Impact of an Innovative, Multi-Dimensional Capacity Building Intervention for RI Line Managers in 6 Northern Nigeria states

SCIDaR
SOLINA CENTRE FOR INTERNATIONAL DEVELOPMENT AND RESEARCH

insights innovation impact

Source: SCIDaR

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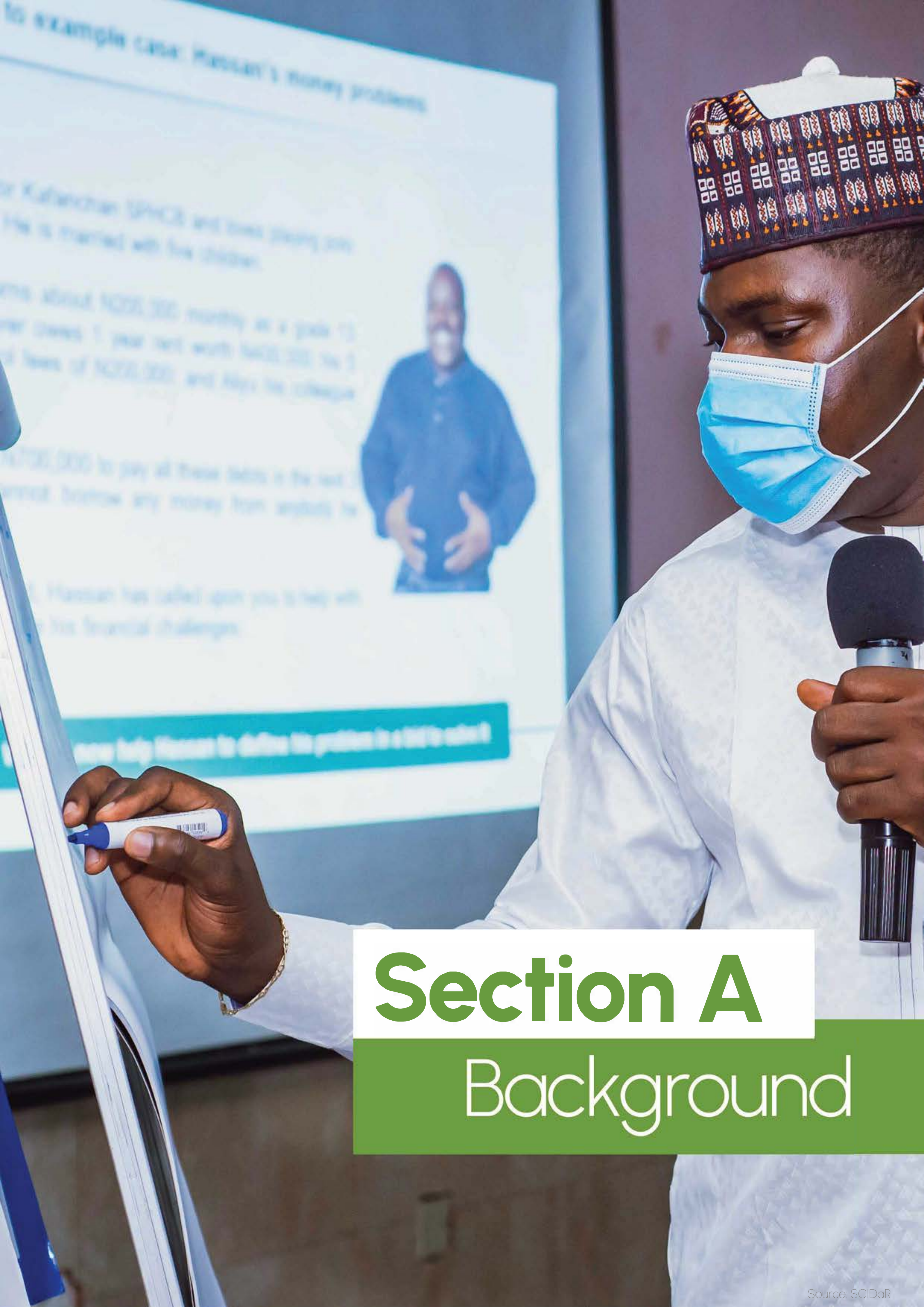


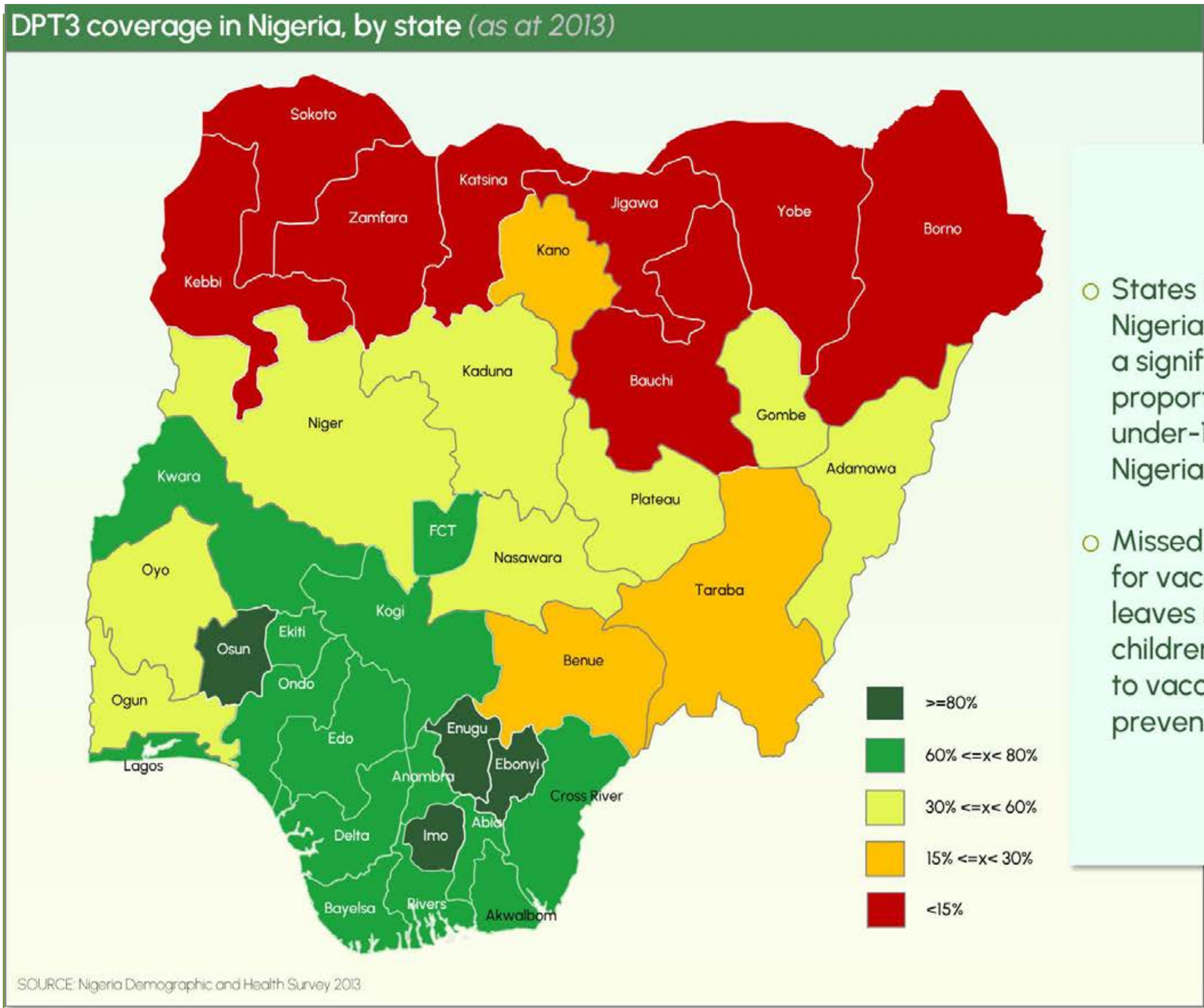
Section A
Background

Source: SCIDaR

Introduction

Immunization is a crucial aspect of public health, because of its cost-effectiveness and efficiency in preventing vaccine-preventable mortality These preventable diseases accounted for 413% of deaths among children under the age of five in Nigeria in 2019 (Kurayi et al , 2022) An estimated 14% of unvaccinated children globally live in Nigeria Improving routine immunization coverage is a significant public health concern in Nigeria

