Report of Third Quarter Supervisory/Data Verification Visits to Twenty Nine states and FCT.

MONITORING AND EVALUATION BRANCH,

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FEDERAL MINISTRY OF HEALTH

FEBRUARY, 2013

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1.0 Background

The National Malaria Control Programme (NMCP) carried out the second quarter supportive supervisory visits to the States of the federation and FCT from 11th to 22nd February 2013. During the visit, the programme assessed State and LGA levels programme administration and management of RBM activities; took stock of malaria commodities (SP, ACTs, RDTs and LLINs) and other supplies at the States' stores; assessed malaria records and data management; enlisted and strengthened the commitment of State and LGA policy makers to malaria control activities through advocacy; identified challenges/bottlenecks/gaps in programme implementation and proffered on-site solution where possible.

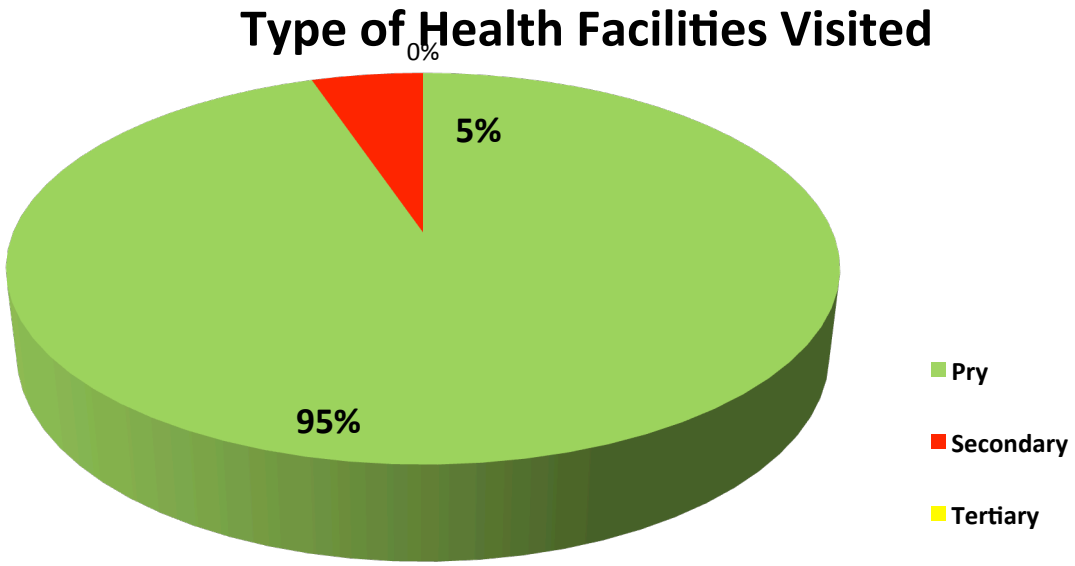
The States visited include Bayelsa, Ekiti, Ogun, Edo, Taraba, Kaduna, Enugu, Lagos, Nasarawa, Katsina, Borno, Abia, Adamawa, Cross river, Imo, Ebonyi, Borno, Yobe, Plateau, Benue, Kogi, Osun, Kebbi, Sokoto, Zamfara, Delta Kwara, Niger, FCT and Oyo. However, data from Abia State was not submitted as at the time this analysis was done.

2.0 Scope of Assignment

The national officers assigned to the States visited the State RBM secretariat, State medical stores, RBM secretariat in two LGAs and two Health Facilities in each LGAs. Supervisory checklists were completed at these levels capturing such information as store records, availability of treatment guidelines, commodity utilization and stock outs, morbidity and mortality data. Data were verified using data verification form at the LGA and Health Facility levels.

A total of one Hundred and Sixteen (116) Health Facilities were visited during the quarter under review. Of these 95% were Primary Health Care (PHC) Centers while 5% and 0% were secondary and tertiary hospitals respectively.

Fig.1 below shows the type of health facilities visited.



3.0 Key Findings from the Field Supervision

3.1 Programme Administration and Management

Contact details of key officers managing the programme at the State and LGA levels were collected and programme management was assessed based on availability of workplans, functional RBM coordinating committee and funding appropriated and released for malaria control by the State government and LGAs.
In all the States visited, about 100% States' work plans were reported available.

