Rapid State and Health Facilities VAS Qualitative Assessment in Adamawa, Akwa Ibom, Katsina and Taraba States, Nigeria. September 2021

1. BRIEF SUMMARY OF METHODOLOGY

In order to expand the vitamin A program in Nigeria and identify the need in the new States, Helen Keller Intl conducted the qualitative assessment at the State Level and Health facility levels in 4 states: Akwa Ibom, Adamawa, Katsina and Taraba states. The aim was to assess the status of VAS delivery in the states in terms of the partner landscape, areas of support, funding gap and coverage.
Questions asked to the focal person in charge of the Maternal Newborn and Child health Week (MNCHW) at state level as well as the Officers-in-Charge at the health facility level.

2. RESULTS

2.0 Respondent's Background / Profile Questions

2.1 Number of Health Workers Interviewed per HF: 1 health worker per health facility

2.2 Total Number of Health Workers Interviewed: 120

2.3 Sex of the Health Workers Interviewed:
The distribution of respondents in the health facilities by sex shows a predominance of females in three states, except for Katsina State.

Table 1: Distribution of health facility staff interviewed by gender

State	Male	Female
Adamawa	**30%**	**70%**
Akwa Ibom	**6.7%**	**93.3%**
Katsina	83.3%	**16.7%**
Taraba	**53.3%**	**46.7%**

2.4 Cadres of health workers interviewed:

	Adamawa	Akwa Ibom	Katsina	Taraba
• State Nutrition Officer	**0%**	**0%**	**0%**	**0%**
• MNCHW Focal Person	**20%**	**73.3%**	**6.7%**	**3.3%**
• Volunteer	**0%**	**13.3%**	**0%**	**3.3%**
• JCHEW	**6.7%**	**0%**	**3.3%**	**3.3%**
• CHEWS	**90%**	**20%**	**86.7%**	**93.3%**

• Registered Nurse	0%	26.7%	10%	3.3%
• Mid-Wife	3.3%	6.7%	10%	0%
• Chief Nursing Officer	0%	6.7%	3.3%	0%
• Medical Doctor	0%	0%	0%	3.3%
• Laboratory Technician/scientist	3%	13.3%	0%	0%
• Others	46.7%	80%	30%	90%

3.0 General Performance of 2021 VAS

3.1 VAS Coverage January to June 2021.

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Comment
Adamawa	0%	0%	0%	0%	0%	0%	Zero coverage for VAS from January to June 2021, the state claimed supplementation was done in August 2021, but no record at the facility level to validate this.
Akwa Ibom	29.6%	19.6%	20.5%	21.5%	21.2%	16.7%	Poor coverage of VAS, children 6-11 months rather than 6-59 months were targeted and supplemented. No MNCHW was conducted.
Katsina	10.1%	7.4%	4.9%	9.4%	93.6%	11.9%	MNCHW was conducted in May 2021, but most reported coverages of assessed facilities were only available at the state level. Data was not available at source
Taraba	10.4%	11.2%	10.2%	10.2%	10.9	9.9%	Poor coverage of VAS. No MNCHW was conducted.

3.2 2020 MNCHW

Was the MNCHW conducted in your facility in May/June and November / December of 2020?

All interviewees affirmed that there were no MNCHW in 3 states, while 100% of respondents confirmed that MNCHWs were held in the first and second semester of the year 2020

Table 2: Was the MNCHW conducted in your facility in May/June and November / December of 2020

	Yes	no
Adamawa	0%	100%
Akwa Ibom	0%	100%
Katsina	100%	0%
Taraba	0%	100%

3.3 Reasons why MNCHW was not Conducted in the health facilities:

Percentage of respondents and their specific responses
NB – Since all Katsina respondents answered that MNCHW was conducted in 2020, this question was skipped for them.

	Adamawa	Akwa Ibom	Taraba
Funding	**70.0%**	**53.3%**	**86.7%**
Capacity building	**0.0%**	**3.3%**	**60.0%**
Poor advocacy	**0.0%**	**43.3%**	**63.3%**
Poor social mobilization	**20.0%**	**10.0%**	**60.0%**
Poor supervision	**0.0%**	**3.3%**	**43.3%**
Poor logistics	**3.3%**	**10.0%**	**63.3%**
Lack of capacity building	**10.0%**	**10.0%**	**36.7%**
Poor planning	**0.0%**	**30.0%**	**16.7%**
Inadequate evaluation	**0.0%**	**6.7%**	**6.7%**
COVID-19 / Inadequate supply of VAS and failure of govt. to show interest	**86.7%**	**100.0%**	**83.3%**

3.4 Reasons for not meeting the minimum coverage for VAS in 2020:

Percentage of respondents and their specific responses
NB – Since all Adamawa, Akwa Ibom and Taraba respondents answered that MNCHW was not conducted in 2020, this question was skipped for them.
For the respondent from Katsina State the main reasons for not meeting the minimum coverage is the lack of funding (10%) and the poor social mobilization (13%).