A 2013 survey revealed that Nigeria's coverage of the Penta 3 vaccine was 38% compared to the global average of 86% (WHO), with a maJority of states in northern Nigeria having less than 15% coverage The poor-performing states in Nigeria were responsible for 30% of the overall number of unimmunized children in the world (STC 2022) The reasons for these results include poor coordination of routine immunization programs and a lack of technical, leadership, and management capacity among program officers



- States in Northern Nigeria accounted for a significant proportion of the under-1 population in Nigeria
- Missed opportunities for vaccinations leaves millions of children susceptible to vaccine-preventable diseases

To address these issues, the Bill & Melinda Gates Foundation and the Aliko Dangote Foundation partnered with the governments of six least-performing northern states to provide funding and technical assistance for routine immunization programs. The partnership was formalized through a multi-year Memorandum of Understanding (MoUs) and is supported by national-level reforms through the National Primary Health Care Development Agency (NPHCDA). This document aims to document the design, implementation and successes recorded from the capacity building interventions of the Mou via a systems strengthening grant (NNRISP) implemented across the 6 northern states.

The State Primary HealthCare Development Agency or Management Board (SPHCDA/CMB) is the state equivalent of the National Primary HealthCare Development Agency (NPHCDA). The NPHCDA is a parastatal under the Federal Ministry of Health of Nigeria founded in 1992 through Decree 29 of 1992. The NPHCDA was created on the advice of a high-level WHO review team in order to take advantage of significant improvements in primary healthcare delivery made in Nigeria between 1986 and 1992. The SPHCDAs have several directorates as shown in the Figure below. The Capacity building program targeted the Directorate (DCI) and the Directorate of primary health care services. While the DCI focused on Routine Immunization, the PHC directorate specialized in maternal and child health. Both of this programs are coordinated by SERICC (State Emergency Routine Immunization Coordination Centre) and the PHC technical working group. Under the various working groups, SPHCDA officers and managers were the direct beneficiaries of the capacity building program.

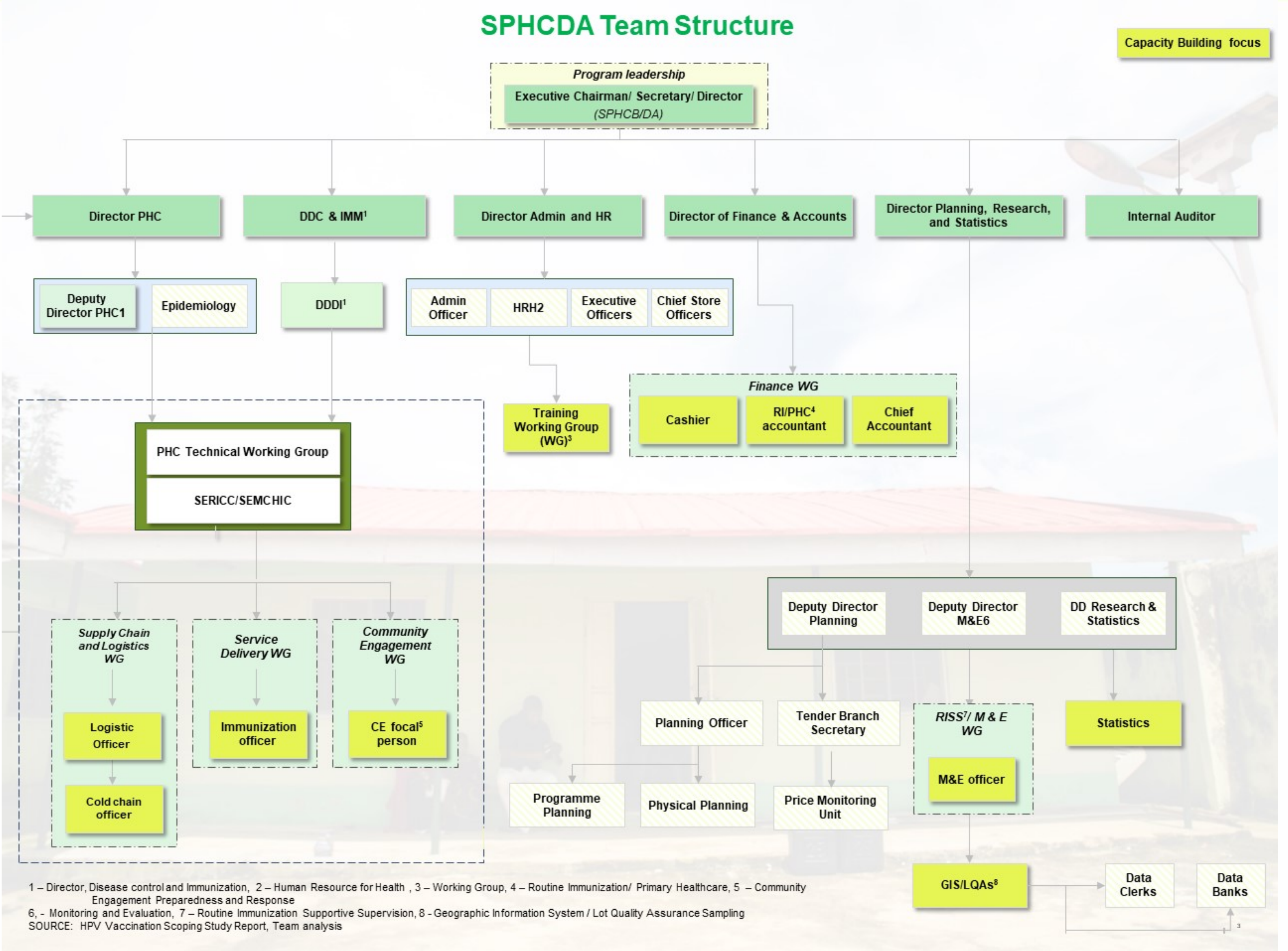


Figure 2: The SPHCDA/CMB structure and targeted offlcers for capacity building

Section B

The SCIDaR Capacity Building approach

Solina Centre for International Research and Development (SCIDaR), is a non-profit organization that works with governments, donors, and the private sector to characterize and address development challenges of various public health organizations at national and subnational levels in Nigeria and other African countries. SCIDaR adopts a unique contextualized approach for capacity building of public health organizations.

Source: SCIDaR

Description of the SCIDaR Capacity-Building Framework

SCIDaR's capacity-building framework addresses 3 interwoven domains, namely - the Institutional, Programmatic, and Personnel domains of capacity within the context of health systems. From diagnostics to design and implementation, the framework is useful in ensuring that both internal and external factors that contribute to the capacity of personnel are addressed in a comprehensive manner.

The 3 Domains of SCIDaR's Unique Capacity Building Framework

The domains of the capacity building program can be described across governance and operational themes as follows:

1. **INSTITUTIONAL CAPACITY:** This refers to defined and functional organizational processes and structures that enable the smooth running of programs in organizations. Institutional capacity can be described along governance themes in terms of guiding policies (PHCUOR), a defined organizational structure and full control of facilities, staff and funding. This also encapsulates **strong institutional processes** in human and financial resource management.

2. **PROGRAMMATIC CAPACITY:** This focuses on the governance structures and processes for programs such as functional working groups, revamped work planning, budgeting, and financing processes etc.

3. **CORE PERSONNEL CAPACITY:** At the leadership level, this addresses the transfer of strategic organizational, leadership, and program management skills that are required by the leading program officers. It also involves the core technical and functional skills required by each program officer which are essential to the smooth running of the organizational programs.

