Rapid State and Health Facilities VAS Qualitative Assessment in Ekiti State, Nigeria. January 2022.

1. BRIEF SUMMARY OF METHODOLOGY

To expand the vitamin A program in Nigeria and identify specific needs prior to intervention, Helen Keller Intl conducted a rapid assessment at the state and health facility levels in Ekiti state. Key informants include the focal person in charge of the maternal newborn and child health week (MNCHW) at state level as well as thirty (30) officers-in-charge (1 per facility, 3 per LGA) at the health facility level across 10 LGAs. The assessment revealed the status of VAS delivery in the state with regards to the partner landscape, areas of support, funding gaps and coverages.

2. RESULTS

2.1 Number of health workers interviewed per HF: 1 health worker per health facility

2.2 Total number of health workers interviewed: 30

2.3 Sex of the health workers interviewed:
The distribution of respondents in the health facilities by sex shows a predominance of females.

Table 1: Distribution of health facility staff interviewed by gender

Male	Female
13.3%	86.7%

2.4 Cadres of health workers interviewed:

- MNCHW Focal Person 43.3%
- Volunteer 0%
- JCHEW 0%
- CHEWS 16.7%
- Registered Nurse 3.3%
- Mid-Wife 0%
- Chief Nursing Officer 0%
- Medical Doctor 0%
- Laboratory Technician/scientist 40.0%
- Others 0%

2.4. VAS Coverages 2018 to 2021 (administrative data):

2018 – 63.7%%
2019 – 61.5%%
2020 – Not done
2021 – 51.2% (Vit A was distributed during the micronutrients deficiency supplementation (MNDC) campaigns).

2.5. 2021 MNCHW

Was the MNCHW conducted in your facility in May/June and November / December of 2021?
All interviewees (100%) affirmed that there were no MNCHW in the state in both May/June and Nov/Dec of 2021.

2.6. Reasons why MNCHW was not Conducted in the health facilities:

Percentage of specific respondents' responses

Funding	93.3%
Poor advocacy	0.0%
Poor social mobilization	0.0%
Poor supervision	0.0%
Poor logistics	3.3%
Lack of capacity building	16.7%
Poor planning	33.3%
Inadequate evaluation	0.0%

Other reasons include that the state engaged in VAS distribution during the micronutrients deficiency supplementation (MNDC) campaigns, and this was due to lack of funding to carryout MNCHW in the state.

2.7. Government support at all levels and partner support for MNCHW in the states:

There was no support from the government at all levels.

2.8. Partner who supported MNCHW in the Ekiti State in 2021.

There was no partner support for MNCHW in 2021. Although Saving One Million Lives SOML supported micronutrient deficiency campaign (MNDC), this was not efficiently conducted and had a low VAS coverage (see below for more details). **Further probe to SOML activities revealed that the 2021 MNDC support was the last one for the state as the program has ended.**

2.9. Respondents' recommendations and challenges they highlighted:

2.9.1. What are the biggest challenges that hamper high VAS coverage among 6–59-month-old children during the MNCHW?

Funding	96.7%
Poor advocacy	13.3%
Poor social mobilization	53.3%
Poor supervision	10.0%
Poor logistics	30.0%
Lack of capacity building	46.7%
Poor planning	40.0%
Poor reporting	10.0%
Inadequate evaluation	10.0%

Other challenges are;

a. Staff should be kept in facilities for a longer time before transfer, this is because frequent transfer of skilled staff affects implementation, especially as training and re-training are not frequent and/or adequate.
b. Poor payment of health workers stipends.
c. Lack of opportunities for community volunteers to work.
d. Urgent need for the training of health workers involved in the delivery of MNCHW services.
e. Unavailability of the capsules. Many of the drugs are usually expired before they get to the facilities. Facilities are either given expired or near expired commodities.
f. Lack of funds is a major challenge of data reporting. Facilities have agreed on specific reporting timelines, but many officers find this difficult.
g. Inadequate staff strength.

2.9.2. What suggestions do you have for ensuring high coverage during the next MNCHW?

Sufficient advocacy to government and key stakeholders	70.0%
Availability and sufficiency of funding for campaigns	96.7%
Early and adequate planning.	36.7%
Adequate training of health personnel at all levels	56.7%
Adequate sensitization and social mobilization/SBCC	86.7%
Sufficient tools, commodities and Supplies (procurement and logistics).	50.0%
Adequate monitoring and evaluation of the campaign	43.3%

Other recommendations to ensure high coverages given by the respondent were;

a. Supervision should be decentralized at local government level.
b. Improved incentives.
c. Due to high population in the coverage area, there is need to engage community Volunteers in administration of VAS.
d. Good logistics.
e. Most of the workers use their personal funds to run the program, this should be addressed.
f. People like the program, but there is no support, partner support is highly solicited.
g. Increased community advocacy and community sensitization
h. More personnel should be engaged and involved.
i. Increased number of staffs in the health facility.
j. "Funding is the major thing, we are available, though we need more staff"

4. DISCUSSION

The facility and state assessments were conducted in Ekiti state from the 10th to 14th of January 2022. The aim of the assessment was to obtain a snapshot of the VAS landscape in the states with regards to delivery platforms, partners, areas of support, availability of funding and coverage figures**.** The survey collected data from 30 health workers in the state.

