powered borehole (N18,000); we settle the bills of poor families during delivery; we fumigated the health workers'/students' quarters; we constructed a maternity clinic.

We plan to place a focal person at the general hospital to continue to intervene on the misunderstanding between clients and the health workers; identify/sponsor blood donors within the community in case of emergencies.

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

We work with FOMWAN; Kainuwa; TBAs; WOFAN; Rahama; ActionAid; LEAD; Fahimta; IPC

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

We lobbied for the construction of toilet but was unsuccessful

We lobbied for the construction of borehole, abattoir and drainage at our HF (the LGA did them) and provided a generator.

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

"We first of all talk to the husbands if they are around, if they resist, we inform the WDC. Previously mothers could spend up to 2 days in labor, but now the husbands rush them to the hospital."

WDC members enlighten men at the mosque, wedding ceremonies, and at mourning places (previously ANC visit was less than 20% but now it is more than 80%)

10. Has the participation of women increased in your group? What's the evidence?

We have women in all our WDCs: 11/27; 4/15; 11/26; 9/15

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

LGA should:

- Involve WDCs in all health-related activities

- Involve WDCs in the budget process

- Sustain the community health volunteers "they convey the message that the LGA cannot"

- Should increase the allowances of the community health volunteers

- "WDC volunteers are no more paid their stipends (for 9 months now)"

Other:

Most utilized services: ANC; immunization; hospital delivery; malaria treatment;

Less utilized services: FP

Shira LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP.

The respondents indicated that the things that happen different are positive changes in the health system. And all of the respondents said that they and their communities benefitted from the TSHIP program. In the course of the discussion, the respondents indicated the following benefits they and their communities received from TSHIP:-

1. Activation of WDCs which facilitated many achievements in the health sector of the LGA.
2. The respondents said TSHIP has enlightened and sensitized the communities on appreciating the importance of patronizing health facilities. According to them, such enlightenment and sensitization has increased the community's utilization of Health Care Services.
3. TSHIP provided them with drugs in their Health Facilities and to the CDI+ volunteers. Such drugs include Chlorhexidine, Misoprostol, and contraceptives. Also they are taught how to make Sugar Salt Solution for the management of diarrhea.
4. Renovation of many health facilities. The respondents cited provision of water, electricity and basic drugs as some of the benefits they have in their health facilities.
5. Capacity building of WDC members and some health personnel.
6. Introduction of Monthly meeting where WDCs and Health Care Providers meet and discuss the community's health problems and seek solutions to the problems.
7. Immunization became acceptable and many children were vaccinated. According to them, parents now take their children to the Health Facilities for immunization.
8. They also indicated that now they use MIS forms for records of interventions they conducted. Such records are reported to the M&E officer in the LG secretariat.
9. They said there are now remarkable increase in Health care services utilization, and a decrease in Maternal and Children mortalities and morbidities.

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. All the respondents indicated that they were trained. The trainings were on leadership managements, advocacy, sanitation, and family planning.

The respondents indicated that the training helps them to improve in working as follows:

1. That they are now more united and meet to solve their problems
2. They use the knowledge acquired during the training to inform and sensitize their community members
3. After the training, they developed a work plan for developments in their various wards.
4. They now contribute money from which they buy drugs for the Health Facilities and the CDI+ volunteers. They also assist the poor members of the community to access Health Care Services.
5. Participating better in their community mobilization, sensitization and advocacy.

Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many positive changes.

They indicated that the following are the things they now do differently and have seen changes

1. Their attitude and perception to environmental sanitation and hygiene has changed. Now they maintain clean environment and observe good hygiene.
2. Now they ensure that their Health Facilities are clean, drugs available, and monitor the activities of the Health Care Providers

3. Female members of the WDCs enter Houses and sensitize women to patronize Health Facilities and to maintain clean environment.
4. The WDCs now assist the Health Facilities in infrastructural repairs such as repairs of roofing when wind blew it up, repairs of seats and toilets.
5. That they now get more collaboration and support from the traditional rulers.
6. That they now disseminate health messages to the grassroots and the hard-to reach communities.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited many examples of areas of collaboration between the community/group and the health Facilities which can be group into:

- a) Regular visits to the Health Facilities by the WDC officials to see and know what are happening so that they can assist. These visits improve the quality of services in the Health Care Facilities. They also buy drugs and give the Health Facilities, thus minimizing the 'out-of-stalk' syndrome.
- b) Increasing utilization of MNCH/FP/RH services. This is done by providing financial assistance to families that cannot afford buying their drugs or operation fees, accompanying the sick woman to the Health Facility to ease logistic issues, and helping to make the Health Facilities more clients friendly.
- c) Increasing community awareness. These are done through organizing public lectures and a Health Facility staff is invited to give lectures, and through distribution of IEC materials.

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in TSHIP project.

They gave examples of how the Health Facilities benefitted from their contributions as:

1. They gave various instances where they contributed in maintaining or providing infrastructure in many Health centers. They said WDCs repaired toilets at Beli Dispensary, repaired access road in Disina, dug drainage to prevent flooding in Gagidiba ward, repaired clinic roof in Dango ward, and repaired Generator at Faggo A ward.
2. The WDCs contributed in community enlightenment and sensitization; which increase community patronage. This according to them is manifested in the increased turn-out of women attending ANC clinics, Facility deliveries, Family Planning, and immunization.

Q6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

A6. They indicated that there is no another community organization that they are collaborating with.

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. The respondents indicated that they lobby for resources from the LGA by initially conducting advocacy visit to the District Head; who assist them in intimating the local government officials. Then they go to the Chairman with their request. That was how they succeeded in the repairs of Disina Health Center.

But if that fail, they go through the other key stakeholders such as the Philanthropists within the communities. Sometimes they tax themselves to get money for their projects.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that occasionally, they make contribution to buy some basic drugs. And they also

executed some projects through direct labour Examples are mentioned in question 5(2).

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are more supportive to their wives in utilizing the Health Facilities. They gave many examples of Husbands accompanying their spouses to the hospital when the wives are sick or attending ANC clinics.

Husbands now allow immunization workers to enter their houses and administer the vaccines without the usual resistance.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. The participation of women in their group has increased considerably. The respondents indicated the establishment of WDC women's wing as a manifestation of the increase. Also, the integration of CDI+ Volunteers into the WDC has increased the number of WDC membership.

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LGA counsel to:

- a) Continue to train and re-train them on issues of advocacy and community mobilization.
- b) The LG to sponsor and ensure the WDC's monthly meetings continue uninterrupted. To also continue the pay of N2, 000:00 to the WDC members; which are paid by TSHIP after each monthly meeting. This, according to the respondents, will encourage them to do more.
- c) The LG to maintain the present TSHIP activities and infrastructures put in place within the LGA.

Tafawa Balewa LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP.

The respondents indicated that the things that happen different are positive changes in the health system. And all of the respondents said that they and their communities benefitted from the TSHIP program. In the course of the discussion, the respondents indicated the following benefits they and their communities received from TSHIP:-

1. TSHIP provided them with drugs in their Health Facilities and to the CDI+ volunteers. Such drugs include Chlorhexidine, Misoprostol, and contraceptives. Also they are taught how to make Sugar Salt Solution for the management of diarrhea.
2. Capacity building of WDC members and some health personnel. WDC members were trained on Advocacy, community mobilization, and self dependence among other things.
3. The respondents said TSHIP has enlightened and sensitized the communities through religious and traditional leaders. According to them, such enlightenment and sensitization has increased the community's utilization of Health Care Services. The CDI+ members also conduct house-to-house enlightenments.
4. Renovation of many health facilities and providing the Facilities with drugs and equipments.
5. Training of CDI+ members provide opportunities for women to be assisted in their houses. They conduct some deliveries using clean delivery kits, prevent bleeding after deliveries, manage umbilical cords of the newborn babies, and improve sanitation. Also materials for the CDI+ members were supplied by TSHIP.
6. Introduction of environmental sanitation and hygiene, which enhances well being and reduces ill-health.
7. Reactivation of WDCs and the creation of Emergency Transport System (ETS) and the DRF.
8. Introduction of Monthly meeting where WDCs and Health Care Providers meet and discuss the community's health problems and seek solutions to the problems.
9. They said there is now remarkable increase in Health care services utilization and a decrease in Maternal and Children mortalities and morbidities

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. All the respondents indicated that they were trained. The trainings were on leadership, advocacy, sanitation, and family planning.