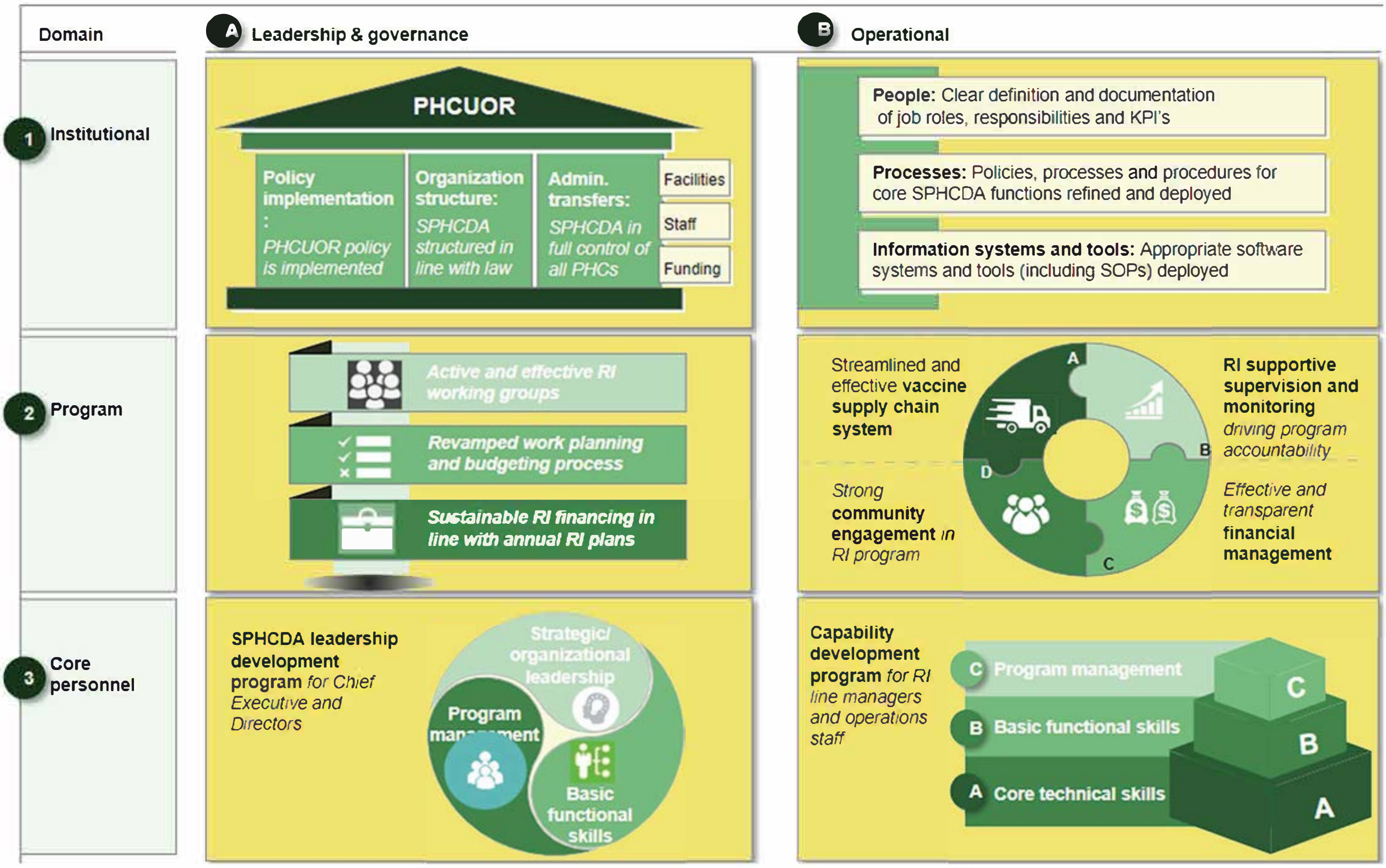
Adapting SCIDaR's Capacity Building Framework to Strengthen the RI Program in the 6 MoU States

In 2013, the National Demographic and Health Survey (NDHS) revealed that the states of Bauchi, Borno, Kano, Kaduna, Sokoto, and Yobe had the lowest RI coverage. In response to this, the Bill and Melinda Gates Foundation (BMGF) and the Aliko Dangote Foundation (ADF) signed a Memorandum of Understanding (MoU) with the states to provide the critical resources to deliver quality immunization programs, and later broader Primary health care, in a sustainable manner. Within this arrangement, SCIDaR provides technical support and advisory to design and implement program interventions, while building government capacity to independently sustain and implement these interventions.

To achieve this goal, SCIDaR adapted its universal capacity building framework to the specific needs of each state. Using a human-centered design and problem-solving approach, SCIDaR conducted a **comprehensive diagnostic** to identify capacity gaps and focus areas for each state.

After completion of the state diagnostics, workshops were held with SPHCDA staff and implementing partners to review findings and create a roadmap for improved capacity. The roadmap was tailored to the specific needs of each state and aimed to sustainably transfer capacity to the SPHCDAs, enabling them to independently manage RI/PHC programs without external technical assistance. This approach would ensure that progress made through the system strengthening efforts is sustained institutionalized and owned by the government, and establish SPHCDA/ MBs to drive a unified and coordinated management structure for all PHC services in each state.

As a result of SCIDaR's technical support, the 6 MoU states saw improved performance in their RI/PHC programs, due to the transfer of sustainable capacity. Overall, the capacity-building program aimed to empower the states to take ownership of their PHC programs and ensure long-term sustainability.



The SPHCDA capacity building program will build institutional, program and core staff capabilities across all 6 MoU states

To build capacity in the identified domains, the SPHCDA and Partners utilized different methods. Partners like SCIDaR, UNICEF, CHAI and AFENET among others advocated with the government and provided technical assistance to strengthen institutional capacity regarding the PHCUOR elements. The partners also provided support for everyday activity to develop and strengthen program capacity. Furthermore, Embedded Management consultant teams and coaches from partners built the capacity of officers through on-the-job mentoring, in-class training, learning exchanges, prompts, and reminders.

For in class training, different tutors impart knowledge to program officers on a needs basis. In class sessions only made up 20% of all training endeavors. For on the job mentoring, coaches demonstrate technical skills to the beneficiaries. Afterwards, the coach supervises the participants in their conduct of tasks requiring the transferred technical skills. Coaches also prompt and remind program officers to conduct tasks according to the predetermined work plans. To Facilitate the learning exchanges, MoU partners convene participants in capacity building from the six (6) states for knowledge sharing sessions. During these sessions, all the states share lessons they've learnt in implementing RI programs, the enabling factors and best practices as observed in the context of their states. The learning exchanges are held in conference style for a week at a time.

Source: SCIDaR

Determining Capacity Building Outcomes

Based on this 3-domain capacity building framework, the following outcomes were set for the capacity building intervention in the RI programs across the 6 states.

Domains	Focus Areas	Target Beneficiaries	Approach	Expected outcomes
Institutional system strengthening	**PHC Under – One Roof (PHCUOR)** ▪ Workspace optimization ▪ Transfer of personnel to the SPHCBs ▪ Administrative control of PHC programs ▪ Development of standard operational guidelines **Strengthening SPHCB finance units**	State Primary Health Care Agency / Board	▪ High level advocacy to state government ▪ Advocacy for full staffing from ministry of finance ▪ Technical assistance for PHCUOR element	▪ Organizational vision, strategy and organizational structure defined and shared with all staff ▪ Total operational control of all PHC staff, facilities and funds administered by the SPHCDA/MBs ▪ Human resource for health unit set up and overseen by the SPHCBs ▪ Finance and internal audit units set up, with defined staff roles, policies and processes, KPIs and work-tools ▪ SPHCDA workspace assessment conducted with gaps identified and filled
RI system strengthening	**Setting up of coordination forum** ▪ Quarterly reviews ▪ Working groups **Annual Operational plan** ▪ Harmonized Budgeting ▪ Harmonized work planning **Monitoring and Evaluation** ▪ KPI dashboards **Standard operating procedures and guidelines** **Deployment of terms of reference**	RI and PHC implementation program officers RI operational working group	Embedded management support for day-to-day activities	▪ RI working groups established and functional, utilizing KPIs and reporting activities using adopted metrics ▪ Costed work plans addressing program priorities are developed and reviewed on time
Core personnel skill building	**Technical capacity** **Leadership capacity**	RI program officers RI line managers	▪ On-the-job mentorship ▪ In-class sessions ▪ Reminder/Prompts ▪ Learning Exchanges	▪ All RI program officers executing core job functions independently, and have competent backstops