All facilities assessed reported that MNCHW was not conducted in 2021. As for reasons why MNCHW was not conducted, 93.3% reported that it was due to lack of funding, 3.3% poor logistics, 10% lack of capacity building and 33.3% poor reporting among others.

Furthermore, some respondents opined that MNCHW was not conducted in 2021 because the state implemented Micronutrient's deficiency campaigns (MNDC) in which vitamin A distribution was carried out. However, the effectiveness and reach of this campaign was poor due to the inadequate implementation strategies and challenges with the VAS supplies (expired or insufficient quantities and

near expiry commodities which eventually expired in the facilities before they could be distributed. Unfortunately, some health facility staff were seen distributing the expired vitamin A as routine supplementation during this assessment. Compounding this effect is the fact that, saving one million lives (SOML), who supported the MNDC program in September, is yet to pay the stipends to implementers adding to a sad history of non-payment during several past nutrition activities.

The assessment also revealed that the quality of implementation and trainings in the past has been marred by several factors, a key one is that OICs have to stand throughout to receive poorly conducted trainings as there were no funds to secure conducive venues and no technical support for facilitation. It was also clearly learnt, that most nutrition officers are new in the LGA and so there is a need for comprehensive and effective trainings.

Lastly, since MNCHW was not conducted, there was no facility level MNCHW records for the implementation and even the routine VAS was accompanied with poor documentation. Therefore, for effective MNCHW implementation in the state, beyond providing financial support, there is a need to provide robust technical support for effective MNCHW Implementation.

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Recommendations

The assessment has revealed gaps and challenges in implementing MNCHW in the state. The state does not have partner support for MNCHW and have very low routine supplementation figures.

Based on the findings from the assessment, it is recommended that Helen Keller should:

- Initiate an entry visit to the state to communicate assessment results and officially communicate Helen Keller's intentions and areas of support to the state.
- Initiate planning meetings, engagements, and harmonization/optimization of resources towards the first semester MNCHW intervention.
- Provide technical support for commodities quantification, requisition, internal redistribution, and logistics to ensure no stock out of VACs at the health facility during the MNCHW, optimize usage, and minimize or eliminate wastages/expiries.
- Support the implementation of a robust social mobilization intervention.
- Support the availability of data collection and management tools at all level
- Build the capacity of health teams on comprehensive data management using existing structures for system strengthening and sustainability.
- Support robust supervision, monitoring and evaluation, comprehensive / real-time monitoring of implementation using standard monitoring checklists and sampling/deploying independent monitors to ensure that every area is covered.
- Support advocacy to both government/non-government stakeholders for timely and adequate allocation and release of resources.
- Support microplanning meetings at the ward/health facility levels.
- Support cascaded trainings at the State, LGA, ward and facility levels for health workers, state, LGA and ward level officials.
- Support daily review meeting during implementation and post implementation review meetings
- Implement post event coverage surveys (PECS) after implementation in the State to validate administrative VAS coverages.
- Provide technical support for MNCHW implementation in the context of COVID-19.

5.2 Conclusion

This assessment gives a brief snapshot of the quality of the VAS campaign implementation across 30 primary health care facilities in Ekiti states. Findings from the assessment reveal that funding/support is unavailable in the state. Because of this, there are gaps in the procurement of commodities, community sensitization activities, training and deployment of health personnel, town announcers and outreach teams to hard-to-reach areas. Social mobilization activities are also either absent or inadequate.

The assessment also found poor documentation at the PHC level, which affects the quality and output of the campaign. Review of historical health facility and state admin coverage revealed low coverages, which can be attributed to the identified gaps. Given these challenges, there is the need to implement the recommended interventions to bridge the gaps.

Annex

1.0 Health Facilities (HF) Visited:

IDO – OSI Local Government

1. Basic Health Care Centre Ido ward 1
2. Comprehensive Health Centre Ido ward 2
3. Basic Health Centre Ifaki ward 2

Ekiti West Local Government

4. Basic Health Care Centre Oke-Oja, Aramoko
5. Erio Basic Health Centre
6. Iwaro Health centre, Iwaro ward 1

Ilejemeje Local Government

7. Comprehensive Health Centre, Iye. Ilefon WARD
8. Basic Health Centre, Ijesamodu. Ijesamodu WARD
9. Comprehensive Health Centre, Iludun. Iludun WARD

Emure Local Government

10. Comprehensive Health Centre, Oke-Emure WARD
11. Basic Health Centre, Ode-Emure WARD
12. Model Health Centre, Ariyasi WARD

Oye Local Government

13. Basic Health Centre, Ishan. Ile-Ile WARD
14. Comprehensive Health Centre, Oye WARD 1
15. Basic Health Centre Oye, Oye WARD 2

Okesa Local Government

1. CHC Okesa
2. BHC Idolofin Health Center
3. BHC Odo-Ado Health Center

Ikere Local Government

4. CHC Afao,
5. BHC Okesun
6. BHC Atiba

Ikole Local Government

7. Methodist CHC, Ikole
8. CHC, Aiyedun
9. BHC, Ijesha-Isu

Moba (Itun) Local Government

10. CHC, Otun 3
11. BHC, Otun 1
12. BHC, Osun

Ekiti East (Omuo) Local Government

13. CHC, Ilisa
14. BHC, Iludofin
15. BHC, Ijero