	Katsina
Funding	**10.0%**
capacity building	**3.0%**
poor advocacy	**0.0%**
poor social mobilization	**13.0%**
poor supervision	**0.0%**
poor logistics	**6.0%**
lack of capacity building	**0.0%**
poor planning	**3.0%**
poor reporting	**0.0%**
inadequate evaluation	**0.0%**
Others (Insecurity)	**3.0%**

3.5 Availability of any MNCHW records and Documentations

3.5.1 Are there records at this health facility to show that VAS was given to children 6 - 59 months during the May/June or November / December of 2020 MNCHW?

86,7% of interviewees note the existence of records at health facility
Percentage of respondents and their specific responses

	Katsina
Yes:	**86.7% of respondents**
No:	**13.3% of respondents**

3.5.2 To validate the above responses, data collectors asked to see the records. The following were the percentages of health facilities whose records sighted, disaggregated by specific records.

	Katsina
Tally sheets	**76.7%**
Health facility registers	**50.0%**
Tally sheet and register	**47.7%**
Incomplete records	**30.0%**
No records sighted	**23.3%**

NB – Since all Adamawa, Akwa Ibom and Taraba respondents answered that MNCHW was not conducted in 2020, this question was skipped for them.

- VAS administered during the MNCHW is usually recorded on the tally sheets and in the health facility registers. However, out of the 30 PHCs visited only 47.7% PHC had both documents, 30% had incomplete records and 23.3% had no document at all to show that VAS was given to children 6 - 59 months during the May/June or November / December of 2020 MNCHW.

4.0 Government support at all levels and partner support for MNCHW in the states

4.1 State government support

	Adamawa	Akwa Ibom	Katsina	Taraba
Yes	**6.7%**	**0.0%**	**83.3%**	**3.3%**
No	**0.0%**	**0.0%**	**16.7%**	**0.0%**
No Idea	**93.3%**	**100.0%**	**0.0%**	**96.7%**

4.2 Local government support

	Adamawa	Akwa Ibom	Katsina	Taraba
Yes	**3.3%**	**0.0%**	**63.3%**	**3.3%**
No	**3.3%**	**0.0%**	**36.7%**	**0.0%**
No Idea	**93.3%**	**100.0%**	**0.0%**	**96.7%**

4.3 Ward level government support

	Adamawa	Akwa Ibom	Katsina	Taraba
Yes	**0.0%**	**0.0%**	**56.7%**	**0.0%**
No	**6.7%**	**0.0%**	**43.3%**	**3.3%**
No Idea	**93.3%**	**100.0%**	**0.0%**	**96.7%**

4.4 Partner who supported MNCHW in the States

	Adamawa	Akwa Ibom	Katsina	Taraba
Helen Keller	**0.0%**	**0.0%**	**0.0%**	**0.0%**
SOML	**0.0%**	**0.0%**	**43.3%**	**0.0%**
UNICEF	**0.0%**	**0.0%**	**63.3%**	**0.0%**
NI	**0.0%**	**0.0%**	**23.3%**	**0.0%**
Vitamin Angels	**0.0%**	**0.0%**	**0.0%**	**0.0%**
MC	**0.0%**	**0.0%**	**3.3%**	**0.0%**

5.0 Respondents recommendations and challenges they highlighted:

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

	Adamawa	Akwa Ibom	Katsina	Taraba
Funding	**70.0%**	**96.7%**	**46.7%**	**100.0%**

Capacity building	**26.7%**	**46.6%**	**6.7%**	**80.0%**
Poor advocacy	**36.7%**	**70.0%**	**23.3%**	**86.0%**
Poor social mobilization	**40.0%**	**70.0%**	**70.0%**	**90.0%**
Poor supervision	**10.0%**	**33.3%**	**20.3%**	**63.3%**
Poor logistics	**63.3%**	**76.7%**	**73.3%**	**90.0%**
Lack of capacity building	**10.0%**	**66.7%**	**23.3%**	**63.3%**
Poor planning	**16.7%**	**50.0%**	**46.7%**	**40.0%**
Poor reporting	**3.3%**	**23.3%**	**6.7%**	**13.3%**
Inadequate evaluation	**33.3%**	**20.0%**	**36.7%**	**16.7%**
Inadequate supply of VAS / PPEs and failure of govt. to show interest / Insecurity	**13.3%**	**86.7%**	**23.3%**	**60.0**