Figure 4: The Capacity Building Approach

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 Score	Yearly	PHCUOR Scorecard
Program	Working group functionality Work planning	Monthly Quarterly, Yearly	SCIDaR NNRISP dashboard (DMS); work plan templates and trackers
Personnel	Ability to carry out activities independently	Monthly	Monthly Capacity building reports

Table 2: Key Performance Indicators for Capacity Building across the three main domains

The frequency of measurement differed across the various indicators because the period required for noticeable improvement or achievement varied. While institutional capacity was measured by the PHCUOR Scorecard evaluations. Programmatic capacity was evaluated through work planning and workgroup functionality. Personnel capacity on the other hand was monitored through monthly reports reviewed by relevant stakeholders including the Directors at the SPHCDA/ MB and program funders - BMGF. This personnel capacity report culminates into an innovative 5-points gradient system as described below[1]

Staff performance is assessed using a 5-point scale which determines the approprite capacity building intervention to be deployed

Performance level	Symbol	Example	Potential interventions
1 Does not conduct activity	○	Health facility stock allocations are not conducted by primary staff	• Develop/revise staff ToR to include activities • Share necessary work tools with staff • Determine teaching approach either classroom or on-the-job coaching
2 Conducts activity with support from partners	◔	Partners support assigned staff to revise health facility stock allocations to meet deadlines	• Conduct on-the-job coaching sessions • Hold in-class training sessions • Share SOPs/guides with staff
3 Conducts activity with prompting from partners	◑	Partners constantly remind assigned staff to revise health facility stock allocations on time	• Engage supervisor to hold staff accountable • Share and paste SOPs with clear timelines • Set up reminders on computers/phones
4 Conducts activity independently	◕	Assigned staff revises health facility stock allocations (as required) by him/herself within the stipulated timelines	• Provide/train backstops to carry out activities • Plan for transitioning of thematic area to full SPHCDA support
5 Activity institutionalised (at least one competent backstop & SOPs)	●	Assigned staff revises health facility stock allocations by him/herself and has a backstop that can do same in case of absence of the assigned staff	• Completely transition thematic areas to SPHCDA

Figure 5: Five-point measurement rubric and corresponding interventions for assessing and optimizing personnel capacity

[1] Details of the SCIDaR-adapted measurement framework for capacity building are currently under peer review for publication

Implementing the CB Program In the 6 MoU States

Implementation of the capacity building intervention started in 2018, led by SCIDaR consultants in partnership with RI implementing partners, including WHO, UNICEF, and CDC-AFENET in each state.

PHCUOR Policy and Strengthening Institutional Capacity

The Primary Health Care Under One Roof (PHCUOR) policy was established in 2011 to improve the delivery of primary healthcare services in Nigeria. Since 2016, annual assessments have been conducted to measure the implementation of the policy across different thematic areas. The goal of institutional capacity strengthening in each state is to fully implement the PHCUOR policy which calls for the operationalization of state agencies to administer all primary healthcare services. As of 2018, Kano, Bauchi, and Yobe had successfully transferred operational control of PHC staff. facilities, and funds to the respective Primary Healthcare boards, while Sokoto and Yobe had defined their organizational vision, strategy. and structures.

A major area of focus is also the development of the organizational vision, strategy. and structure for the state primary healthcare development agency/management board (SPHCDA/MB), particularly for agencies that are in their early stages, such as Borno. In 2018, SCIDaR facilitated workshops in Bauchi and Borno where key SPHCDA staff collaborated with implementing partners to define its operational guidelines, vision, mission statements, and a plan for personnel capacity building.

Furthermore, SCIDaR supported the strengthening of HRH units and finance/audit teams across all states for central coordination of all human and financial resource activities, as well as the application of the MoU fund accountability pathway. This involved defining essential job roles and providing appropriate tools to program officers in funds management. financial reporting, auditing, procurement and asset management. SCIDaR also supported the SPHCDA/ MBs to conduct a comprehensive workspace assessment and develop a roadmap outlining required adjustments, needed resources, and potential sources of funding.

Strengthening Programmatic Capacity

The second domain of the capacity-building intervention was program capacity. which focused on improving planning, implementation, and management of RI/PHC programs across the states. To achieve this, SCIDaR worked to create or revitalize technical working groups to serve as effective platforms for such coordination. The goal was to equip the state primary healthcare development agency/management board (SPHCDA) to sustainably deploy best practices in overseeing financial management, community engagement, supply chain, supportive supervision, and data monitoring.

At the start of MoU, only the polio eradication working group was functional. SCIDaR worked with the SPHCDAs to review and revise working group terms of reference (TORs) and membership, to ensure clear day-to-day operations and processes towards the overall goal of improved RI/PHC coverage. SCIDaR also supported the working groups to develop annual work plans and budgets, and to transition the capacity for work planning process to the SPHCDA and ensure sustainability in the long run.

