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IMPLEMENTING THE CAPACITY BUILDING PROGRAM

Introduction

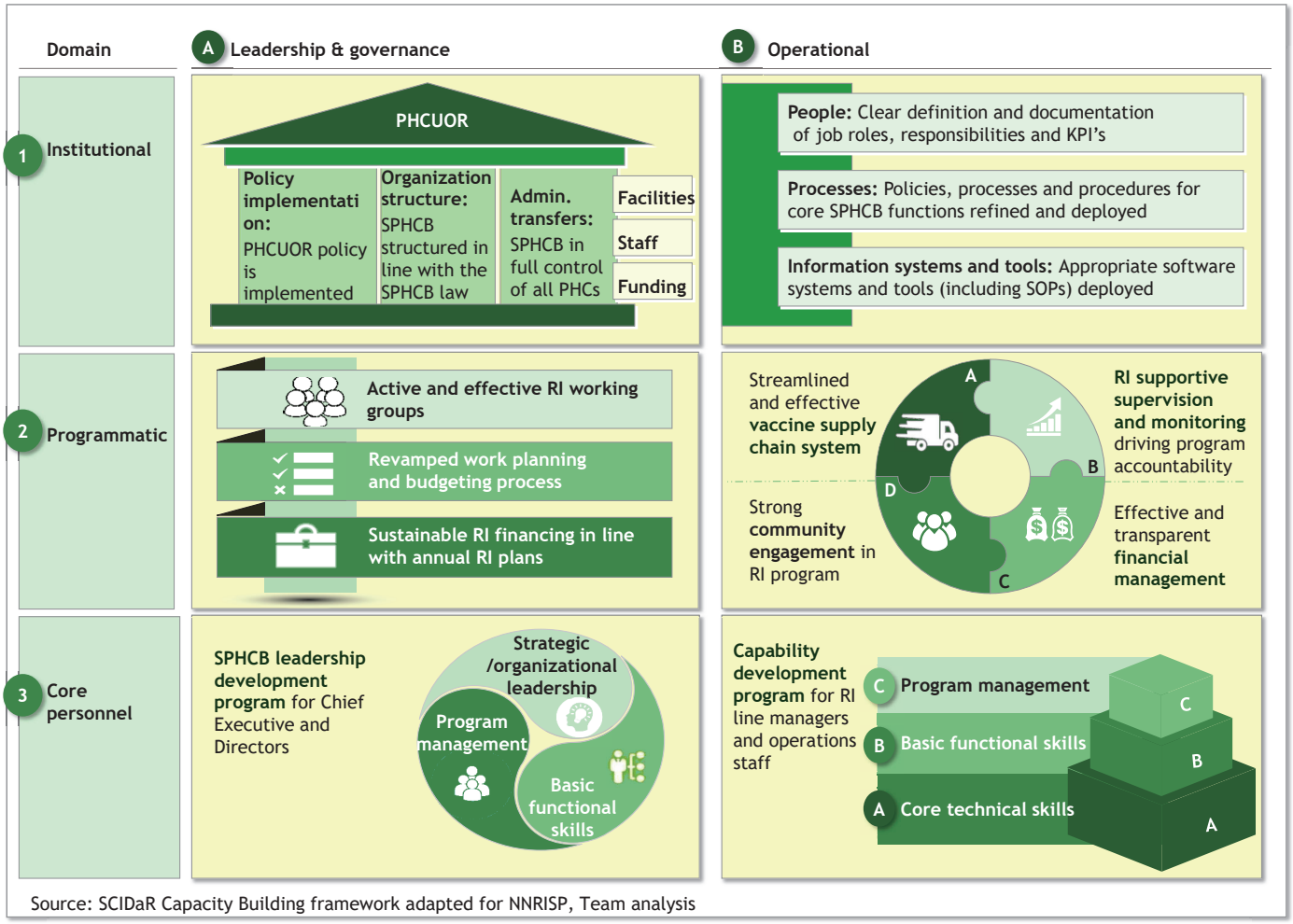
Immunization is critical for public health as it efficiently prevents vaccine-preventable mortality. To this end, the government of Nigeria and implementing partners invest significantly in a myriad of RI systems strengthening interventions. However, despite these efforts, northern Nigeria still had a significant number of unvaccinated children.