The respondents indicated that the training helps them to improve in working as follows:

1. Because of the capacity building they received from TSHIP, they conduct advocacy visits to key stakeholders from time to time.
2. That they did step-down training to other WDC members and some people in their wards. This, according to them, created awareness and shared the knowledge acquired during the training.
3. That the WDCs now keep their environment clean and people maintain their personal hygiene.
4. They created Village Development Committees (VDC) in many Villages, who are trained by the WDCs.
5. They meet monthly to discuss their health issues, and they created Quality Improvement Team (QIT); who review meetings and monitor activities in Health Facilities
6. Create awareness on MNCH/FP in their communities
7. The CDI+ members now use drugs such as Misoprostol, Chlorhexidine and ORS in their work.

Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many positive changes.

They indicated that the following are the things they now do differently and have seen changes

1. The WDCs now assist the Health Facilities in infrastructural repairs such as repairs of roofing when wind blew it up, repairs of seats and toilets.
2. Self-esteem; that they now contribute and solve their problems without the contribution of the LG.
3. Creating awareness in the communities leading to increase services utilization.
4. The CDI+ volunteers now enter houses for community enlightenments on Health issues such as family planning, immunization, and danger signs of pregnancy.
5. The WDCs have more collaboration with the Health Care Providers and the traditional leaders. WDCs contribute in environmental sanitation and hygiene. Now they ensure that their Health Facilities are clean, drugs available and monitor the activities of the Health Care Providers.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited many examples of areas of collaboration between the community/group and the health Facilities which can be group into:

- a) Increasing utilization of MNCH/FP/RH services. This is done by creating awareness in their communities, providing means of transportation to Health facilities, financial assistance to families that cannot afford buying their drugs or operation fees, and accompanying the sick women to the Health Facility to ease logistic issues.
- b) Increasing community awareness. These are done through organizing public lectures and a Health Facility staff is invited to give lectures, information sharing, and through distribution of IEC materials.
- c) Regular visits to the Health Facilities by the WDC officials to see and know what are happening so that they can assist. These visits improve the quality of services in the Health Care Facilities. They also have DRF, thus minimizing the 'out-of-stalk' syndrome

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in TSHIP project.

They gave examples of how the Health Facilities benefited from their contributions as:

1. The WDCs contributed in community enlightenment and sensitization; which increase community patronage of Services. They also settle any misunderstanding between the Health Care Providers and the patients or patients' relatives. They also enlighten and encourage women and their husbands to avail themselves for Health care services, especially ANC, Delivery and Family Planning services. This, according to them, is manifested in the increased turn-out of women attending ANC clinic, Facility deliveries, Family planning, and immunization services.
2. They gave various instances where they contributed in maintaining or providing infrastructure in many Health centers. They said WDCs built toilets and repaired Roof at Kardam Dispensary, repaired access road to Lere MCH, also Gital Dispensary was connect to the National Grid by WDCs.

Q6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

A6. They indicated that they collaborate with NURTW and 'Achaba Union' in transporting patients. Other NGOs that they collaborate with in development activities that improve MNCH include Women Initiatives and Empowerment of Nigeria (WIEN), Tafawa Balewa Youth development Association and religious organizations

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. The respondents indicated that they lobby for resources from the LGA by initially conducting advocacy visit to the District Head; who assist them in intimating the Local Government officials. Then they go to the Chairman with their request. Through that five (5) Ambulances were bought and distributed in the LGA. Also when there was outbreak of diarrhea and vomited, the WDCs through the PHC coordinator, chemicals were bought and distributed

to the WDCs for decontamination of their Wells.

But if that fails, they go through the other key stakeholders such as the Philanthropists within the communities.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that they change the batteries and service their Ambulances, and construct Toilets at the Lere Clinic. The CDI+ members transport themselves to houses and occasionally outside their wards to provide services. And they also execute some projects through direct labour Examples are mentioned in question 5(2).

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are more supportive to their wives in utilizing the Health Facilities. They gave many examples of Husbands accompanying their spouses to the hospital when the wives are sick or attending ANC clinics.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. The participation of women in their group has increased considerably. The respondents indicated the establishment of WDC women's leader as a manifestation of the increase. Also, the integration of CDI+ Volunteers into the WDC has increased the number of WDC membership. They indicated that women constitute about one third (1/3) of their meetings' attendance.

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LGA counsel to:

- a) That they want to see the LG officials participating in all the WDC meetings and other activities.
- b) The LG to sponsor and ensure the WDC's monthly meetings continue uninterrupted. To also continue the pay of N2, 000:00 to the WDC members; which are paid by TSHIP after each monthly meeting.
- c) The LG to maintain the present TSHIP activities and infrastructures put in place in the LGA.
- d) Employ or at least continue with the financial assistance given to the CDI+ Volunteers. And their drugs and other working materials are provided by the LG on a regular basis.

Warji LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

Yes (all participants)

TSHIP reactivated the WDCs and formed the community health volunteers, who sensitize the community. Women in labor used to be carried on a cart, bleeding until they reach the hospital. Now that doesn't happen anymore, "you only hear about the naming ceremony but not complications during delivery (due to the use of misoprostol and chlorohexidine)."

Before TSHIP came, most women deliver at home, but with the involvement of traditional and religious leaders, as well as the community health volunteers the community has been sensitized.

2. Has your group been trained by TSHIP? How do you use this training?

Yes (all participants)

We were trained on community action cycle, FP and exclusive breastfeeding. "I use to tell mothers that I'm a living witness, I exclusively breastfed my baby, now he is fifteen and very brilliant."

The awareness on using LLINs has reduced malaria incidence; we educated the community on how to use the LLINs the first time in order to avoid allergies.

We were provided with pictorial counseling cards, which aid the work of the community health volunteers.

We have been trained on environmental sanitation and personal hygiene, which reduced diarrhea cases.

3. Did the use of this training change anything? What do you do differently?

(See 2 above)

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

Previously our only business with the HFs is to access health care services, now the health workers invite us to their meetings to discuss and solve public health concerns.

We jointly discuss problems facing the HFs; we mobilize resources, and reach out to traditional and religious leaders.

5. How do you think the health facility benefit from your contributions? Please give examples.

We constructed Wuha dispensary with 50% counterpart funding from LEEMP (before TSHIP); constructed burn/bury incineration pit; repaired ceilings; and provided benches for the hospital waiting area.

It is through the WDC the government knows the problems facing the HFs; patients referred by WDC get more attention

We constructed burn/bury incineration pit; we conduct minor repairs (the health workers task themselves to raise funds)

We clean the general hospital; we provided furniture to our dispensary

We constructed a local canopy at the waiting area of the town maternity; we conduct minor repairs

We provided electricity (we bought 8 poles); we installed the solar power provided by a donor organization

6. Does your committee or group collaborate with other community organizations to support local

MNCH/FP/RH activities?

We work with LEEMP (closed out); WASH; Association of local barbers; TBAs; herbalist; union of road transport workers, and motorcyclists association

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

We spent over N100,000 to repair a borehole but couldn't fix it, we reached the LGA but was not successful

We lobbied the LGA on the purchase of tires for our ambulance, but was not granted

We lobbied the LGA to repair the roofing of the maternity hospital but the repairs was not satisfactory

We lobbied the LGA to repair our dilapidated maternity hospital, but no action was taken

The LGA provided additional 10 beds to our hospital

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

Sometimes some husbands attempt to hear our conversation with their wives, especially on FP, when they realize it is something important, they give-in.