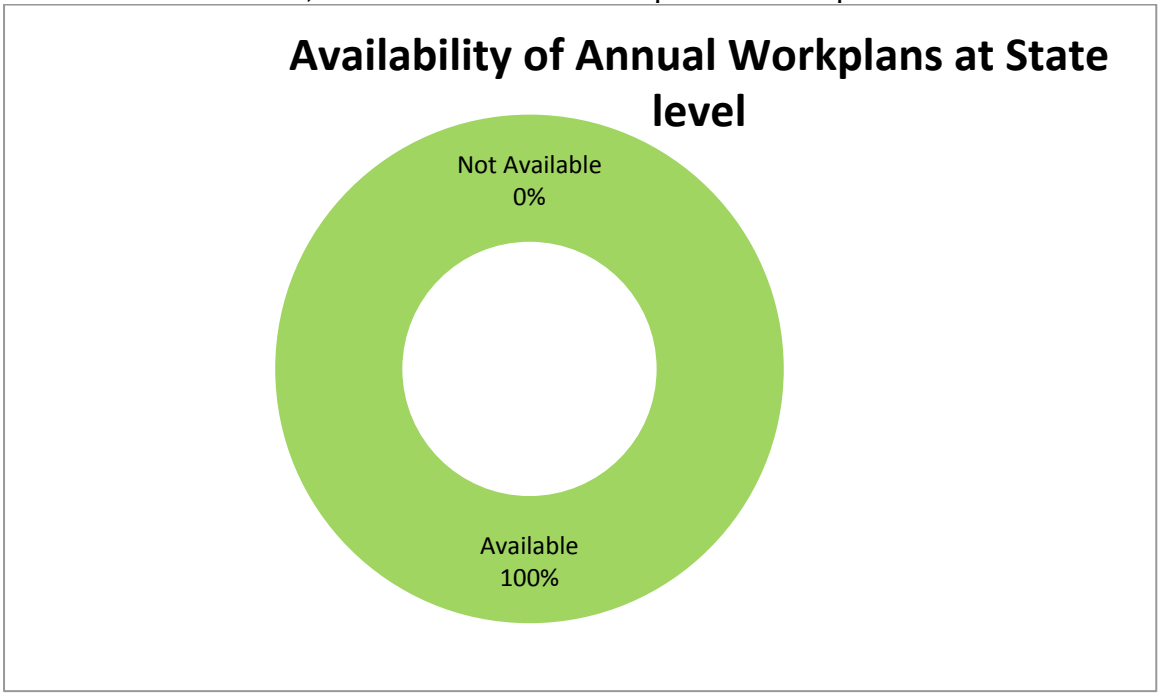
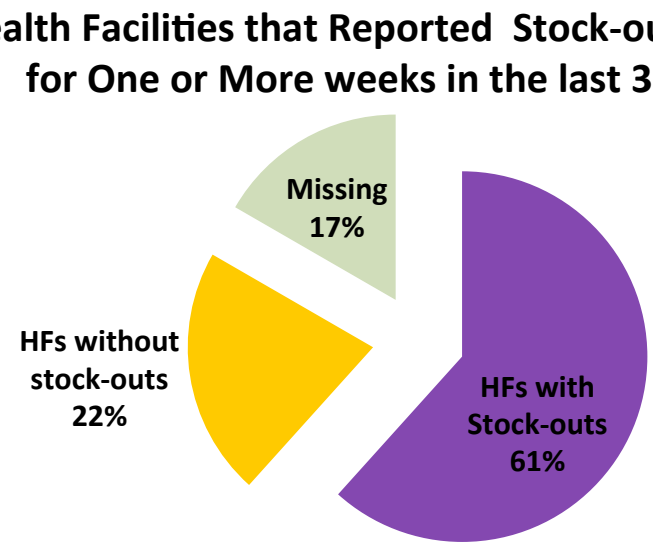


Fig. 2 shows the Availability of annual workplans at State level.

3.2 Reported Stock-outs of Anti-malarial medicines

In the quarter under review, 61% of the health facilities visited reported stock outs of ACTs for one week or more in the past 3 months and 22% reported with no stock-outs while 17% where reported missing.