In 2013, the National Demographic and Health Survey revealed that the states of Bauchi, Borno, Kano, Kaduna, Sokoto, and Yobe recorded some of the lowest RI coverages in the country.

A diagnosis of the situation revealed that funding, ineffective coordination, and deficiencies in program and personnel capacity in the State primary healthcare boards (SPHCBs) contributed to the low coverage numbers. To address these issues, the Bill & Melinda Gates Foundation and Aliko Dangote Foundation partnered with the governments of the six least-performing northern states and other partners to provide funding, drive political will, and invest in catalytic technical assistance - delivered by SCIDaR - channeled towards strengthening routine immunization systems and building institutional capacity for program coordination in a sustainable manner.

The three-pronged framework

As part of the technical assistance delivered by SCIDaR towards this objective, the Capacity Building intervention deployed a unique 3-pronged framework along the Institutional, Programmatic, and Personnel domains to strengthen the organizational capacity of the SPHCB, system capacity of the immunization program, and technical capacities of RI/PHC line managers respectively. Summarily, the capacity-building program aimed to empower the states to take ownership of their PHC programs and ensure long-term sustainability beyond the MoU term.



Source: SCIDaR Capacity Building framework adapted for NNRISP, Team analysis

Figure 1: SCIDaR's Three-pronged Capacity building framework

To establish a baseline, the SPHCB and partners conducted a capacity needs assessment, collectively reviewed and validated the results, and adapted the capacity-building framework to the respective state contexts to create a roadmap for optimizing capacity.

Implementing the Capacity Building Program

To implement the capacity building roadmap, the partners embedded a team of consultants in each of the SPHCBs to deploy suites of interventions including advocacy, data delivery, and technical and capacity-building support to the agencies/boards.

To strengthen **institutional capacity**, SCIDaR consultants, under the leadership of the State Primary Health Care Boards (SPHCBs) partnered with implementing partners, including WHO, UNICEF, AFENET and the SPHCB leadership, to provide technical support for implementing the national Primary Health Care Under One Roof (PHCUOR) policy in the six states such that the boards had autonomy and an enabling environment to coordinate primary health care service delivery in the respective states. As part of the support, the partners conducted high-level advocacies to secure political will for adopting and domesticating the national policy. Additionally, focus was placed on articulating and disseminating clear SPHCB operational guidelines; optimizing staff workspace and tool; administratively domiciling all health programs and transferring health workers to the SPHCB; and establishing and optimizing finance and HRH units in the Boards. As of 2022, several of the SPHCBs had made relevant updates to their mission statements and guidelines, and had successfully transferred operational control of PHC staff, facilities, and funds to the respective Primary Healthcare agencies/board

The **programmatic capacity** building focused on improving the planning, implementation, and management of RI/PHC programs across the states, through the establishment and coordination of working groups which were structured along the seven pillars of public health as defined by WHO. These working groups - Routine Immunization Operation; Community Engagement; Supply chain; Service delivery; Financial management; Monitoring and evaluation; Supportive supervision; and Human resource for health/Training were structured to have clear terms of reference and membership, standing routines, trackers and deliverables, and direct lines of accountability to the overarching PHC governance structures. This oversight structure includes the PHC TWGs, the SPHCB Executives, and ultimately to the State Taskforce on Immunization/PHC. Additionally, the programmatic capacity building also focused on optimizing annual operational planning, quarterly implementation reviews and routine performance management.