We revisit houses to educate/enlighten them on the importance of ANC

The male volunteers enlighten men at gatherings, which led to positive change

10. Has the participation of women increased in your group? What's the evidence?

We have women in all our WDCs: 1/7; 2/13; 4/13; 3/9; 4/13; 3/15; 1/17

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

LGA should:

Continue to provide misoprostol

Provide enough vaccines and in good time

Ensure regular supportive supervision to the HFs

Provide ANC drugs

Sustain the community volunteers' activities

(TSHIP should recognize the efforts of the WDC by giving them certificate of appreciation)

Other:

Most utilized services: ANC; immunization; malaria treatment

Less utilized services: FP; exclusive breastfeeding

Sokoto state

Bodinga LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

Yes (all participants)

The introduction of misoprostol and chlorohexidine has reduced maternal and infant mortality; provision of vaccines reduced childhood illnesses; TSHIP brought ANC services to our doorstep (especially in rural areas) with the help of the community-based health volunteers (CBHVs).

Previously mothers wanted to use modern FP methods but had no knowledge about them, but now many of them are aware of the methods and are using them; they have also been educated on the importance of environmental sanitation and personal hygiene.

2. Has your group been trained by TSHIP? How do you use this training?

Yes (all participants)

We have been trained on community action cycle, advocacy, work plan development, maternal and child health, and on creating the 100 women group.

TSHIP reactivated WDCs, trained them on advocacy (to be objective persistent, and document progress) now we develop 3, 6 and even 12 months work plan on immunization, environmental sanitation.

We conduct birth registration (issued by the National Population Commission) in collaboration with the CBHVs and TBAs, and death registration in collaboration with ward heads.

We now document house-to-house mobilization records; five drug keepers per ward were trained by TSHIP who work with CBHVs to keep and issue misoprostol and chlorohexidine.

3. Did the use of this training change anything? What do you do differently?

Previously 95% of women deliver at home and do not attend ANC. Now mothers expecting babies have to book for the misoprostol ahead of delivery; chlorohexidine saves the lives of dozens of newborns.

Immunization coverage used to be poor, now it has increased tremendously; we now keep proper records "we are like a government ministry, TSHIP is like just another government, they trained us more than what the government taught us."

TSHIP also provided Mama kit.

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

Previously our relationship with the service providers wasn't good, but now they involve us in monitoring the supply/distribution of drugs. In the WDC composition, TSHIP instituted that service providers (health facilities in-charge) should be the secretaries of the committee.

5. How do you think the health facility benefit from your contributions? Please give examples.

We undertook the repairs of a HF's roofing, clean hospitals environment, supplied pipe borne water, connect a HF with electricity, maintain the water well at Takatuku, fuel and maintain the hospital ambulance provided by the state government.

We constructed drainage at our HF, constructed burn/bury for medical wastes; repaired roofing, and keep the hospital environment clean.

We constructed toilet blocks at the dispensary, and repaired the water borehole twice.

We maintain the solar-powered borehole provided by TSHIP with huge amount of money.

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

We work jointly with the association of the disabled to mobilize other community members by sharing the story of the disabled in convincing the community to allow their children for polio immunization.

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

LGA has never responded to our pleas for financial assistance.

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

When we see danger signs in mothers, we try to find out the details and subsequently reach their husbands in order to convince the husbands.

Previously many babies died due to poor newborn care, but this has improved with the use of chlorohexidine.

We have been trained on how to talk to non-compliant husbands, now they allow their children to be immunized.

"I met a woman in labor, her mother in-law refused to take her to the hospital, I informed the settlement head to intervene."

"We tell husbands if you wife is ill, you don't have a wife."

FP acceptance has creased.

Uniformed TBAs (CBHVs) are more accepted by the community than their counterparts.

10. Has the participation of women increased in your group? What's the evidence?

The 100 women group (managed by the Life Helpers, a TSHIP sub-grantee) has empowered women through vocational skills training; CBHVs are members; they have been linked with suppliers of law materials, and has been able to access loan from financial institutions.

We have 35 out of 155 women in our group; 45/140; 25/90; 35/150; 56/145

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

First and foremost depoliticize the LGA operations

Sustain CBHVs, drug keepers, and give allowance to issuers of birth certificates

Sponsor the revisit team for house-to-house immunization

Other:

Most utilized services: Immunization; ANC; use of LLINs

Less utilized services: Hospital delivery; FP

Dange Shuni LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

Yes (all participants)

"The capacity building we had from TSHIP, made us feel like 'government,' we command respect in our communities." We provided water to some of our HFs, we don't wait for government on problems we can solve (we undertook some works worth N200,000); we maintain the hospital ambulance.

We have seen reduced maternal and child mortality that were caused by malaria and diarrhea, due to sensitization of the community on malaria prevention and preparation of ORT. We hired a driver who conveys mothers on labor to the hospital.

2. Has your group been trained by TSHIP? How do you use this training?

Yes (all participants)

"Our initiative of hiring a driver was presented to the state government, which subsequently made the government provide ambulances to all LGs in the state [WDC Tuntube Tsefe]."

3. Did the use of this training change anything? What do you do differently?

We have established the drugs revolving fund; monitor hospitals' performance; and pay advocacy to the LG.

Parents now hold teachers accountable for the performance of their children at school. Some community men reported service provider to the LGA for not going to work at his designated health facility.

We constructed a borehole in order to prevent cholera disease; we sensitized people to desist from open defecation.

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

"We now hold our service providers accountable; we are regarded by our community like health workers."

Previously service providers did as they wished (hospitals were dirty, there was no privacy) but now things have changed for good. WDC members are now aware of supplies of drugs to the hospital.

5. How do you think the health facility benefit from your contributions? Please give examples.

We generate revenue/levies to conduct minor repairs of our HFs; we participate in immunization campaigns, we resolve non-compliance cases.

We hold monthly meetings with the service providers to discuss issues; we constructed a medical records unit, and we fuel the generator.

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

We work with the local barbers' association; herbalists; local orthopedic doctors (we enlighten them on hygiene and also on subsidizing their fees for services).

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

We repaired the borehole of one of our HFs three times (amounting to N100,000) we approached the LGA and was

finally repaired.

We advocated to the LGA and secure an electricity transformer; secure a scanning machine from the Usman Dan Fodio University teaching hospital.

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

Now husbands realize the importance of ANC (it used to be a taboo to allow their wives to attend).

We were trained by Pathfinder International on peer-educating men, we have seen increase in ANC attendance (especially where we have female service providers); we serve as role models to other husbands by taking our wives and children to the hospital.

10. Has the participation of women increased in your group? What's the evidence?

We have four sub-committees in the WDCs each with women representation.

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

The LGA should sustain the WDCs in community mobilization as TSHIP and LEAD did, we have seen tremendous improvement.

The LGA should sustain and increase the allowance given to the CBHVs

Involve WDCs in the supply chain process of medical supplies, as well as projects (constructions) monitoring.

The LGA should sustain the provision of misoprostol and chlorhexidine (LGA should learn from TSHIP how this is done).

Other:

Most utilized services: ANC; immunization; use of LLINs

Less utilized services: Hospital delivery; FP

Gwadabawa LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP.

The respondents indicated that the things that happen different are positive changes in the health system of their communities. And all of the respondents agreed that they and their communities benefitted from the TSHIP program in many ways. In the course of the discussion, the respondents mentioned the following benefits:-

1. Renovation of many health facilities. The respondents cited provision of water, electricity and basic drugs as some of the benefits they have in their health facilities
2. Creating unity among the people of the communities. The activation of the WDCs helps the communities to work for a common purpose. They now meet and make financial contributions to solve their problems.
3. TSHIP community sensitization has created awareness among men, such that men are now more responsive to their wives' and children's health. Some accompany their wives to the hospital now unlike before the TSHIP project.
4. More drugs are available in Health Facilities courtesy of TSHIP program. These drugs, according to the respondents include; anti-malarial (ACT), Misoprostol, Chlorhexidine, and family planning commodities. But they said they are not aware of Vitamin A supply.