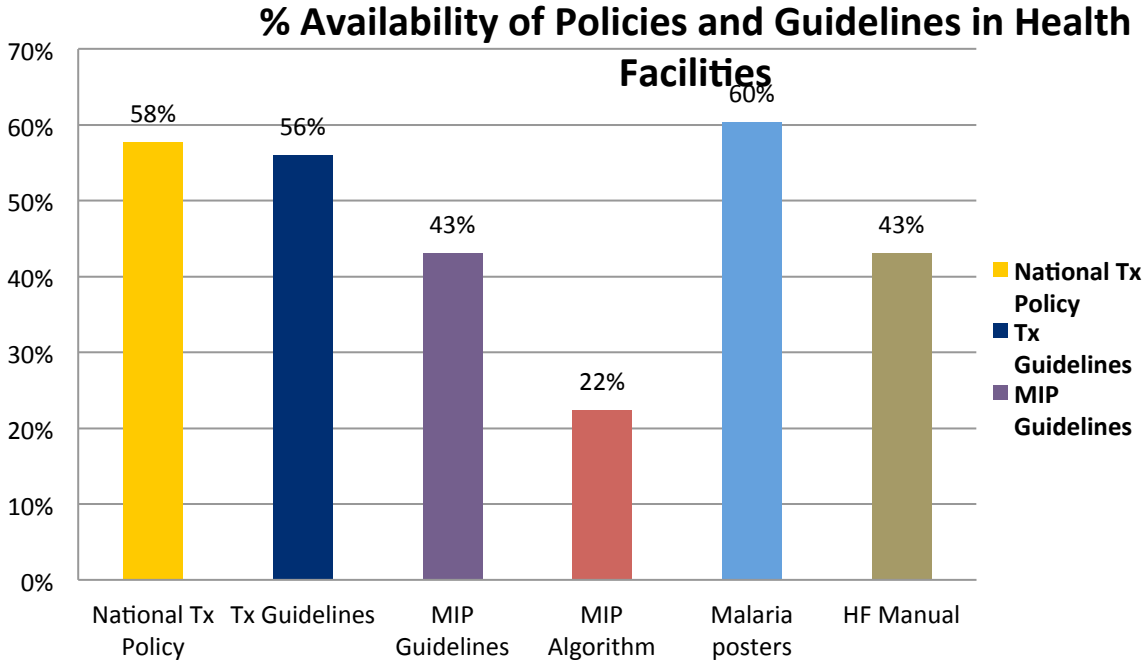
Figure. 3 Below shows percentage of Health Facilities that reported Stock-out of ACT/SP for one week or more in the last 3 months.



3.3 Availability of Malaria Treatment Policies, Guidelines and Other Materials at Health Facilities

Figure 6 below shows the distribution of Malaria documents in the health facilities visited during the second quarter supervisory visit to the States. The proportion of Health Facilities visited that had malaria documents are as follows: National Treatment Policy (58%), Treatment Guidelines (56%), Malaria in Pregnancy Algorithm (22%), Malaria in Pregnancy Guidelines (43%), Malaria Posters (60%) and Health Facility Manual (43%).

Figure 4 below shows % Availability of Policies and Guidelines in Health Facilities