Illustrative: Current PHC Program structure in Sokoto state

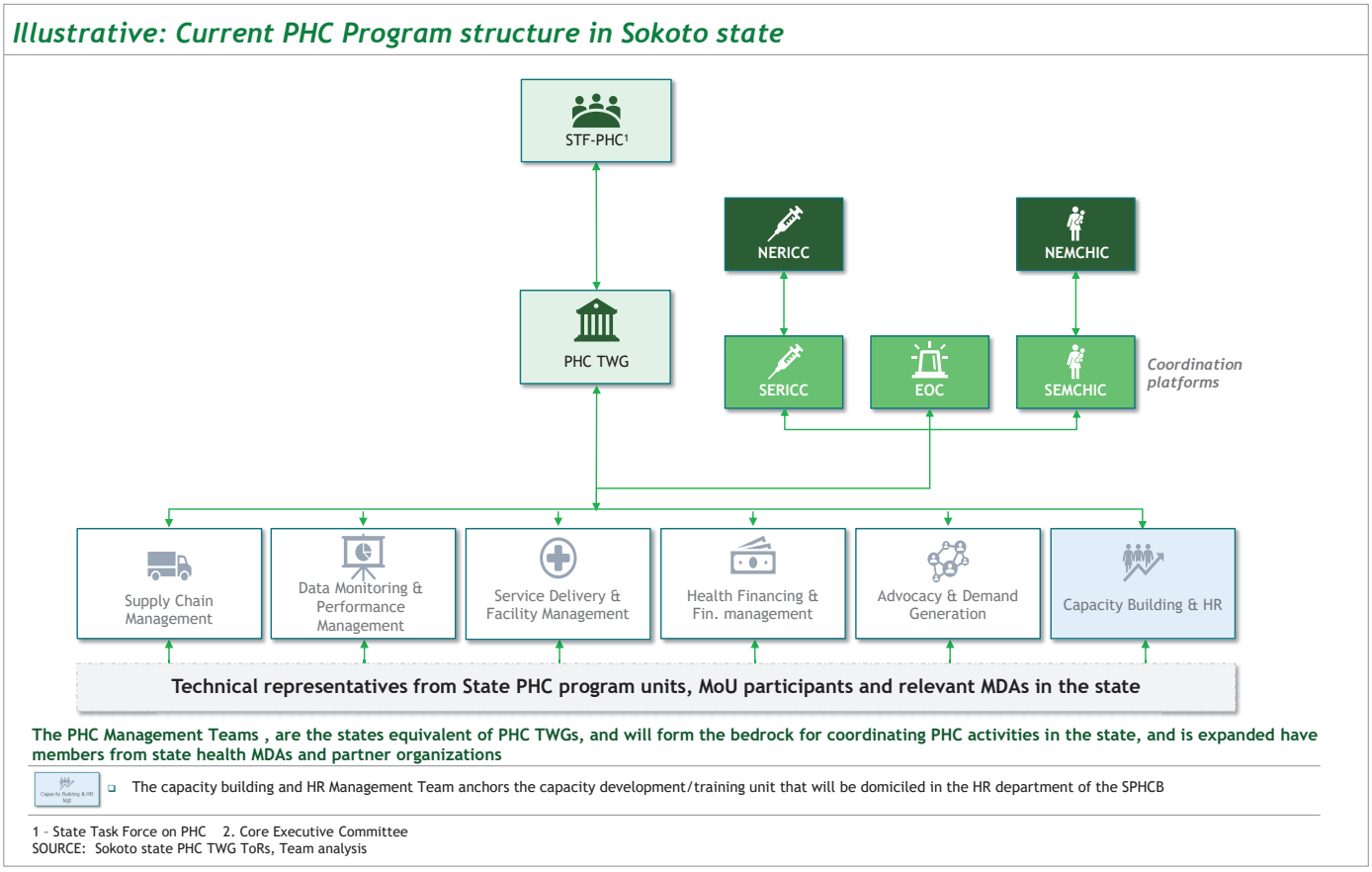


Figure 2: Overview of technical coordination structures established for the state PHC programs

The **core personnel capacity** building intervention was designed to transfer skills to state RI/PHC program managers such that they could perform their tasks independently. An average of seven key state program managers from each of the states level were prioritized for this initiative. For these managers, the capacity-building partners defined and documented their TORs, against which their performance was routinely measured. The SPHCB/DA's partners co-developed the approaches with the beneficiaries/managers and deployed a suite of interventions, including on-the-job mentoring, practical in-class sessions, one-on-one coaching sessions, and learning exchanges/tours.