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. Eight (8) out of the 16 respondents 5 male and 3 female respondents indicated that they were trained. The training was on leadership managements, awareness creation, and advocacy. In addition, the female respondents also said they were trained on sanitation, and care of the umbilical cord of newborn babies

The respondents indicated that training help them to improve in their activities in their communities as follows:

1. Creating awareness for increased utilization of Health Facilities.
2. Advocacy for repairs of some Health Facilities in their LG. E.g. repairs of Toilets
3. The CBHVs said they use the knowledge acquired in assisting women in labour and the newborn babies in preventing infections. They also assist in maintaining good hygiene in the Houses.

Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many changes.

They indicated that the following are the things they now do differently and have seen changes

1. Their advocacy strategy is now different. They pass through the Ward Counselors to channel their complaints to the LG Chairman. But in some occasions they go through the District Head.
2. Now they coordinate their activities much better. For example, if some drugs are exhausted in one ward, WDCs contribute money to buy the drugs.
3. The Chairman and deputy Chairman of the WDCs responded by indicating their assistance in monitoring the Health Facilities and when something get wrong, they seek for solution. For example if the environment is dirty, they mobilize youth to clean the premises, or the staff are not reporting to work they advise the staff.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited few examples of areas of collaboration between the community/group and the health Facilities which can be group into:

1. Increasing community awareness. These are done through organizing public lectures or dialogue and Health Facility staff is invited to give lectures or to moderate dialogue

2. Increasing utilization of MNCH/FP/RH services. This is achieved by making the use of Ambulance in the transporting the sick patient or laboring woman, accompanying the sick woman to the Health Facility to ease logistic issues.

3. Also they collect drugs from the Health Facilities for the use of the CBHVs.

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in TSHIP project.

They gave examples of how the Health Facilities benefitted from their contributions as:

1. The WDC's contributed in community enlightenment and sensitization; which increase community patronage to Health Facilities. This according to them is manifested in the increase turn-out of women attending ANC clinic, Facility deliveries, Family planning acceptance, and immunization

2. The WDC's sensitization encouraged husbands to not only support their wives, but also accompany the women to the hospital for ANC and FP.

3. Voluntary work in the Health Facilities further assisted in keeping the Hospital premises clean and repairing access roads to some Health Facilities.

4. Their advocacy activities to the LG Chairman led to the repair of Toilets in Digane Dispensary.

Q6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

A6. They indicated that they work with NURTW and the CBHVs; who are also members of the WDC.

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. Their advocacy strategy is now different. They pass through the Ward Counselors to channel their complaints to the LG Chairman. But in some occasions they go through the District Head. The example they cited was that of Digane Dispensary Toilet repairs. When these key stakeholders fail, the respondents said they have no solution to that problem.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that occasionally, they make contribution to buy some basic drugs.

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are more supportive to their wives in utilizing the Health Facilities.

But two issues came up during answering this question. That even though the husbands permit their wives to go to the Health Facilities, some women refuse to utilize Health Centers because of shyness, and that some women still don't like male to attend to them in the Health facilities. They gave examples of women who said they better die than be examined by a male Health Care Provider.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. There was disagreement among the WDCs on this issue. Some are with the opinion that women are not involved in WDC activities in their wards while others said they have women in WDC's activities in their Wards, however, the later fail to provide evidence of female involvement beside the CBHVs.

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LGA counsel to: -

- a) Continue the pay of N2,000:00 to the WDC members; which are paid by TSHIP after each monthly meeting. This according to the respondents will encourage them to do more.
- b) A female respondent recommended the employment of more CBHVs and the LG to also take the responsibility of paying the monthly N2,000:00.
- c) The LG to maintain the present TSHIP activities and infrastructures put in place in many Wards.
- d) Some WDCs requested the LGC to provide their Health Facilities with Midwives. E.g. Digane Dispensary.

Kware LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

Yes (all participants)

TSHIP reactivated the WDCs to sensitize women to go for ANC. It also trained service providers on malaria treatment, FP, ORT (this encouraged the service providers).

ANC attendance was about 30% but now it is about 70%; the use of referral forms boosted immunization coverage; there has been reduced maternal mortality due to the use of misoprostol, "a woman who had 8 children said she felt significant difference the first time she used the misoprostol."

TSHIP has provided registers to all HFs for recording data.

2. Has your group been trained by TSHIP? How do you use this training?

Yes (all participants)

We have been trained on FP, ANC and on how to administer the misoprostol.

We now know we have to delay bathing a newborn baby until after 12 hours of applying chlorohexidine.

We were trained on how to prepare ORT and we also trained mothers, they can now identify anemia and danger signs during pregnancy; CBHVs educate mothers on the importance of exclusive breastfeeding, and family planning.

3. Did the use of this training change anything? What do you do differently?

(See 2 above)

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

"We now know our rights, we monitor service delivery, although some of the service providers see us as policing them."

5. How do you think the health facility benefit from your contributions? Please give examples.

We sensitize the community; we conduct minor repairs of our HFs; we provide portable water.

We mobilize resources including levies from members (N200 fortnightly) "we hired a female health worker to provide outreach ANC, we pay her N2,000" we procured hand globes; we trained non-TSHIP TBAs and provided them with hand globes "a TBA confessed to have never used a hand globe in conducting delivery for 20 years until this time around."

We repaired the roofing of the staff accommodation in one of our HFs; repaired the borehole (N40,000); repaired some portion of the electric wiring of one of our HFs.

We constructed a toilet block with the support of the LGA.

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

UNICEF also created volunteer community mobilizers; we also work with CDC

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

We advocated for more toilet blocks in one of our HFs, the LGA constructed them.

We complained about blown-off roof in one of our HFs, the LGA did not respond.

We lobbied for provision of electricity and water to one of our HFs, but we had to do it ourselves.

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

Husbands now realize their wives get better if they visit hospital, we educated them on the importance of FP.

Now husbands entrust us to take their wives to the hospital; mothers now improve personal hygiene (husbands are appreciative).

10. Has the participation of women increased in your group? What's the evidence?

We have 6 out of 10 women in our group; 7/27; 20/30; 15/35; 10/20

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

The LGA should sustain and increase the allowance given to the CBHVs

Other:

Most utilized services: ANC; immunization; use of LLINs

Less utilized services: Hospital delivery; FP

Rabah LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP.

The respondents indicated that the things that happen different are positive changes in the health system of their communities due to the TSHIP project. And all of the respondents said that they and their communities benefitted from the TSHIP program. In the course of the discussion, the respondents indicated the following benefits they and their communities received from TSHIP:-

1. Activities of the CBHV assist women in the communities. According to the respondents, pregnant and women in labor are assisted always by the CBHVs whenever the former are having complications. Even in the night, the CBHVs are call upon to attend to the women and their newborn babies.
2. TSHIP training of the WDCs – including the CBHVs help the WDCs/CBHV to perform community services much better with good outcome. The CBHVs cited the use of Misoprostol and Chlorhexidine as one of the best benefits to the communities and the practicing CBHVs.
3. TSHIP Hygiene training helps the communities to be cleaner and healthier. According to the respondents, they teach the households to be clean and eat balanced diet, and occasionally, the CBHVs assist some household by sweeping the house, and ensuring the family members wash their hands before eating.
4. TSHIP supply of drugs such as Chlorhexidine and Misoprostol; which help in reduction of newborn infections and bleeding in women during childbirth are another benefits. They also learnt to prepare ORT solution for diarrheal diseases and to tepid sponge babies before going to the Health Facilities in cases of Feverish conditions.
5. The respondents said TSHIP has enlightened the communities in appreciating the importance of patronizing Health Facilities. According to them, such enlightenment has increased the community utilization of antenatal, delivery and postnatal services. Also, more women and men avail themselves for HIV counseling and testing,
6. TSHIP community sensitization has created awareness among men, such that men are now more responsive to their wives' and children's health.
7. More drugs are available in Health Facilities courtesy of STHIP program. These drugs, according to the respondents include; anti-malarial (ACT), Misoprostol, Chlorhexidine, Folic acid, Fersolate, and family planning commodities.
8. The respondents also indicated that Maternal and Child Mortalities and Morbidities have reduced drastically in their communities as a result of the TSHIP project.
9. Provision of Ambulances help in transporting the sick to the Health Facilities especially women and children.