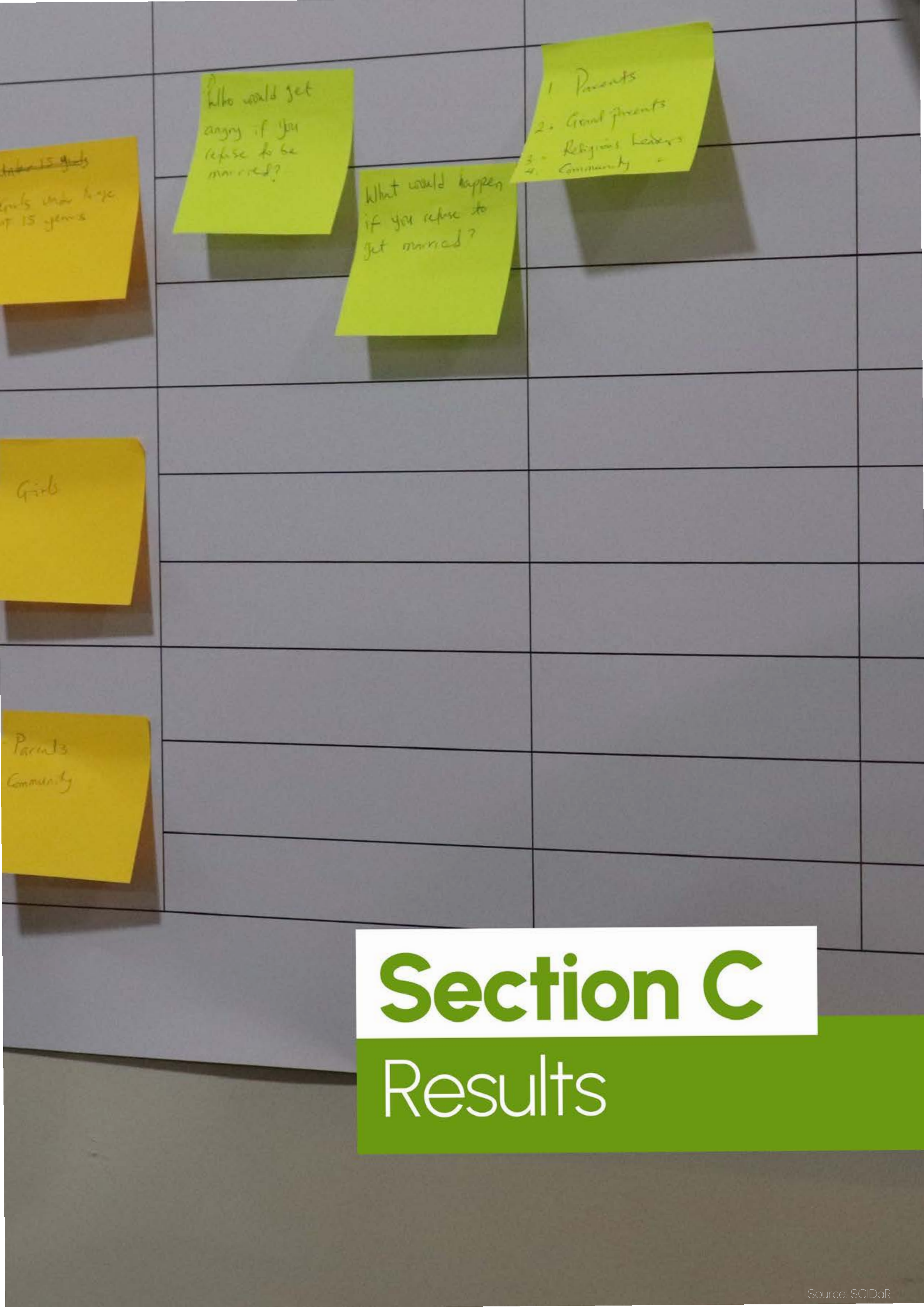
Building the Capacity of Core Personnel

The core personnel capacity building aimed to transfer skills to RI/PHC program officers to enable them to perform tasks independently, as many officers heavily relied on partner support and staff turnover contributed to capacity losses in the states. The goal was to improve the leadership skills and capabilities of the SPHCDA management team and improve the competency of line managers and operations staff.

Capacity building for core RI program officers was delivered through various channels such as targeted in-person training, on-the-job coaching and mentoring, learning tours, reminders and staff prompting. These were accomplished with support from SCIDaR consultants and implementing partners such as UNICEF, WHO, and CDC-AFENET. Program officers were selected based on a gap analysis conducted at the beginning of the MoU and an average of 7 key program officers at the state level were identified as essential to the smooth operation of the program. Details of the selected program offices are highlighted below.

SN	Theme	Program Officer	Functions
1	Service Delivery	SERICC Program Manager	▪ Coordinate REW microplanning ▪ Monitor conduct of RI services across all PHC facilities through routine review of admin data ▪ Provide periodic updates on RI activities to all stakeholders
2	Vaccine Supply Chain	State Cold Chain Officer or State Logistics office	▪ Forecast vaccines for all health facilities annually ▪ Manage CCE inventory including replacement, procurement and installation of new CCE ▪ Manage vaccine distribution operations across all levels (state, LGA and HF) ▪ Monitor stock performance on direct delivery dashboard and revise allocations if required ▪ Manage all cold chain equipment maintenance in the state ▪ Provide periodic updates on vaccine supply chain activities to all relevant stakeholders ▪ 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
3	Financial Management	Internal Auditor / PHC Accountant	▪ Disburse funds for all RI activities ▪ Analyze budget performance of all thematic areas and discuss at FWG ▪ Manage monthly RI account reconciliation ▪ Provide periodic updates on RI financial management activities to all stakeholders ▪ Manage validation, collation/submission of RI retirements ▪ Provide periodic updates on internal/external audit activities to all relevant stakeholders ▪ Use financial accounting software to manage accounts ▪ Manage SPHCDA asset register
4	Riss and Data management	M&E Officer / RISS Coordinator	▪ 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) ▪ Analyze RISS data and develop insights and recommendations ▪ Provide periodic updates on RISS activities to all relevant stakeholders ▪ Manage RI data tools to all points and LGA RI review meetings ▪ Review state level DHIS data, correct entries and develop report ▪ Supervise the conduct of DQS and develop report following conduct ▪ Develop a micro analysis and reports of LQAS data and manage action-planning ▪ Provide periodic updates on data management activities to all stakeholders
5	Demand generation	State Community Engagement Focal Person	▪ Coordinate activities of the state community engagement (CE) program ▪ Develop Work plan and budget for CE programs ▪ Coordinate central dissemination of information to LGA and sometimes ward CEFPs ▪ Collate reports and disseminate to all stakeholders

Section C
Results



Source: SCIDaR

Source: SCIDaR

RESULTS

The capacity building intervention led to improvements across all 3 domains in the 6 states by September 2022.

Institutional capacity

With SCIDaR's 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, an average of 85% of all milestone activities were completed across the states. This progress was made in setting up the state primary healthcare development agency /management board (SPHCDA) and achieving proper coordination and ownership of primary healthcare programs at various levels.

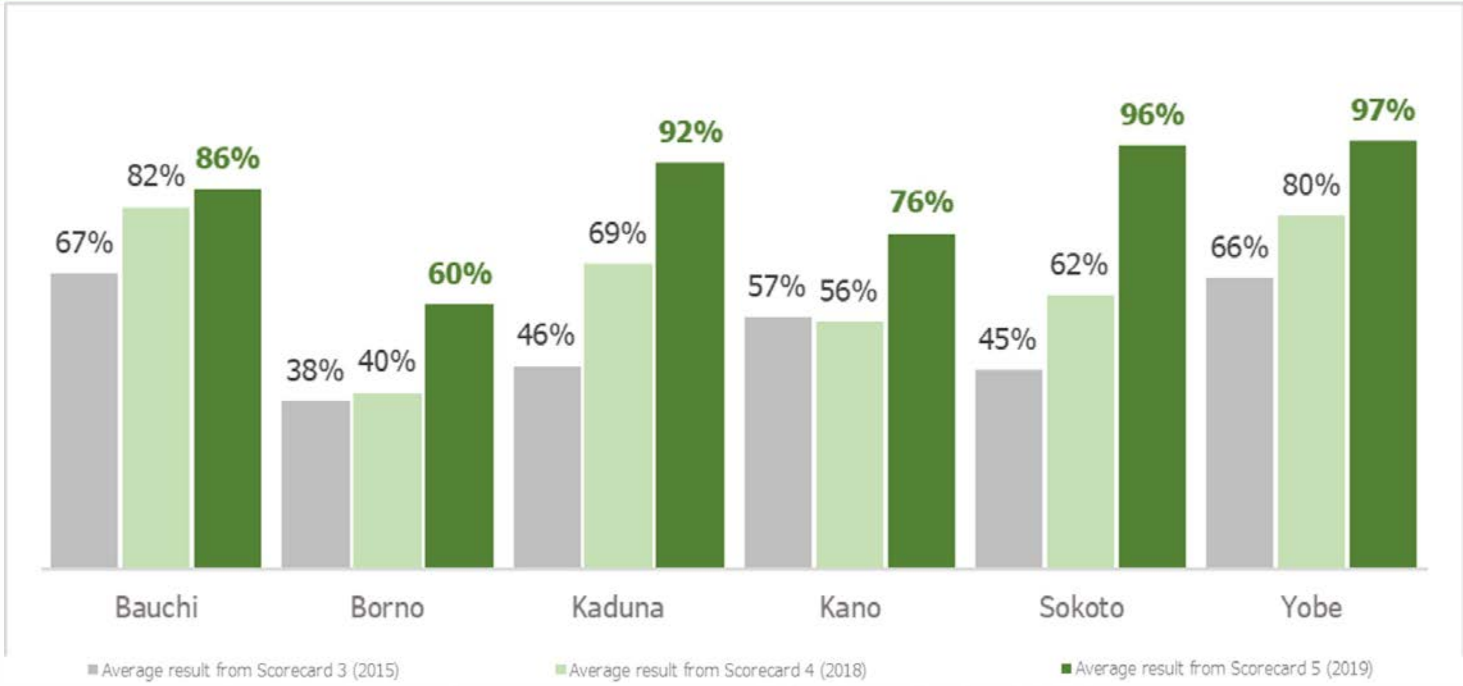


Figure 6: Impact of the capacity building program on the institutional capacity in the 6 MoU states

Institutional Capacity Building in Borno state: The BSPHCDA's Quest for Sustainable Autonomy

The Borno State Primary Health Care Development Agency (SPHCDA) was established in 2013 to improve the quality of primary healthcare delivery and create strategic public health policies for the state (BSPHCDA 2017). However, the agency lacked the necessary structures, tools, and processes for its operations and was heavily dependent on partners. Additionally, the state had not yet transferred full responsibility for all primary healthcare programs, health facilities, and staff to the agency. Despite the responsibility for RI and PHC outcomes being placed on the SPHCDA, health workers and resources were still under the jurisdiction of the Ministry of Health and the Ministry of Local Government and Emirates Affairs.