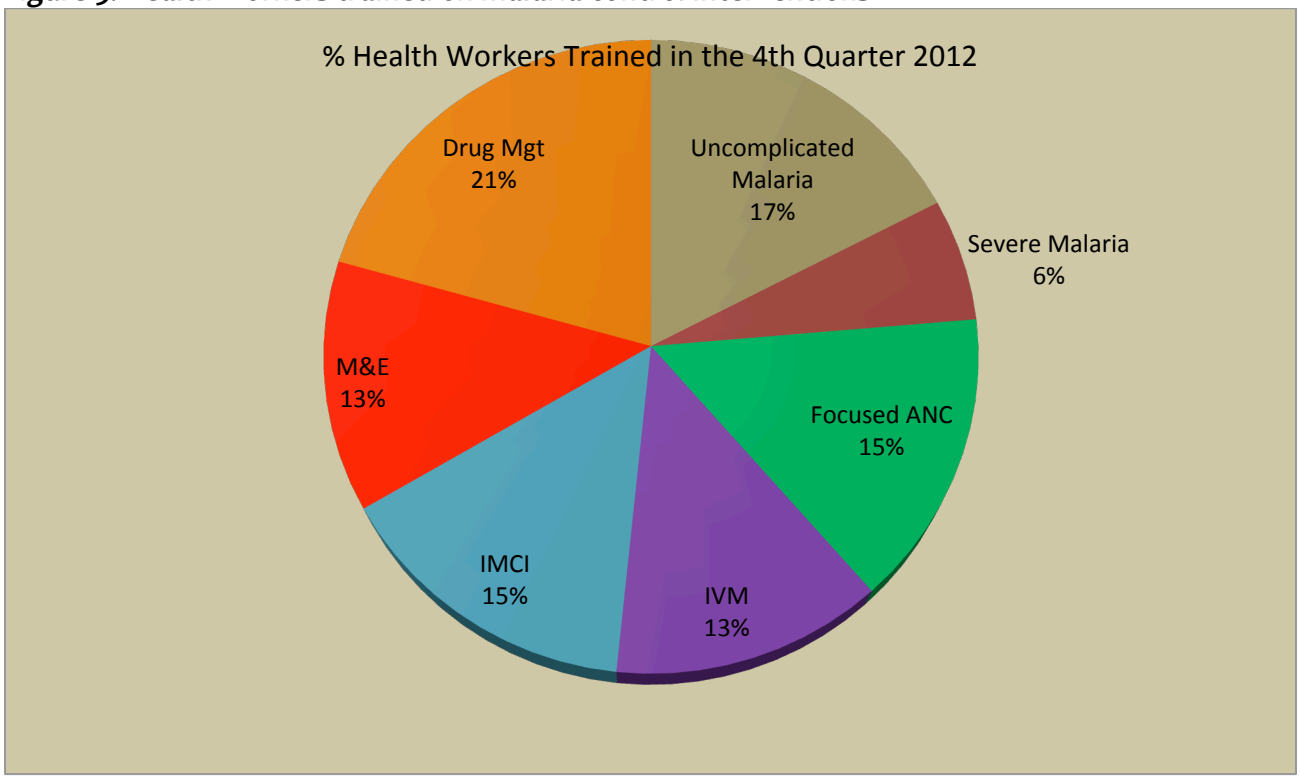


3.4 Training of Health Workers on Malaria Control Interventions

Out of One Hundred and four (116) health facilities visited, Ninety Nine percent (90%) had information on total number of staff, which sum to 1,144. Of these, less than half, 435

(45%) were reported to have received any training on malaria control interventions. A breakdown of the types of training received is shown in figure 5 below as: Uncomplicated Malaria (17%), Severe Malaria (6%), Focused ANC (15%), IVM (13%), IMCI (15%), M&E (13%), and Drug Management (21%).

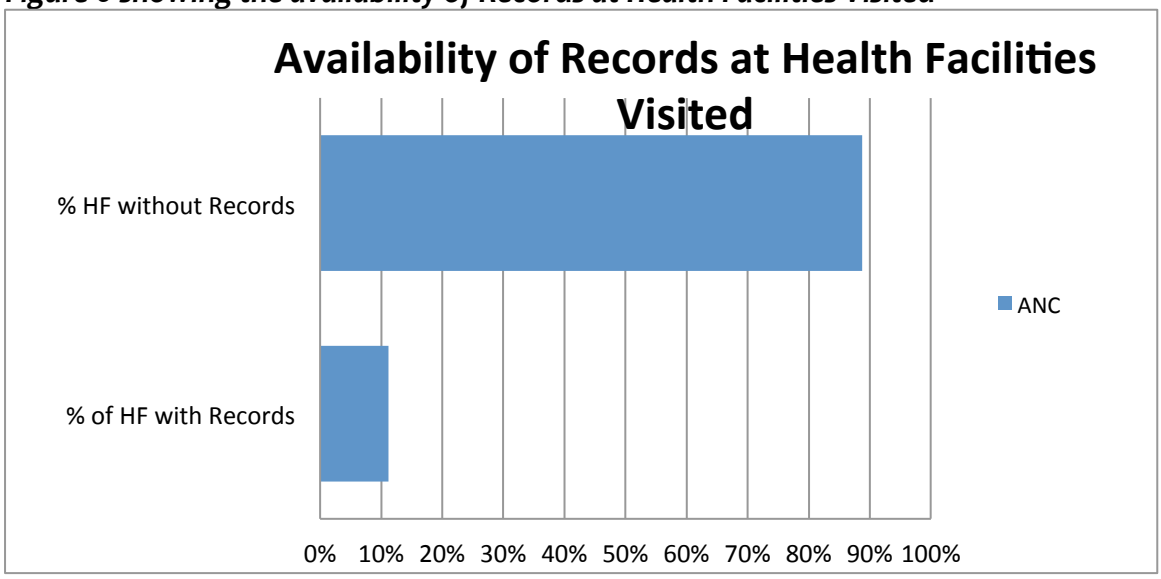
Figure 5: Health workers trained on malaria control interventions