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. All the respondents said they were trained at one time or another and some said they were trained more than three times. The trainings were on leadership managements, advocacy, hygiene, community sensitization, and family planning. In addition, the female respondents also said they were trained on the use of essential drugs (Chlorhexidine, Misoprostol, Fersolate, Folic acid etc.).

The respondents indicated that the trainings help them to improve in working as follows:

1. Good leadership in their WDCs management and better interaction with their communities. They became more acceptable to the community members.
2. They use the knowledge in correct management of some ill-health conditions such as treatment of malaria, prevention of anemia in pregnancy, management of neonatal umbilical cord to prevent infection
3. Participating better in their community mobilization, sensitization and advocacy.
4. The trainings sensitized them to help their communities. For example, WDCs, as a group and sometimes individuals, voluntarily buy drugs and give to the CBHVs when that of TSHIP is not available.

Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many positive changes.

They indicated that the following are the things they now do differently and have seen positive changes

1. Awareness creation is what they now do regularly. Initially they do not do any community awareness activities but now they do community sensitization. These community sensitization activities have made their communities to accept Exclusive Breast Feeding (EBF) and Family Planning (FP).
2. Now WDC members provide financial assistance to buy drugs and also sometimes assist poor patients financially. CBHVs also encourage women to save money for the purpose of birth preparedness.
3. CBHVs, who are Traditional Birth Attendants (TBAs), now use Misoprostol for the prevention of bleeding during childbirth and Chlorhexidine for prevention of neonatal infection.
4. CBHVs prevent the use of cow dugs and other dirty materials for managing umbilical cords of newborn babies. Discourage the use of water to the newborn babies; but encourage the practice of Exclusive Breast Feeding.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited many examples of areas of collaboration between the WDCs/CBHVs and the Health Facilities which can be group into:

- a) Increasing utilization of MNCH/FP/RH services. This is achieved by making the use of Ambulance in transporting the sick patients or woman in labor, accompanying the sick woman to the Health Facility to ease logistic issues, and attaching 10 Community-Based Health Volunteers (CBHV) in each Ward to Health Facilities in the Ward. This relationship between the CBHVs and the HF encourage the CBHVs, improve their community mobilization and ease logistics and hence increase utilization of the services.
- b) Increasing community awareness. These are done through organizing public lectures or dialogue and a Health Facility staff is invited to give lectures or to moderate dialogue. The monthly meetings of the WDCs include Health Facility staffs, and that provide an avenue for discussing health issues of the communities and together developing strategies for handling such issues. To get community confidence and acceptance, Muslim Scholars are included in WDCs. This made the Scholars to preach on Maternal and Child Health during their sermons on Fridays.

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in the TSHIP project.

They gave examples of how the Health Facilities benefited from their contributions as:

1. The WDCs contributed in community enlightenment and sensitization; which increase community patronage to Health Facilities. And the CBHVs sensitize women in their houses to also utilize the Health Facilities. These according to them are manifested in the increased turn-out of women attending ANC clinic, Facility deliveries, Family Planning acceptance, and immunization
2. The WDC's sensitization encouraged husbands to not only support their wives, but also accompany the women to the hospital for ANC and FP.
3. The collaboration between the WDCs and the Health Care Providers provided mutual understanding and cooperation between the two to the advantage of the Health Facilities. This is because the more the community members understand that the Health Care Providers are friendly, the more the patronage.

Q6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

A6. They indicated that their group collaborates with members of NURTW in getting transport for the patients, but with the presence of Ambulances now, this activity is much reduced. Also they cited other local CBOs that they

collaborate with – including GANZAK and RADDA (Rabah Area Development Association); 2 local CBOs addressing different developmental issues in the Local Government Area.

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. The WDC's members said after discussing a problem and determining their needs, they meet the Chairman of the LG council and put their complaint directly. And in most cases it is done. Few examples they gave were the construction of drainage in Tursa town and the purchase of Generator for Rare town Borehole. But if direct consultation fails, they meet the rich indigenes of the local government area and make their complaint and it can be done. But in either case, they always start some significant efforts of solving the problem before contacting the Chairman or any Philanthropist.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that occasionally, they make contributions to buy some basic drugs. They pointed out that there was a time when TSHIP did not bring drugs and those at stock had been exhausted. So, they taxed their members and the money collected was used to buy drugs (however, they could not recollect the precise time). Also some female members said on several occasions they personally paid poor patient's bills in their Health Facility.

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are now more supportive to their wives in utilizing the Health Facilities. They indicated two main reasons for the male involvement. First is the awareness created by TSHIP using IEC materials, outreach sensitization lectures and rallies. And secondly, more female Health Care Providers (CHEW) are employed and posted to the Health Facilities. These gave the husbands confidence and trust, thus allowing their wives and even accompanying them to the Health Facilities.

They also said the husbands are now more accepting immunization and use of drugs (e.g. Misoprostol) to their wives.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. Most of the respondents said the participation of women in their group has increased considerably. Beside the CBHVs, who are members of WDCs, other women also join the WDC's meetings and activities. They indicated that the position of treasurer of WDC is reserved for the female members.

Through the UNICEF project, Voluntary Community Mobilizers (VCM), who are all female members, more female community members are involved in their activities.

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LGA counsel to:

a) Continue to train and re-train them on issues of advocacy and community mobilization.

b) All the respondents recommended the employment of more CBHVs and the LG to take the responsibility of paying the monthly N2, 000:00, and providing them with drugs. They also indicated the need for re-training of these CBHVs on a regular basis.

The LG to maintain the present TSHIP activities and infrastructures put in place in many Wards.

Sokoto North LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

Yes (all participants)

There has been more acceptance of polio vaccine; ANC visit has increased due to community mobilization; we now conduct environmental sanitation; we promote exclusive breastfeeding.

Community-based health volunteers (CBHVs) go house-to-house to counsel mothers on the importance of accessing health care services (TSHIP supports CBHVs with N2,000 monthly transportation stipend).

TSHIP renovated some of our health facilities, provided equipments, trained us on interpersonal communication and on using misoprostol, which led to more attendance of ANC.

"There used to be frequent cases of post-partum hemorrhage before TSHIP, but now with misoprostol available with the 'drug-keepers' at the community, maternal mortality has reduced."

"Involvement of CBHVs has made TSHIP outstanding among other health projects/interventions. Some mothers give their children to the CBHVs to take them for immunization."

2. Has your group been trained by TSHIP? How do you use this training?

Yes (all participants)

"We became aware of our rights to monitor/supervise the service providers."

3. Did the use of this training change anything? What do you do differently?

"With the community action cycle training, we can now identify, prioritize, and solve local problems with local solutions."

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

"Our relationship with HFs has become more cordial, we used to see ourselves as rivals, but with trainings from TSHIP, we now know our roles and responsibilities."

5. How do you think the health facility benefit from your contributions? Please give examples.

We supplied BP apparatus to one of our HFs, we usually sponsor abandoned children for health care, we constructed incineration pit, and we provided portable water (which was even extended to the community [Magajin Gari 'A' WDC].

We provided chairs, constructed a laboratory, and provided a drug revolving fund [Sarkin Ari WDC].

"When I came to the hospital, there was no single drug, the WDC chairman provided N10,000 to buy drugs and sell at affordable prices [health facility in-charge Sarkin Ari ward].

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

We work with youth development associations, and the road transport workers' union.