Mentors, and coaches were drawn from a pool of implementing partners to provide day-to-day capacity optimization support, and conduct monthly evaluations of staff performance.

Monitoring the Capacity Building Intervention

The monitoring and evaluation framework for the intervention encompassed all 3 domains of the capacity building framework as follows:

Domain	Indicator	Frequency	Tool
Institutional	PHCUOR Performance Score	Yearly	PHCUOR Scorecard
Programmatic	Working group functionality	Monthly	SCIDaR NNRISP dashboard (DMS); work plan templates and trackers
	Work planning	Quarterly, Yearly	
Personnel	Ability to carry out activities independently	Monthly	Ability to carry out activities independently

Table 1: Key Performance Indicators for Capacity Building across the three main domains

While institutional capacity was measured periodically through the annual national PHCUOR Scorecard evaluations, programmatic capacity was evaluated through work planning and working group functionality. Personnel capacity on the other hand was monitored through monthly performance reports reviewed by the officer/manager's supervisors and relevant stakeholders including the SPHCB Directors and the BMGF Program Officers. This personnel capacity report culminates into an innovative 5-points gradient system as described below:

- Level 1: Does not conduct the activity - Program officer does not conduct function/ function is conducted primarily by partners
- Level 2: Conducts activity with support - Program officer requires support from partners/other parties to carry out function
- Level 3: Conducts activity with prompting - Program officer requires reminders or prompts to carry out function
- Level 4: Conducts activity independently - Program officer conducts function without support or prompting but has no backstop
- Level 5: Role is institutionalized - Program Officer conducts function independently without support or prompting; and has trained a competent backstop who is also able to conduct functions independently

Source: SCIDaR

Results

Stemming from these collaborative efforts the 6 MoU states recorded improvements in RI/PHC performance across the 3 broad domains as follows:

Institutional capacity

With close technical support, state agencies were able to achieve a continuous degree of autonomy as outlined in the Primary Health Care Under One Roof (PHCOUR) guidelines. In 2018, an average of 53% of milestone activities had not been completed. However, by 2019, only 15% of all milestone activities were yet to be completed across the states. This progress was made through establishment and/or optimization of the state PHC boards and respective governance structures, and achieving proper coordination and ownership of primary healthcare programs at various levels.