3.5 Availability of Records at Health Facilities Visited

The visit to health facilities revealed that 89% of Health Facilities visited were without Records while only 11% of them have Records as shown in figure 6 below.

Figure 6 showing the availability of Records at Health Facilities Visited



3.6 Summary of Forth Quarter Data Quality Assessment

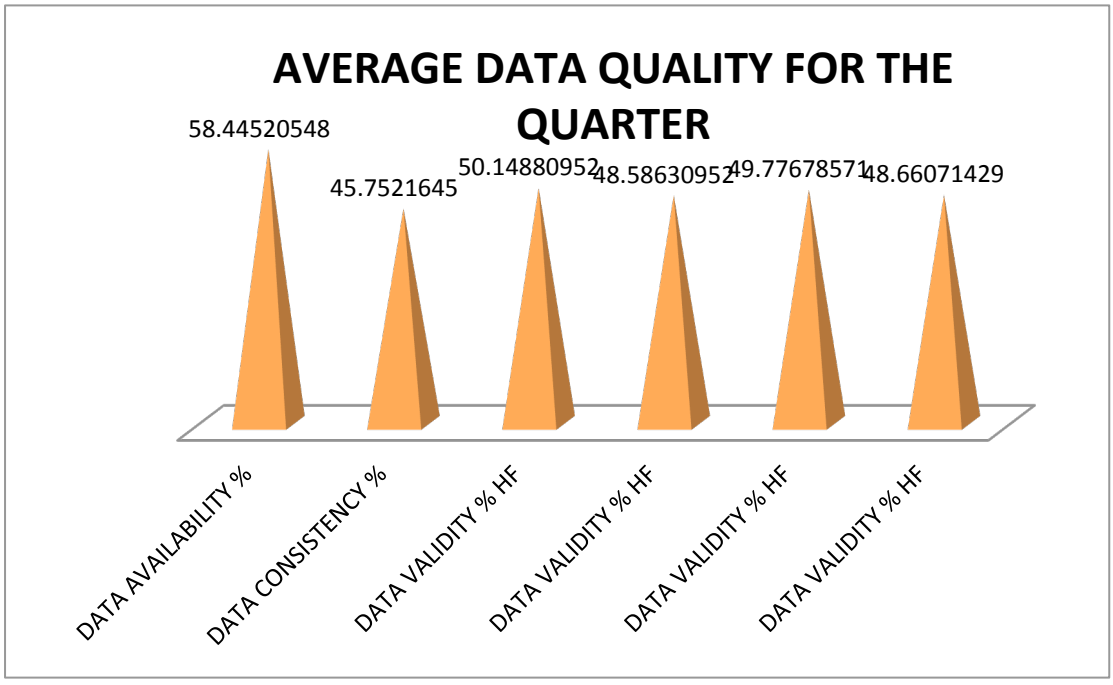
During the fourth quarter, the 30 Global fund supported States were visited for supportive supervisory visit/data verification but Data Quality Assessment (DQA) reports were gotten from 29 States with the exception of Abia State at the time of compiling this report though some reports were incompletely filled. The summary of findings is as shown in figure 7 below.

The percentage of data availability in the States, LGA's and Health facilities was approximately 58%, percentage data consistency was approximately 46% while percentage data validity in the selected facilities ranged between 49-50%.

The quality of data in the fourth quarter was poorer than preceeding quarters as the data availability, consistency and validity was slightly below average. Some of the challenges encountered during the DQA exercise include: Incessant strikes in public health facilities in Plateau State; increasing number of health facilities without data capturing tools in many of the States including Kebbi, Ondo, Osun amongst others; lack of commodities; insecurity in some States, inability to cite forms at some health facilities and available data capturing tools not being filled in some Health Facilities.