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

We handle almost everything ourselves, sometimes we organize fund-raising events (the LGA has not been

supportive.

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

"Initially husbands drive us away, but now they welcome us [CBHV]."

ANC visit has increased tremendously as a result of sensitizing husbands.

10. Has the participation of women increased in your group? What's the evidence?

Some of our members are also traditional birth attendants; the structure of the WDC requires involvement of women.

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

We need expansion of some of HFs

The LGA should sustain and increase the allowance given to the CBHVs (currently N2,000)

The LGA should increase the allowance given to the community midwives

Other:

Most utilized services: ANC; immunization; malaria treatment; use of LLINs

Less utilized services: Hospital delivery; FP

Sokoto South LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP, and some went to the extent of saying TSHIP is an organization that came to Sokoto to improve maternal and child health.

The respondents indicated that the things that happen different are positive changes in the health system and girl-child education in all the communities that TSHIP is working in the LGA. And all of the respondents said that they and their communities benefitted from the TSHIP program. In the course of the discussion, the respondents indicated the following benefits they and their communities received from TSHIP:-

1. Activation of WDCs which facilitated many achievements in the health sector of the Sokoto state.
2. Renovation of many health facilities. The respondents cited provision of water, electricity and basic drugs as some of the benefits they have in their health facilities.
3. Integration of Vitamin A and immunization of children as one of the great innovation of TSHIP in Sokoto. The respondent indicated that when they reach a household, they first introduce and administer Vitamin A and at the same time give the immunization. This practice was said to be acceptable to the communities
4. Introduction of the use of Chlorhexidine and Misoprostol; which help in reduction of newborn infections and bleeding in women during childbirth. One of the female respondents said "I cannot remember when last I heard of a woman bleeding after childbirth after the introduction of Misoprostol".
5. Capacity building of WDC members and some health personnel.
6. The respondents said TSHIP has enlightened the communities in appreciating the importance of patronizing health facilities. According to them, such enlightenment has increased the community utilization of antenatal, delivery and postnatal services. Also, more women and men avail themselves for HIV counseling and testing,
7. TSHIP collaboration with local governments resulted in purchase of Ambulances; which are given to the WDCs for fueling and maintenances.
8. TSHIP community sensitization has created awareness among men, such that men are now more responsive to their wives' and children's health.
9. More drugs are available in health facilities courtesy of STHIP program. These drugs, according to the respondents include; anti-malarial (ACT), Misoprostol, Chlorhexidine, Folic acid, Fersolate, Vitamin A and family planning commodities.
10. TSHIP program also encourage Girl-Child education; as a result many girls are now enrolled into various schools.

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. Out of the 12 respondents 2 male and 2 female respondents indicated that they were trained. The trainings were on leadership managements, advocacy and family planning. In addition, the female respondents also said they were trained on use of essential drugs.

The respondents indicated that training help them to improve in working as follows:

1. Good leadership in their WDCs management and better interaction with their communities. They became more acceptable to the community members.
2. They use the knowledge in correct management of some ill-health conditions such as treatment of malaria, prevention of anemia in pregnancy, management of neonatal umbilical cord to prevent infection
3. Participating better in their community mobilization, sensitization and advocacy.

Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many changes.

They indicated that the following are the things they now do differently and have seen changes

1. Advocacy strategies are done differently. Now they pass through the District Head first then to the local government council and sometimes to the Ministry of Health or any other line Ministries.
2. Now they coordinate their activities much better. For example, if some drugs are exhausted in one ward WDCs facilitate receiving the said drug from another ward and give to the wards that lack the drug. A typical example of drug having such problem is Misoprostol. Another example is the maintenance and control of the Ambulance.
3. They now photocopy MIS forms to keep records of their activities. These forms are consistently filled and submitted to the M&E officer of the local government.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited many examples of areas of collaboration between the community/group and the health Facilities which can be group into:

a) Increasing utilization of MNCH/FP/RH services. This is achieved by making the use of Ambulance in the transporting the sick patient or laboring woman, accompanying the sick woman to the Health Facility to ease logistic issues, and attaching 10 Community-Based Health Volunteers (CBHV) to one Health Provider (HP). This relationship between the CBHVs and the HP gives more guides to the CBHV, improve their community mobilization and ease logistics and hence increase utilization of the services.

b) Increasing community awareness. This are done through organizing public lectures or dialogue and a Health Facility staff is invited to give lectures or to moderate dialogue.

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in TSHIP project.

They gave examples of how the Health Facilities benefitted from their contributions as:

1. The WDCs contributed in community enlightenment and sensitization; which increase community patronage. This according to them is manifested in the increased turn-out of women attending ANC clinic, Facility deliveries, Family planning acceptance, and immunization

2. The WDC's sensitization encouraged husbands to not only support their wives, but also accompany the women to the hospital for ANC and FP.

3. The collaboration between the WDCs and the Health Care Providers provided mutual understanding and cooperation between the two to the advantage of the Health Facilities. This is because the more the community members understand that the Health Care Providers are friendly, the more the patronage.

4. The respondents also included their fueling and maintenance of the Ambulance as one of the ways the hospital get more acceptances and therefore more patronage from the communities. That also relieved the Hospitals from fueling and maintaining the Ambulances.

Q6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

A6. They indicated that there is no another community organization that they are collaborating with.

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. The respondents indicated that they lobby for resources from the LGA by initially conducting advocacy visit to the District Head; who assist them in intimating the local government officials. Then they go to the Chairman with their request. Sometimes they go through the other key stakeholders such as the Philanthropists within the communities. It sometimes works well but occasionally fails. When it fails they tax themselves and get the finance

to execute their small projects.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that occasionally, they make contribution to buy some basic drugs. They pointed out that there was a time when TSHIP did not bring drugs and those at stock had been exhausted. So, they made taxed their members and the money collected was used to buy drugs (however, they could not recollect the precise time).

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are more supportive to their wives in utilizing the Health Facilities. They gave many examples of Husbands and even Islamic scholars accompanying their spouses to the hospital when the wives are sick or attending ANC clinics.

They also said the husbands are now more accepting immunization and use of drugs (e.g. Misoprostol) to their wives. Husbands now allow immunization workers to enter their houses and administer the vaccines without the usual resistance.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. The participation of women in their group has increased considerably. The respondents indicated the establishment of WDC women's wing as a manifestation of the increase. Also, the integration of Community Based Health Volunteers (CBHVs) into the WDC has increased the number of WDC membership.

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LGA counsel to:

- a) Continue to train and re-train them on issues of advocacy, community mobilization and record keeping.
- b) Continue the pay of N2,000:00 to the WDC members; which are paid by TSHIP after each monthly meeting. This, according to the respondents, will encourage them to do more.
- c) A female respondent recommended the employment of more CBHVs and the LG to take the responsibility of paying the monthly N2,000:00.
- d) The LG to maintain the present TSHIP activities and infrastructures put in place in many Wards.

They also want the LG to facilitate the integration of WDC members into the state 'social mobilization committee'

Wamakko LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP.

The respondents indicated that the things that happen different are positive changes in the health system of their communities due to the TSHIP project. And all of the respondents said that they and their communities benefitted from the TSHIP program.