Developing the BoSPHCDA Standard Operational Guidelines

A preliminary assessment of the BoSPHCDA in 2018 revealed that the agency was understaffed at senior and technical levels. The agency staff also had a limited understanding of the PHCUOR policy, the agency mission/vision, or their roles and responsibilities within that framework. At the time, the agency had no predefined structure for monitoring and evaluation, providing feedback to staff members, nor did it have a policy for rewarding or motivating high-performing staff. Other challenges included inefficiency in coordinating structure, poor work planning and budgeting, and prevailing supply chain issues leading to the prevalent stockout of vaccines.

Committed to solving the identified issues, SCIDaR supported the Borno SPHCDA in 2018, to develop its operating guidelines. In a workshop, state directors with their deputies, senior members of the agency and representatives of state partners,reviewed the assessment findings and harmonized national and state health policy with the best practices and lessons learnt in the state, and other MoU states to propose a capacity-building plan and standard operational guidelines.

The operational guidelines produced defined the roles and responsibilities of every person within the Borno SPHCDA. It laid the framework for generating service demand, monitoring and evaluation as well as problem-solving. The operating guidelines also included problem-solving pathways to identify priority bottlenecks and collaborate with agency personnel to create innovative context-specific solutions to arising problems.

PHC staff transfer in Borno

Since the creation of the agency, achieving the PHCUOR goal of a single administration for all PHC staff has been delayed. During this time, the SPHCDA did not have the authority to oversee or manage health workers or ensure compliance with policies or SOP guidelines. The PHC staff transfer was instrumental in enabling the agency to effect its accountability framework and ensure congruence of oversight over managing services, personnel, and resources. In July 2022, after several years of advocacy and efforts, the SPHCDA and partners secured the government will that aided the transfer of primary healthcare workers from Level 6 and above from the state and local government authorities to the agency. The SPHCDA leveraged success stories and best practices from similar transitions in neighboring states like Adamawa and Yobe to provide guidance and recommendations to the state government during this process. While the transfer of PHC staff (Level 6 and above) has now been completed, the SPHCDA must focus on finalizing the organizational structures that will enable smooth oversight for PHC staff at the LGA and HFs. It is also important to note that the BoSPHCDA will require specific support to grow and refine the HR processes and capabilities needed.

"Management is about authority and responsibility, in time past we had responsibility in the agency but the authority for health personnel in the state and local government made it difficult to roll out accountability framework."

- Sanusi Usman, McKing Consultant, Borno State

Strengthening the Department of Human Resources to oversee PHC staff

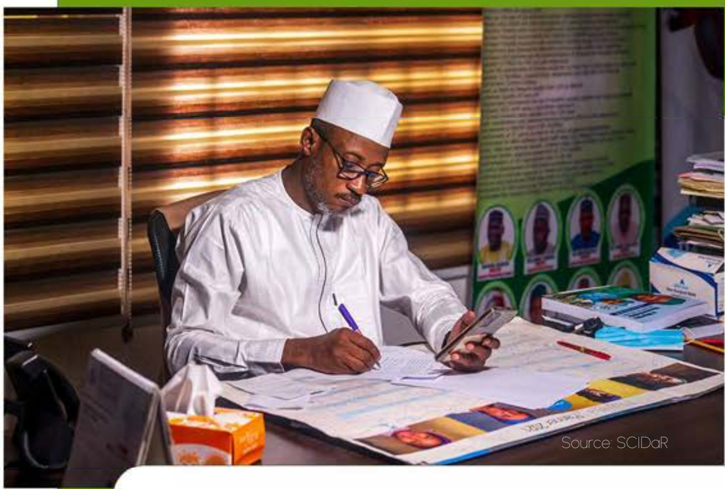
With the successful transfer of administrative responsibility for PHC staff to the SPHCDA/MBs comes a need for strong human resources management capabilities within each agency. As part of the institutional capacity building support SCIDaR provided, there were 4 key roles that were targeted - HR information management; staff recruitment and distribution; staff capacity building; and performance management.

Kano's SPCHCMB's journey towards establishing an efficient and effective HRH unit

Kano state is one of the larger MoU states. With a workforce of about 18,000 health workers distributed across 1,200 facilities in 44 LLGAs, some of them are hard to reach. Coordinating human resources in such a context was daunting. There was limited information regarding the qualifications and the location of several health workers. Given the relationship between health worker performance and health outcomes in a community, the Kano State Primary Health Care Management Board (SPHCMB) desired to achieve an efficient and equitable distribution of health workers as well as improved health worker productivity. The Board thus created the Human Resource for Health (HRH) unit with a mandate to manage and optimize the health workforce in the primary healthcare management board.

With the support of SCIDaR, CHAI, and HSDF, the SPHCMB transitioned from traditional paper-based record-keeping to an electronic HR information system (HRIS). The HRIS led to the profiling and biometric capture of staff members, which then served as the basis for a comprehensive workload analysis to identify human resource gaps and redundancies, while also enabling optimal deployment and redeployment of staff.

Despite some challenges such as poor internet availability, low familiarity with the IT system, and staff resistance, the rollout of the HRIS is ongoing and it is a positive step forward in enabling the Kano state SPHCMB to implement the minimum service packages among other policies.



Source: SCIDaR

"The establishment of human resources was a painstaking process. We envisage that for us to optimize our human resources for health, we need to move away from the traditional method of filing papers. We will ultimately get better performance from our staff and ensure that gaps are filled appropriately."
- Dr Tijani Hussaini, Executive Secretary, Kano SPHCMB

"Developing Human Resource units in other states will cause them to achieve a lot because we're trying to facilitate the policy like in Primary health care minimum service package"
- Aminu Abdul, HRH coordinator, Kano SPHCMB

Source: SCIDaR

Programmatic Capacity

By 2019, SCIDaR had done the work of revitalizing RI working groups across the states. However, due to the global pandemic, working group meetings were conducted at rates between 50-90% across the states by 2022. Adoption of KPIs and TORs led to improved processes and outcomes of the RI program in all states. Financial management indicators improved dramatically due to strengthened capacities of financial working groups. Vaccine stock-outs were reduced to less than 8% due to revitalization of the State Logistics Working Group (SLWG). All health facilities received direct funding and 96% of defaulters were effectively tracked in Kano and Yobe with help of PHC officers and community volunteers. A granular breakdown of state performance along program lines is detailed below.

As a result of SCIDaR's warp-around support, the MoU states have achieved significant systems and capacity development improvements…

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	
	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After
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

- SCIDaR support across these themes facilitated responsive immunization program management; ensured availability of vaccines at the last mile; guaranteed funds flow to end users and accountability for MoU funds; and triggered a paradigm shift in the PHC landscape
- These successes further positioned the states to transition systems strengthening efforts to broader PHC

SOURCE: Team analysis, NNRISP Program Dashboard/Trackers, National Nutrition Health Survey 2014, 2015 & 2018, NDHS 2008, 2013 and 2018; State capacity building dashboards

Figure 7: Impact of the capacity building program on the RI program in the 6 MoU states

Ownership of the Capacity building by the state investigating the institutionalization and success of the state Capacity building unit and training working groups in Bauchi State.

Source: SCIDaR

"The Training working group has helped with better coordination of training and has helped focus the impact of training on PHC programs. It has also reduced over-reliance on partner support."
- Dr Salisu Idris Isah Training Working Group Deputy Lead Bauchi SPHCDA

To ensure sustainability and ownership of capacity building intervention in the state, a government-led team named the Training Working Group was formed to oversee and manage all capacity-building processes. Led by the Director of Admin and Finance, the group includes leaders of all technical working groups in the state.

The working group meets monthly to evaluate progress and plan training needs based on the capacity gaps analysis at the LGA levels upward. Over 500 participants have been trained so far, with efforts to cascade competency to local levels for PHC programs. The group also works to adopt and adapt new innovations efficiently and quickly. The training working group has empowered program officers to perform their responsibilities independently, and in some cases, handle matters in the absence of incumbent officers.