The newly harmonised NHMIS tools are currently being printed and distributed to the States and trainings have commenced in seven (7) GF supported States. Data quality is expected to improve with supply of commodities and data capturing tools as well as the completion of training in the 30 GF supported States.

Figure.7 shows the summary of data quality assessment



4.0 Summary of observations reported by national supervisors

- Most LGA focal persons had no plans of action for malaria control in their LGAs and Some States' programme managers could not make available their work plan for malaria control in their States.
- Poor record keeping for all interventions at the health facilities. Most records not available, where they are, they are not properly completed.
- The officers-in-charge of health facilities had sole access to information on commodities supplied and where they were unavailable; it was difficult to get such information.
- General stock out of ACTs and other medicines in most States.
- Implementation of activities not guided by work plan in some States, weak internal coordination.
- No evidence of LGA and State supervision by LGA focal persons and State Malaria Programme Managers in some states visited.
- Inadequate capacity of all categories of staff in some States.
- Non - availability of the newly updated data capturing tools and malaria control policy documents in most States.
- Lack of SOPs and Job Aids in health facilities.
- Poor funding of Programme implementation by state authority.
- Large disparities between the Reported and Actual data from the LGAs and health facilities
- RBM Partners' Forum is not functional and in some States non existence.

5.0 Challenges

Some challenges identified by national supervisors during the supervision include the following:

- Inadequate funds for supervision in some States and LGAs, which makes supervision to the HFs difficult.
- Poor collaboration between the Public and Private sectors on malaria control.
- Government support to some LGAs for malaria Control is low and in some cases non existence
- Inability to hold monthly coordination meetings regularly affect timely submission of monthly data.
- Lingering Health workers strike has made it difficult to retrieve data in the Health facilities.
- Insecurity surge especially in North East and North Western States has impeded the programme's activities.
- There was a recent massive transfer of health staff across the LGAs, which caused staff attrition.
- Lack of supervision of the health facilities and LGAs by responsible officers contributes to poor quality of data generated from these levels.
- Some states are still using the old M&E forms despite the trainings conducted. This results in missing data on key indicators that have now been added to the new tool.

- Community data still not available at the health facilities because where RMMs have been trained, they have not been empowered with medicines due to shortage of such in the facilities.

6.0 Lessons Learnt

- Availability of project vehicle donated by global Fund have enhanced and facilitated the success of the exercise.
- There is noticeable improvement in the data quality in the third quarter as the data availability, consistency and validity are well above average despite the challenges faced.
- Many States have not carried out step down training on the new data capturing tools and where the training had been done the forms were not properly completed especially at the health facilities.
- Data are not properly kept. State is ready to support the program if advocacy is done through the right channel.
- The state is currently undergoing a process of harmonizing mortality data in the state. LMIS training was recently conducted at the HF level but yet to start using the inventory card at the HF. Most of the HF only report on fever seen and treated.

7.0 Recommendations

- Advocacy should be intensified to state authorities to improve funding for malaria control and provide programme vehicles to enable the Programme Officers carry out supervision to the lower levels.
- There is an urgent need for the PSM branch to intervene in the general stock out of ACTs in the country.
- There is need for printing, distribution and training of the health workers responsible for data capturing at the health facility level on the harmonized NHMIS tools. This will raise the quality of data being generated at this level. A designated record officer should be appointed at the health facility level to be responsible for record keeping. However, State Ministries of Health should be encouraged to complement the efforts of Federal Ministry of Health by printing and distributing more of the tools.
- It is recommended that the Sub-recipients, who have direct oversight for the states under the R8 project be allowed to handle the disbursement of funds to the states for the monthly coordination meetings. This would give them some level of authority and ownership to ensure that the states comply with the requirements for supervision and data verification on a monthly basis.
- There is need for PSM Branch to develop a drug distribution template from the state central medical store to service delivery point especially in the global fund supported facilities. In an effort to hasten the distribution process that would eventually correct the delay in transfer of drugs to LGAs and Health facilities before expiration.

- There is need for urgent roll out of DHIS version 2.0 to Local government levels; this would enhance prompt transmission of data from the sub national level.
- Based on the findings from DQA, it shows a noticeable improvement with above average score in the data components assessed. It can be assumed and attributable to the efforts of States' M&E officers and hence, the need to continue and maintain the good work.