In the course of the discussion, the respondents indicated the following benefits they and their communities received from the TSHIP project:-

1. TSHIP training of the WDCs members in various aspect of health and community enlightenment. And TSHIP pays each WDCs – including the CBHVs N2,000:00 monthly.
2. Provision of drugs to the Health Facilities and the CBHVs. These drugs include Misoprostol, Chlorhexidine, antimalarial (ACT and SP), and hematinics. Also, Insecticide Treated Net distributed for prevention of Mosquito bites and Malaria.
3. Pregnant and women in labor are assisted always by the CBHVs whenever the former are having complications. The CBHV also carry newborn babies to the Hospital for immunization.
4. That the TSHIP project has now united the community members. The Health Care Providers and the WDCs meet monthly to discuss their health issues and seek for solutions to the issues
5. TSHIP has enlightened the communities in appreciating the importance of patronizing Health Facilities and Environmental sanitation. According to them, such enlightenment has increased the community utilization of antenatal, delivery and postnatal services. Also, they pointed out that their communities are now neater than before.
6. TSHIP project has also made them to be responsive to their communities independent of Government. Now they contribute money or physically (manually) execute some projects in their communities without involving Government.
7. Renovation of Health facilities and supply of drugs in the Health Facilities courtesy of STHIP program. They gave example of Bini town Dispensary, where TSHIP built two-room block for laboratory and also send midwife to man the Dispensary.
8. The respondents also indicated that Maternal and Child Mortalities and Morbidities have reduced in their communities as a result of the TSHIP project.
9. TSHIP give them advice whenever they have problems.

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. All the respondents said they were trained at one time or another,

The respondents indicated that the trainings help them to improve in working as follows:

1. The WDCs and the CBHVs meet monthly to discuss Maternal Child and other Health issues.
2. They use the knowledge in correct management of some ill-health conditions such as treatment of malaria, management of neonatal umbilical cord to prevent infection, and the preparation and use of ORT solution.
3. Participating better in their community mobilization, sensitization and advocacy. This resulted in increased utilization of health services and clean environment. They indicated that before the TSHIP project, Wamakko town was full of human feces, but now you hardly see any person defecating outside toilets.
4. The trainings sensitized them to help their communities. For example, WDCs, as a group and sometimes individuals, voluntarily buy drugs and give to the CBHVs when that of TSHIP is not available. The Muslim scholars among them indicated that they preach during sermon, ceremonies and give religious verdict on issue pertaining to MNCH issues. They indicated that with their activities now many accept Family Planning, immunization and allow their wives to utilize Health Facilities.

Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many positive changes.

They indicated that the following are the things they now do differently and have seen positive changes

1. CBHVs, who are Traditional Birth Attendants (TBAs), now use Misoprostol for the prevention of bleeding during childbirth and Chlorhexidine for prevention of neonatal infection. The CHBVs take babies to the Health Care Facilities for immunization.
2. CBHVs prevent the use of cow dugs and other dirty materials for managing umbilical cords of newborn babies. Discourage the use of water to the newborn babies; but encourage the practice of Exclusive Breast Feeding. The CBHVs also said the use of baby's suckling breast help them to manage retained placenta instead of other bad traditional practices.
3. Awareness creation for increased utilization of Health Facilities and has made their environment cleaner.
4. WDC members give financial assistance to buy drugs and also sometimes assist poor patients financially.
5. WDCs and CBHVs now have better relationship with the Health Facilities. They work together for the benefit of their communities.
6. Meet regularly with traditional leaders; who supervise them and sometimes take critical decision on sensitive issues affecting the communities.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited many examples of areas of collaboration between the WDCs/CBHVs and the Health Facilities which can be group into:

- a) Increasing utilization of MNCH/FP/RH services. This is achieved by making the use of Ambulance in transporting the sick patients or woman in labor, accompanying the sick woman to the Health Facility to ease logistic, and awareness creation. CBHVs bringing babies to the Hospital for immunization.
- b) Increasing community awareness. These are done through organizing public lectures and a Health Facility staff is invited to give lectures. The monthly meetings of the WDCs include Health Facility staffs, and that provide an avenue for discussing health issues of the communities and together developing strategies for handling such issues.
- c) Better working relationship between the Health Care Providers and the WDCs, especially the CBHVs increase both utilization of services and creating awareness. Also it improves quality of services.

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in the TSHIP project.

They gave examples of how the Health Facilities benefited from their contributions as:

1. They sensitize the communities to avail themselves for health services in the Health facilities, they assist in providing transportation, and they even notify the Health Providers presence or outbreak of ill-health in the communities.
2. They help in providing infrastructure or make repairs in the Health facilities.
3. The WDC's sensitization encouraged husbands to not only support their wives, but also accompany the women to the hospital for ANC and FP.
4. They help keep the Health Facility environment clean and assist in repairing access road into the Health Facilities.

Q6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

A6. They indicated that their group collaborates with members of NURTW in getting transport for the patients when the Ambulances are not available. Also they cited other local CBOs that they collaborate but all have membership in WDC.

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. The WDC's members said after discussing a problem and determining the cost implication of the work, they meet the wards counselor, who take them to the LG Chairman through the Director PHC. That was how they got Kasarawa town PHC borehole repaired.

If that fails, they go to the rich people for support.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that occasionally, they make contributions to buy some basic drugs, especially the Misoprostol and ANC drugs (Hematinics).

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are now more supportive to their wives in utilizing the Health Facilities. According to them more husbands now accompany their wives to the Hospital than those who do not.

They also said the husbands are now more accepting immunization and use of drugs (e.g. Misoprostol) to their wives.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. Most of the respondents said the participation of women in their wards has increased considerably. Beside the CBHVs, who are members of WDCs other women also join the WDCs; they indicated that they even now have women wing with their officers, but also attend WDCs meetings beside theirs.

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LG counsel to:

a) Employ more CBHVs and the LG to take the responsibility of paying the monthly N2, 000:00, and providing them with drugs. They also indicated the need for re-training of these CBHVs on a regular basis.

The LG to maintain the present TSHIP activities and infrastructures put in place in many Wards. They indicated that at least Misoprostol and Chlorhexidine be supplied to the CBHVs on regular basis.

Wurno LGA:

1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples. (Prompt: how has community utilization of services changed and impact on community's general health (morbidity and mortality) especially in women and children under the age of 5 years)

Yes (all participants)

The involvement of community-based health volunteers in sensitizing mothers has increased ANC visits and hospital delivery. The routine immunization has been strengthened, including the tracking of defaulters.

TBAs have been trained to prepare ORT, and educate mothers on the importance of hospital delivery and recognition of complications during pregnancy.

There has been an increase in the provision and uptake of LLINs.

Mothers have been sensitized to improve their personal hygiene, to ensure their children do not play with dangerous items. They have also been educated on the importance of exclusive breastfeeding.

2. Has your group been trained by TSHIP? How do you use this training?

Yes (all participants)

We sensitize/educate husbands on the importance of their families' health.

3. Did the use of this training change anything? What do you do differently?

"Women now voluntarily go to hospital even without complication of pregnancy."

4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

"We have been linked to the service providers, we have cordial relationship with them. We keep proper records of our minutes of meeting as a result of TSHIP, we keep custody of the essential drugs."

5. How do you think the health facility benefit from your contributions? Please give examples.

We sensitized the community, which led to increased uptake of services.

We constructed a toilet block at Alcamo PHC.

6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

We work with the 100-women group, and the road transport workers' union.

7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

We repaired the roofing of one of our HFs with assistance from the LGA.

8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

(See Questions 5 above)

9. What has changed in the way husbands support their wives in utilizing health facilities?

The persistent house-to-house visit, reaching out to husbands now led to husbands accompanying their wives and wait for them to attend ANC (previously ANC visits were not more than 6 women per session, now we have more than 40).

10. Has the participation of women increased in your group? What's the evidence?

Women conduct house-to-house mobilization as well as during ceremonies.

(All the 4 WDCs in attendance had 1 woman in the committee expect one with 2 women).

11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

The LGA should sustain the allowance given to the CBHVs, and increase their number in order to reach more communities.

The LGA should sustain the provision of misoprostol and chlorhexidine

Other:

Most utilized services: ANC; immunization; malaria interventions

Less utilized services: Hospital delivery; FP

Yabo LGA:

Q1. Do you know the TSHIP? With the presence of TSHIP program in your community for the past six years, what has happened differently? Have you and your community benefitted from TSHIP? How? Give examples.

A1. All the respondents said yes, they know TSHIP.