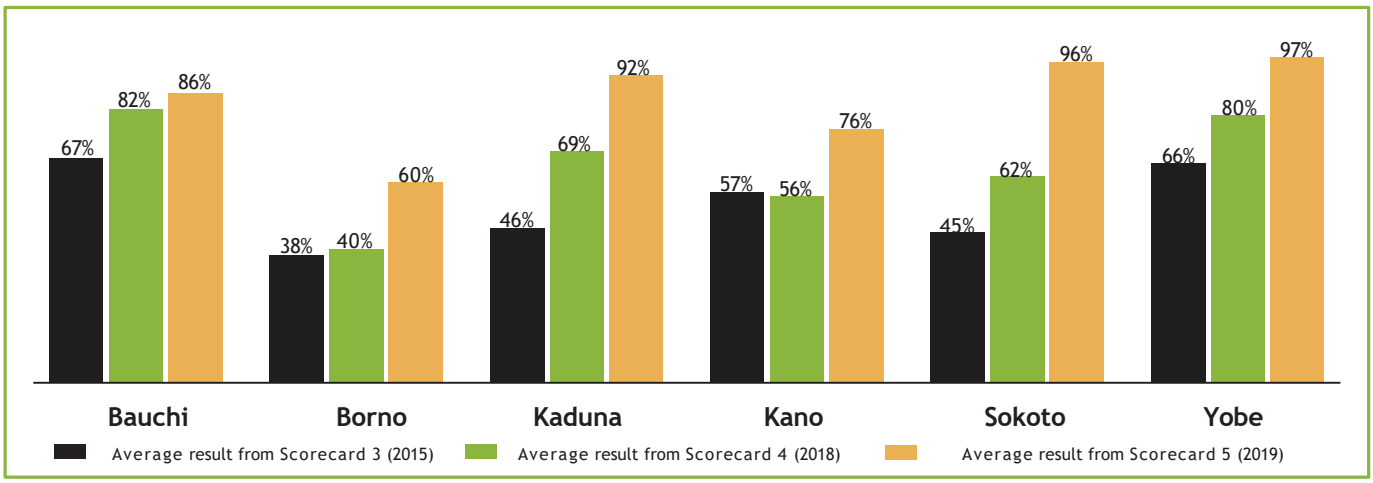


Figure 3: Impact of the capacity building program on the institutional capacity in the 6 MoU states

Programmatic Capacity

By 2019, the SPHCB and its partners had done the work of revitalizing RI working groups across the states. Instituting standing routines, adopting clear KPIs and TORs, and providing embedded management support led to improved processes efficiency and overall effectiveness of the RI program in all states. Financial management indicators improved dramatically due to the strengthened capacities of financial working groups. Vaccine stock-outs were reduced to less than 8% due to the revitalization of the State Logistics Working Group (SLWG). All health facilities directly received and accounted for funds for conduct of outreaches. Also, 96% of defaulters were effectively tracked in Kano and Yobe with the help of PHC officers and community volunteers. A granular breakdown of state performance along program lines is in figure 4.

Before | After | xx # of lots passed | < 50% | 50-79% | ≥ 80% | NA Data not available/applicable

States	System strengthening												Capacity development	
	L&G	SD	VSCL		M&E/RISS		CE		FM		CB	
	% of WG meetings conducted	No of HFs offering RI	% of ward with functional CCE	% vaccine stockout	% of planned RISS visits conducted	% of HFs reporting on DVDMT/DHIS2	% Mai'unguwas linelisting	% of defaulters tracked back to care	% HFs receiving funds	% of HFs retiring funds optimally	% of roles conducted independently	% PHCUOR achieved
Bauchi (Dec. '14 vs Sept '22)	- / 75	841 / 1,072	34 / 95	34 / 1	- / 83	- / 95	NA / 67	NA / 73	0 / 100	NA / 90	0 / 81	NA / 85
Borno (Dec. '15 vs Sept '22)	0 / 83	150 / 357	5 / 92	52 / 14	3 / 83	3 / 83	NA / 71	NA / 81	0 / 100	NA / 80	0 / 97	NA / 71
Kaduna (Dec. '15 vs Sept '22)	0 / 58	1,099 / 1,180	26 / 96	NA / 3	0 / NA	0 / 80	NA / NA	NA / NA	0 / 100	NA / 77	0 / 69	NA / 100
Kano (Dec. '13 vs Sept '22)	15 / 75	857 / 1,257	11 / 79*	41 / 0	29 / 92	29 / 92	NA / 92	NA / 89	0 / 100	NA / 96	0 / 94	NA / 72
Sokoto (Dec. '15 vs Sept '22)	0 / 90	487 / 594	26 / 98	61 / 7	0 / 42	0 / 96	NA / 41	NA / 82	0 / 100	NA / 91	0 / 66	NA / 96
Yobe (Dec. '15 vs Sept '22)	27 / 60	298 / 440	31 / 100	60 / 1	0 / 82	0 / 81	NA / 97	NA / 64	0 / 100	NA / 99	0 / 94	NA / 96

Source: NNRISP Implementation dashboard, State Stock DVD reports, DHIS2, PHCUOR Scorecards

Figure 4: States performance across key thematic areas as a result of programmatic capacity building efforts

Core personnel capacity building

At baseline, almost half (46%) of the program functions in the MoU states required support from partners and/or other parties to be conducted. This is partly due to a limited understanding of the responsibilities of program officers, weak technical capacity and/or poor motivation to carry out their activities. Through tailored capacity building sessions, several functions that required external prompting by partners to be carried out, are now being carried out independently. The figure below shows the evolution of incumbent staff capacity to independently execute tasks between inception of the intervention in 2018 and August 2022.