Core personnel capacity building

At baseline, almost half (46%) of the program functions in the MoU states required support from partners/other parties to be conducted. This is partly due to limited understanding of the responsibilities by program officers, and lack of capacity to carry out their activities. Through capacity building several functions that required external prompting by partners to be carried out, are now being carried out independently. For example, across all the states; Managing RI data tools, managing cold store facilities and warehouse planning process, managing Vaccine level distribution across the state and coordinating REW microplanning are all functions now being conducted by the incumbent officers.

The figure below shows the evolution of incumbent staff capacity from the beginning of the NNRISP program in 2018 and August 2022 in their ability to carry out their functions independently.

RI MoU states capacity building tracker - Core Personel

- ○ – 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
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[6]	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)[7]	○	◕	○	●	◔	●	◔	◕	◔	◑	◔	◑
		Analyze RISS data and develop insights and recommendations	◕	◕	◑	◑	◔	●	◔	◕	◔	◔	○	○
		Provide periodic updates on RISS activities to all relevant stakeholders	◑	◕	○	◕	◔	●	◔	◕	◑	◕	○	◔
	State M&E officer[6]	Manage RI data tools to all points[8]	○	●	◔	◕	◔	●	◔	●	◑	●	◔	◕
		Manage LGA RI review meetings[9]	○	●	◔	◔	◔	●	◑	●	◔	○	◕	○
		Review state level DHIS data, correct entries and develop report[10]	◕	●	◕	◕	◔	●	◔	●	◑	○	◑	◕
		Supervise the conduct of DQS and develop report following conduct	◔	●	◔	◑	○	●	◔	●	◑	○	◕	◕
		Develop a micro analysis and reports of LQAS data and manage action-planning[10,11]	○	◕	○	●	○	●	○	◕	○	○	◔	◔
		Provide periodic updates on data management activities to all stakeholders	◑	●	◑	◕	◔	●	◑	●	●	○	◕	◕

0: Role carried out by M&E officer in Sokoto
1: Role carried out by STA in Bauchi and IM EOC in Yobe
2: Role carried out by SCCO in Yobe, Sokoto and Kaduna
3: Role carried out by SLO in Kano and Bauchi
4: Role carried out by ASLO in Bauchi baseline June '18
5: Role carried out by DVD managerin Yobe and Borno
6: Role carried out by Asst. State M&E Officer in Borno
7: Role carried out by State RI focal person in Yobe
8: Role carried out by SCCO in Kaduna and in Bauchi
9: Role carried out by RISS coordinator in Sokoto
10: Role carried out by DHIS officer in Bauchi and Yobe
11: Role carried out by SERICC secretariatin Kano

Figure 8: Impact of the capacity building program on core personnel capacity in the 6 MoU states

Impact of core personnel capacity building: a program officer's experience

Source: SCIDaR

I joined this agency in late 2016. My main responsibility here is shouldering the Service Delivery Working Group as a Chairperson. Before the capacity building, I noticed that there are lots of things that I can't do on my own. Aside (from) that, (for) some of the activities to be (done), (I needed to be) prompted before I conduct them. But because of the capacity building, I have seen how we are being rated. (And), I can see my capacity being built to the level that I couldn't have expected. I have mentees that I (now) help to build their capacity.

When the capacity building was incorporated, I (can) now plan, coordinate, and collate the whole micro plan of the state without either WHO consultants or LG facilitators to support us in getting that facility done at the facility level. I was able to coordinate from the state level down to the primary health care level. I was linked up with all other program officers so that I can push and obtain my deliverables from them. Thus, I can assure you that capacity building helped me to be on top of my activity.

With this capacity building, numerous ideas, and initiatives (of the way we do things) have evolved. As a (trainee turned) coach who desires betterment for his mentee, capacity building taught me how to exercise resilience, understanding, and self-control. As such, my major concern was to ensure that the individual did the right thing for the work not to suffer, for our state and country's –Nigeria– benefits.

I can assure you that all the program officers that are in this state and are shouldered with responsibilities can carry out their activities independently with no support from others. And I can assure you that this is traceable to capacity building, as we are on top of our activities. However, because of conflicting priorities and insecurity, some areas could not be reached, and there was a need to keep changing plans away from assigned deadlines

I can recommend that (capacity building to other states) and here's why. Assuredly, the difference between us and our colleagues from other states whenever we meet is clear, just because of this kind of opportunity. I can assure you that they are learning from us. We are equipped for whatever task allocated to us and this is because we have a vast knowledge and the ownership mentality (that) has been instituted in us, simply because of this capacity building. As such, all things being equal, we are aware that we are being held accountable for either right or wrong sail. Because of this, we are highly diligent and careful with our work and undertaking. We do not joke with it.

- Ali Danladi Gambo Chairperson, Service Delivery Working Group, Borno state.

Coach Story

Source: SCIDaR

I've been a community engagement focal person since 2017 till present. In the health facility, we are coaching the LGA focal person while the LGA focal person will cascade and coach the community focal person. I coach the 27 LGA focal people are being taught on how to implement our activities in their locations and how to effectively publicize to the community through advocacy and awareness. We also conduct virtual training to discuss and evaluate each LGA.

We coach them (trainees) via several meetings such as quarterly and monthly meetings that are held. Without capacity-building, I don't think achieving our goals will be possible. The RI coverage has really improved by doing all the activities based on the thematic area in our LGAs. Challenges faced include the series of activities we have that might lead to lapses. Another challenge is the security issue. However, we plan to resolve this by integrating several activities into one another for time management's sake.

- Babakura Ali, the Borno state community engagement focal person.

Transforming financial management in the MoU states through capacity building

A robust public financial management system is critical to ensure efficiency and transparency for primary health care programs. At the commencement of the RI MoUs, the financial management systems were very weak. requiring a comprehensive capacity building program to strengthen the systems and ensure the financial controls and tools deployed were institutionalized. This is especially significant in ensuring government/donor buy-in and participation in making available funds as part of their commitments as captured in the **Start-Up MoU Guide.**

With funding from BMGF and the Aliko Dangote Foundation, SCIDaR supported the SPHCDAs across the 6 MoU states supported the initiatives to strengthen the SPHCDA/MBs financial management systems **(Brightspot).** Individual accounts were created for all health facilities, SCIDaR and partners mapped out a direct disbursement pathway of funds from the MoU basket into the SPHCDA to avoid leakages. This necessitated electronic disbursement of funds to individual health facilities and local governments to replaced physical cash handover. fostering transparency in cash flow to all MoU partners. This process alongside other tools for retirement routinely monitored by the agency also ensured that funds got to the designated point of use directly affecting RI outcomes in the state.

The SPHCDA with support from SCIDaR created the RI finance working group. This working group coordinated monitored and evaluated the fiscal activities of the board. SCIDaR supported this oversight body with leadership and governance training as well as the conducting of meetings and execution of action points.

The SPHCDA engaged a third-party body to audit the RI accounts yearly and account for every released fund The external auditors were lso tasked with building up internal auditors to enable the government to be able to adequately drive up its check and balances system.

Lastly, SCIDaR conducted training workshops for all state and LGA accountants, directors of finance and auditors to discuss best practices in financial management and introduce participants to the rudiments of digital accounting; the use of accounting software and fiscal analysis through excel. SPHCDA partners provided on the job trainings for funds disbursement. retirement validation and budget performance analysis to eleven finance officers and seven auditors for a period of three months. Afterwards, a staff succession plan was developed to identify and prepare an appropriate backstop in the event of staff attrition.

"The sessions were helpful. They improved my skills on how to conduct funds disbursement*

- Chief Accountant, Kano

"Taking us out of our work environment for coaching sessions was really helpful. It helped prevent distraction and made us concentrate"

- Finance officer, Borno

""I used to require assistance when operating a computer. I can now independently operate my computer and perform required functions for my job"

- RI Accountant, Kaduna

"Displaying SOPs at my workstation consistently reminded me of timelines and this helped me carry out activities on time."