The respondents indicated that the things that happen different are positive changes in the health system of their communities due to the TSHIP project. And all of the respondents said that they and their communities benefitted from the TSHIP program. In the course of the discussion, the respondents indicated the following benefits they and their communities received from TSHIP:-

1. TSHIP training of the WDCs – including the CBHVs help the WDCs/CBHV to perform community services much better with good outcome. The Health service providers among the WDCs said they were trained on diseases, Family planning and use of basic drugs – such as Misoprostol and Chlorhexidine.
2. The respondents mentioned Insecticide Treated Net distributed for prevention of Mosquito bites and Malaria as another benefit they have.
3. Activities of the CBHV assist women in the communities. According to the respondents, pregnant and women in labor are assisted always by the CBHVs whenever the former are having complications. The CBHV also carry newborn babies to the Hospital for immunization and later return the babies and the mother to their homes. One of the CBHV said she use to deliver up to sixteen babies in a month.
4. TSHIP supply of drugs such as Chlorhexidine and Misoprostol; which help in reduction of newborn infections and bleeding in women during childbirth is another benefit. They also learnt to prepare ORT for diarrheal diseases.
5. The respondents said TSHIP has enlightened the communities in appreciating the importance of patronizing Health Facilities. According to them, such enlightenment has increased the community utilization of antenatal, delivery and postnatal services. Also, more women and men avail themselves for HIV counseling and testing,
6. TSHIP Hygiene training helps the communities to be cleaner and healthier. According to the respondents, they teach the households to be clean and eat balanced diet, and occasionally, the CBHVs assist some household by sweeping the house.
7. Renovation of Health facilities and supply of drugs in the Health Facilities courtesy of STHIP program. These drugs, according to the respondents include; anti-malarial (ACT), Misoprostol, Chlorhexidine, Folic acid, Fersolate, and Family Planning commodities.
8. The respondents also indicated that Maternal and Child Mortalities and Morbidities have reduced drastically in their communities as a result of the TSHIP project.

Q2. Has your group been trained by TSHIP? How do you use this training?

A2. All the respondents said they were trained at one time or another,

The respondents indicated that the trainings help them to improve in working as follows:

1. The WDCs and the CBHVs meet monthly to discuss Maternal and Health issues. Where there is the need they organize a sensitization lecture for the community or ask the ‘town crier’ (community announcer) to announce to the community vital information.
 2. They use the knowledge in correct management of some ill-health conditions such as treatment of malaria, management of neonatal umbilical cord to prevent infection, and the preparation and use of ORT solution.
 3. Participating better in their community mobilization, sensitization and advocacy. This resulted in increased utilization of health services.
 4. The trainings sensitized them to help their communities. For example, WDCs, as a group and sometimes individuals, voluntarily buy drugs and give to the CBHVs when that of TSHIP is not available.
- Q3. Did the use of this training change anything? What do you do differently?

A3. Most of the respondents said that the use of the training resulted in many positive changes.

They indicated that the following are the things they now do differently and have seen positive changes

1. Awareness creation for increased utilization of health facilities.
2. WDC members give financial assistance to buy drugs and also sometimes assist poor patients financially.
3. CBHVs, who are Traditional Birth Attendants (TBAs), now use Misoprostol for the prevention of bleeding during childbirth and Chlorhexidine for prevention of neonatal infection. The CHBVs take babies to the Health Care Facilities for immunization.
4. WDCs and CBHVs now have better relationship with the Health Facilities. They work together for the benefit of their communities.
5. Meet regularly with traditional leaders; who supervise them and sometimes take critical decision on sensitive issues affecting the communities.
6. CBHVs prevent the use of cow dugs and other dirty materials for managing umbilical cords of newborn babies. Discourage the use of water to the newborn babies; but encourage the practice of Exclusive Breast Feeding.

Q4. How does your community/group collaborate with the Health Facility? (Prompt: to increase public awareness and utilization of MNCH/FP/RH services)

A4. The respondents cited many examples of areas of collaboration between the WDCs/CBHVs and the Health Facilities which can be group into:

a) Increasing utilization of MNCH/FP/RH services. This is achieved by making the use of Ambulance in transporting the sick patients or woman in labor, accompanying the sick woman to the Health Facility to ease logistic, and awareness creation. Whenever the number of women in the ANC is low, the Service Providers inform the WDCs and the CBHVs, who in turn mobilizes the women to come to the Clinics.

The Health Care Providers determine the area of operations of the CBHVs and also perform supervisory role to the CBHVs.

b) Increasing community awareness. These are done through organizing public lectures and a Health Facility staff is invited to give lectures. The monthly meetings of the WDCs include Health Facility staffs, and that provide an avenue for discussing health issues of the communities and together developing strategies for handling such issues..

Q5. How do you think the health facility benefit from your contributions? Please give examples.

A5. The respondents indicated that the Health Facilities benefitted positively by their contribution in the TSHIP project.

They gave examples of how the Health Facilities benefitted from their contributions as:

1. They contribute money to buy drugs for the Health Facilities
2. They sensitize the communities to avail themselves for health services in the Health facilities,
3. They help in providing infrastructure or make repairs in the Health facilities. For instance, they perform electric wiring of Birdi Biridi town dispensary, and they provide sand at Yabo Dispensary to prevent water stagnation around the Dispensary during raining season.
4. The WDC's sensitization encouraged husbands to not only support their wives, but also accompany the women to the hospital for ANC and FP.
5. They help keep the Health Facility environment clean and assist in providing access road into the Health Facilities.

Q6. Does your committee or group collaborate with other community organizations to support local MNCH/FP/RH activities?

A6. They indicated that their group collaborates with members of NURTW in getting transport for the patients before the provision of the Ambulances. Also they cited other local CBOs that they collaborate with – including Nasara Social Club and.. Kungiyar Kiwon Lafiyar Mata. The former works on drainages, access roads and disposal of waste from the Health Facilities, while the later buying ANC drugs and mobilizing women to patronize Health facilities.

Q7. How does your group lobby for resources/funds from the LGA? Does it work? Give examples.

A7. The WDC's members said after discussing a problem and determining the cost implication of the work, they meet the Philanthropists in their wards to contribute, after getting a substantial amount of the money; they then seek the assistance of the LGC. If that fails, they go back to the rich people for more support But they said the LG has never assisted them even with such kind of efforts.

Q8. Are there any supports (financial or activities) that you or your committee/group members give to help improve MNCH/RH/FP services in this community? Please give examples

A8. Yes, they indicated that occasionally, they make contributions to buy some basic drugs. They also cited the example of the Generator in Dagawa town; which was purchase by the assistance of the rich people of the Ward, after the LG refuse to buy for them.

Q9. What has changed in the way husbands support their wives in utilizing health facilities?

A9. The respondents indicated that the husbands are now more supportive to their wives in utilizing the Health Facilities.

They also said the husbands are now more accepting immunization and use of drugs (e.g. Misoprostol) to their wives.

Q10. Has the participation of women increased in your group? What's the evidence?

A10. Most of the respondents said the participation of women in their group has increased considerably. Beside the CBHVs, who are members of WDCs,. They indicated that the position of treasurer of WDC is They also mentioned that they have women wing with their officials.

Through the UNICEF project, Voluntary Community Mobilizes (VCM), who are all female, are now members of the WDCs.

Q11. What recommendations do you have for your LGA to improve your community's/group's capacity in supporting MNCH/FP/RH?

A11. To improve their capacity in supporting MNCH/FP/RH, the WDC members want the LGA counsel to:

a) Continue to train and re-train them on issues of advocacy and community mobilization.

b) All the respondents recommended the employment of more CBHVs and the LG to take the responsibility of paying the monthly N2, 000:00, and providing them with drugs. They also indicated the need for re-training of these CBHVs on a regular basis.

c) The LG to maintain the present TSHIP activities and infrastructures put in place in many Wards. They indicated that at least Misoprostol and Chlorhexidine be supplied to the CBHVs on a regular basis.

For the LG to re-institute the payment of monthly N20,000:00 for fueling and maintaining the Ambulances.