RI MoU states capacity building tracker – Core personnel (1/2)

○ – Does not conduct activity
◔ – Conducts activity with support from partners
◑ – Conducts activity with prompting
◕ – Conducts activity independently
● -- Role has been institutionalized (competent backstop & tools/sop)
NA -- Not Applicable

	Roles	Function	Kano		Bauchi		Borno		Yobe		Sokoto		Kaduna	
			May 2018	Aug 2022	May 2018	Aug 2022	May 2018	Aug 2022	May 2018	Aug 2022	May 2018	Aug 2022	May 2018	Aug 2022
Service delivery	SERICC PM[0]	Coordinate REW microplanning[1]	◔	●	◔	◕	◔	●	◕	●	○	●	●	●
		Monitor conduct of RI services across all PHC facilities through routine review of admin data	◔	●	●	●	◕	●	◔	●	◔	◑	●	●
		Provide periodic updates on RI activities to all stakeholders	◔	●	◑	●	◕	●	◔	●	◔	◕	◑	●
Vaccine supply chain	SLO[2]	Forecast vaccines for all health facilities annually[3]	●	●	◔	●	◕	●	◔	●	○	◕	○	◕
		Manage CCE inventory including replacement, procurement and installation of new CCE[4]	◔	●	○	●	◕	●	◕	●	◔	●	◑	◕
		Manage vaccine distribution operations across all levels (state, LGA and HF)	◑	●	◕	●	●	●	◑	●	◑	●	◔	◕
		Monitor stock performance on direct delivery dashboard and revise allocations if required[4,5]	◔	●	○	●	○	◑	*NA*	◕	○	◑	◑	◑
		Manage all cold chain equipment maintenance in the state	◔	●	◕	●	◕	●	◕	●	◑	●	◔	◕
		Provide periodic updates on vaccine supply chain activities to all relevant stakeholders	◑	●	○	●	◕	●	◕	●	◔	●	◔	●
	SCCO	Manage cold store facilities and manage warehouse planning processes	◕	●	◕	●	◕	●	◕	●	●	●	◔	◕
		Monitor temperature of all CCE in satellite and LGA cold stores across the state	◕	●	●	●	◕	●	◕	●	◕	●	◔	○
		Report vaccine data on NAVISION[3]	◕	●	●	●	◕	●	◕	●	◕	●	◕	◕
RISS and Data Management	RISS Coordinator[0]	Coordinate selection and training of competent state and LGA supervisors	◔	◕	◔	●	◔	●	◑	◕	●	◕	◔	○
		Develop budget for all RISS activities and mobilize all necessary resources	◕	◕	◔	●	◔	●	◑	◕	◔	◔	◑	◕
		Manage conduct of RISS activities (pre-cycle meetings, RISS visits, report submission)[1]	○	◕	○	●	◔	●	◔	◕	◔	◑	◔	◑
		Analyze RISS data and develop insights and recommendations	◕	◕	◑	◑	◔	●	◔	◕	◔	◔	○	○
		Provide periodic updates on RISS activities to all relevant stakeholders	◑	◕	○	◕	◔	●	◔	◕	◑	◕	○	◔
	State M&E officer[0]	Manage RI data tools to all points[2]	○	●	◔	◕	◔	●	◔	●	◑	●	◔	◕
		Manage LGA RI review meetings[3]	○	●	◔	◔	◔	●	◑	●	◔	○	◕	○
		Review state level DHIS data, correct entries and develop report[4]	◕	●	◕	◕	◔	●	◔	●	◑	○	◑	◕
		Supervise the conduct of DQS and develop report following conduct	◔	●	◔	◑	○	●	◔	●	◑	○	◕	◕
		Develop a micro analysis and reports of LQAS data and manage action-planning[4,5]	○	◕	○	●	○	●	○	◕	○	○	◔	◔
		Provide periodic updates on data management activities to all stakeholders	◑	●	◑	◕	◔	●	◑	●	●	○	◕	◕