- Deputy Director, DAF, Yobe

Figure 7: Feedback from participants in the first training (Kano, Borno, Kaduna and Yobe)

Dividends of increasing the capacity of finance program officers

Throughout the period of the intervention, RI accountant (now PHC accountant), Chief accountant, internal auditors and in some instances, the Director of Finance and Accounts received technical assistance on a case by case basis. Through this initiative, the finance team members have developed competency across several domains of their responsibilities. At the onset of the Capacity Building program, only 33% of all finance functions were being conducted without support from partners. By the end however, Borno state outperformed other states with 8 out of 9 functions being performed independently. Monthly account reconciliation, and disbursement of funds are functions that are being carried out independently across all states. More details are presented in the figure below.

RI MoU states capacit building tracker - Core Personel 3/3

○ – 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 Born and Store keeper in Sokoto

Figure 9: Detailed change in the overall capacity of RI accountant, Internal Auditor and Chief Accountant in MoU states

Implementing the capacity building program has Increased trust of implementing partners in KSPCHMB

The capacity building program in Kaduna state has had a significant impact on the financial management processes of the state's Primary Health Care Management Board (SPHCMB). One of the officers who has benefited from the training is Joyce Tu, who serves as a PHC accountant. She is particularly impressed with the implementation of a validation process for retirements submitted by state, LGA and health facility officers. This process involves reaching out to community leaders and caregivers to confirm the execution of planned activities before releasing reimbursement for them. This has helped to ensure that outreaches are actually carried out and payments are made only for validated activities.

In addition to the validation process, Joyce is also pleased with the increased efficiency provided by using financial software, which allows her to easily monitor fiscal trends across the different thematic areas of the RI program. The improved financial management capabilities of the SPHCMB have also led to increased trust from partners, who are more comfortable providing funding for program implementation. Similar improvements have been seen in other MoU states, with partners like UNICEF increasing funding for the SPHCDA in Bauchi state due to their confidence in the financial management system. Overall, stakeholders across the MoU states hope that sustained training in the latest trends and best practices will be provided to keep the financial units effective.


Source: SCIDaR

"Honestly, in financial management in Kaduna state, we are much better... Because of our financial management that has been strengthened. we have partners that are giving us their funds, who know that we can take care of their funds very well"

- -Joyce Tu PHC Accountant, Kaduna State


Source: SCIDaR

"Staff are now able to develop their work plan, and make payment schedules independently without support, including the internal auditor"

- Husseini RI Accountant Borno SPHCDA

The capacity building program Introduced electronic payments for seamless payments to LGA and HFs

Alhaji Abba, the Director of Finance and Account at the Borno SPHCDA has led the Finance team since the inception of the Agency in 2013 and has been a principal beneficiary in the SCIDaR-led support for the Agency's finance team. He acknowledges the transition from manual transactions to electronic payments was a big win for the finance team. "We used to take our payment schedules to commercial banks for onward payment in various facilities, which caused us to have lots of challenges. A CBN policy at a time limiting disbursement to just 20 persons per day, resulted in week-long delays in the availability of funds to two hundred facilities. In addition, failed transactions were difficult to track. In response, we adopted Corporate I-Banking recommended by SCIDaR which allows us to make stressless payments from the comfort of our office and mostly guarantees payment within an hour. Payments are made into health facility-specific bank accounts without any intermediary making fund tracking comparatively more transparent.

Notwithstanding, one challenge across the states revolves around capacity loss due to staff attrition. Often, staff with improved capacity are transferred to other parastatals, or move altogether to other humanitarian organizations. To mitigate the capacity loss of this form, SCIDaR and the SPHCDA created an SOP to address capacity loss due to transfer, resignation, retirement, secondment and death. Where there are backstop officers, these officers assume the responsibilities of the outgoing officer. However, this is not always possible because of insufficient human resources in the state.

Challenges

Implementing the capacity-building program is not without its challenges. Lessons learnt in the course of this program centers around human resource management. ownership and training styles.

S/N	Theme	Challenges	Lessons learnt
1	Institutional Capacity Building	▪ Low political will to drive institutional reforms especially within the confines of civil service landscape ▪ Resource deficiencies with no capital investments for ensuring adequacy of workspace and tools etc.	▪ Consensus building and unwavering commitment from leadership should not merely be an end-product but a prerequisite for ICB interventions; the demand for CB needs to be evident, to actively drive and sustain the required systemic changes ▪ Performance scorecards (such as the PHCUOR) tend to spur action and healthy rivalry between states to achieve milestones; enabling systems with strong, transparent and consistent performance management mechanisms are critical ▪ Legislative and policy backing for all institutional changes is key to guaranteeing they take hold; a multipronged approach of advocacy, legislation and technical support is germane to success
2	Programmatic Capacity Building	▪ Slow and protracted change management processes to establish routines and change the way of doing business in the government systems ▪ Poor functionality of the TWGs and consequently inadequate coordination of capacity building activities in the state	▪ Embedded culturally-sensitive technical and management support delivered by professional consultants with influencing and negotiation skills helps to imbibe the cultural change. ▪ High level accountability mechanisms, leveraging agreements such as MoUs and VTC reviews helped to push the required programmatic systems to drive success
3	Personnel Capacity Building	▪ Poor state ownership and leadership for the capacity building intervention ▪ Capacity loss due to staff attrition, Capacity regression due to attitudinal challenges stemming from poor staff motivation and weak accountability systems. ▪ Inconsistent conduct of the coaching sessions due to accountability issues. Delays in identifying backstops due to insufficient human resources	▪ Creating a dedicated unit for capacity building of staff members is important for sustained and seamless planning and Implementation of training pathways. ▪ Incentivizing high performance and other measures should be taken to competitively retain staff members within government agencies to preserve capacity-building investments. Capacity retention and transition planning mechanisms are critical for ICB in government institutions, and should be built in from the start as a key institutional intervention ▪ Improved oversight by healthcare agencies should be highly encouraged to put the agency front and center on the impact of the capacity training program and prompt optimal resolution of bottlenecks.

Conclusion

It is essential to acknowledge that capacity-building programs are crucial enabling factors to drive the desired health outcomes, especially in sub-national contexts in LMICs. The success stories reported by program officers and the impact assessment conducted on the RI program in the six MoU states demonstrate that capacity building can enhance the coordination, planning, and implementation of health programs. This is because capacity building provides individuals with the skills and knowledge required to perform their roles efficiently, resulting in more effective health programs, and, in the long run, better program performance and outcomes.

Nevertheless, the implementation of capacity-building programs within government systems poses several challenges that require strategic and tactical levers to circumvent. These may include low political will to drive institutional reforms, resource constraints to optimize workspace and tools, behavioral issues linked to human motivation and institutional ownership and overall human resource management gaps such as weak accountability and ineffective transition planning.

To overcome these challenges, policymakers and stakeholders must adopt a comprehensive approach to capacity building. This involves non-partisan and high-level advocacy to secure political will for sustained demand and funding for capacity-building interventions. Leaders in government institutions must buy into the need and efficiency of CB endeavors and take ownership of onboarding succeeding state leadership of the need and impact of the same.

In addition, planners must mobilize funds, coordinate needs analyses, and prioritize the crucial materials and equipment needed to develop institutions' capacity in environments with constrained resources.

Furthermore, establishing, equipping, and tasking human resources for health units to develop, implement, and evaluate frameworks for staff motivation, transitioning, and accountability. This ensures the sustainability and ownership of capacity-building interventions in the state. This can be achieved by forming government-led teams, such as the Capacity Building Units established to plan, implement, and manage all capacity-building processes. By doing so, policymakers can ensure that interventions are sustained over time, and that individuals take ownership of their roles within institutions.

Conclusively, Government centered leadership is imperative to the success and sustainability of capacity building endeavors. Secondly, Interventions at the planning stage should accommodate motivational and accountability frameworks, as well as mitigation plans for capacity loss due to staff attrition. Special focus should be placed on mentoring and periodic evaluation of developed competencies.

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