0: Role carried out by Asst. State M&E Officer in Borno
1: Role carried out by State RI focal person in Yobe
2: Role carried out by SCCO in Kaduna and in Bauchi
3: Role carried out by RISS coordinator in Sokoto
4: Role carried out by DHIS officer in Bauchi and Yobe
5: Role carried out by SERICC secretariat in Kano

Source: State CB monitoring tools, Team analysis;

Observed regressions in capacity esp. in Sokoto were due to changes in the personnel performing the function due to death, retirement/resignations and transfers

RI MoU states capacity building tracker - Core personnel (2/2)

- Does not conduct activity
- Conducts activity with support from partners
- Conducts activity with prompting
- Conducts activity independently
-- Role has been institutionalized (competent backstop & tools/sop)
NA -- Not Applicable

	SPHCDA roles	Function	Kano May 2018	Kano Aug 2022	Bauchi May 2018	Bauchi Aug 2022	Borno May 2018	Borno Aug 2022	Yobe May 2018	Yobe Aug 2022	Sokoto May 2018	Sokoto Aug 2022	Kaduna May 2018	Kaduna Aug 2022
Financial management	RI Accountant[1]	Disburse funds for all RI activities[2]	◕	●	○	◕	◔	●	◑	●	◔	◕	◕	◕
		Analyze budget performance of all thematic areas and discuss at FWG	◕	◕	◔	◕	◔	●	◔	●	◔	◔	○	◕
		Manage monthly RI account reconciliation[3]	●	●	◔	◕	◔	●	◑	●	◔	◕	◔	◕
		Provide periodic updates on RI financial management activities to all stakeholders	◑	●	◔	◕	◔	◕	◑	●	◔	◕	○	◑
	Internal Auditor[4]	Manage collation/submission of RI retirements	◑	◕	◔	◕	◑	●	◕	●	◑	◕	○	◕
		Manage validation of all RI retirements	◔	◕	◔	◕	◕	●	◕	●	◔	◕	○	◕
		Provide periodic updates on internal/external audit activities to all relevant stakeholders	◑	●	◔	◕	◔	●	◔	◔	◔	◕	○	◕
	Chief Accountant[1]	Use financial accounting software to manage accounts	*NA*	●	○	◔	○	◑	○	●	◔	◕	○	○
		Manage SPHCDA asset register[5]	●	◑	◔	●	○	●	◕	○	◔	◔	◔	●

1: Role carried out by Deputy Director, Accounts and Finance in Yobe and Ri accountants in Kaduna and Sokoto 2: Role carried out by RI cashier in Bauchi 3: Role carried out by RI Accountant in Kaduna baseline '18 4: Role carried out by RI Accountant in Borno and Store keeper in Sokoto

SOURCE: State team analysis

Figure 5: Impact of the capacity-building program on core personnel capacity in the 6 MoU states

Challenges and lessons learned

The Capacity building intervention encountered a myriad of challenges ranging from high rates of attrition of now capacitated staff on a backdrop of poor succession planning and government transitions, suboptimal accountability for poor performance, and bureaucratic bottlenecks in establishing governing boards and transferring programs to the SPHCB. The challenges faced torched a light on key lessons including the need for

a. Building consensus and securing long term commitments for close accountability
b. Structuring capacity building as a Pull service rather than a partner-led push
c. Institutionalization of HRH units to anchor the intervention within the SPHCB
d. Establishing clear transition/succession plans and adequate backstop mechanisms to ensure retention of capacity

Conclusion

Multi-pronged capacity-building programs are effective in improving overall health outcomes in the states where they are deployed. However, several considerations must be made to ensure that the capacity built is competitively retained within the organization to maximize return on investment, and ensure sustainability of programs.

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