5.2 Recommendations:

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

	Adamawa	**Akwa Ibom**	**Katsina**	**Taraba**
Sufficient advocacy to government and key stakeholders.	**80.0%**	**96.7%**	**36.7%**	**96.7%**
Availability and sufficiency of funding for campaign.	**86.7%**	**96.7%**	**63.3%**	**100.0%**
Early and adequate planning.	**70.0%**	**70.0%**	**60.0%**	**90.0%**
Adequate training of health personnel at all levels.	**80.0%**	**96.7%**	**36.7%**	**93.3%**
Adequate sensitization and social mobilization/SBCC.	**80.0%**	**83.3%**	**60.0%**	**96.7%**
Sufficient tools, commodities and Supplies (procurement and logistics).	**76.6%**	**100.0%**	**86.7%**	**96.7%**
Adequate monitoring and evaluation of the campaign.	**73.3%**	**73.3%**	**50.0%**	**80.0%**
Provision of vitamin A / Routine Supplementation of vitamin A should include children 6 to 59 months instead of 6 -11 months / engagement of more volunteers / community dialogue	**10.0%**	**70.0%**	**6.7%**	**26.7%**

3. DISCUSSION

The facility and state assessments were conducted in Adamawa, Akwa Ibom, Katsina and Taraba states from the 6 to 10 of September 2021. The aim of the assessment was to obtain a snapshot of the VAS landscape in the states in terms of delivery platforms, partners, areas of support, availability of funding and coverage figures**.** The survey collected data from 120 health workers in these 4 states.

6.1 Adamawa -

All facilities assessed reported that MNCHW was not conducted in 2020. Even though 83.3% reported that this was due to the COVID-19 pandemic, 86.7% reported that it was due to lack of funding, 63.3% cited poor advocacy/logistics and 60% poor social mobilization among others. Resultantly, there was no support for advocacy, resource mobilization, microplanning, planning meeting, state level training,

LGA level training, ward level training, health workers training, community sensitization, demand creation, community dialogues, town announcers training, SBCC materials printing, monitoring, supportive supervision, data collection and management, daily evening review meeting, data aggregation, data analysis, data reporting, post event coverage survey, post implementation review meeting and volunteers training in the state. This was due to the absence of government and partner support. As such the estimated supplementation coverage of VAS in the state was 0% in 2020.

Also, there was no facility level MNCHW records in 2020 and even the 2021 routine VAS (supported with SOML funds) was poor with accompanying poor documentation. Therefore, for effective MNCHW implementation in the state, beyond providing financial and technical support for implementation in the context of COVID-19, the state also need support as revealed by the assessment (see above).

6.2 Akwa Ibom –

Similarly, all facilities reported that MNCHW was not conducted in 2020. This was largely due to inadequate or absence of both government and partner support. Respondent also cited COVID-19 (100.0%), poor advocacy (43.3%), funding (53%) and poor planning (30%) among others as major reasons why MNCHW was not conducted in the state in 2020. Because MNCHW was not conducted, there was no support for advocacy, resource mobilization, Microplanning, planning meeting, state level training, LGA level training, ward level training, health workers training, community sensitization, demand creation, community dialogues, town announcers training, SBCC materials printing, monitoring, supportive supervision, data collection and management, daily evening review meeting, data aggregation, data analysis, data reporting, post event coverage survey, post implementation review meeting and volunteers training in 2020. The state therefore achieved an estimated VAS coverage of 0% in 2020.

In 2021, the routine VAS in the facilities also achieved poor coverages which was accompanied by poor reporting especially in the summary forms and DHIS2.

6.3 Katsina –

MNCHW was conducted in Katsina in 2020. The quality of the delivery of this intervention was however greatly marred by the following;

- 23.3% of the facilities assessed could not provide any record showing that implementation was done in the facilities, 30% provided incomplete records. Some facilities visited in Charanchi and Danmusa LGAs had coverages less than the 80% minimum threshold.
- 43.3% of facilities assessed could not provide records of 2020 first round coverage.
- 36.7% of facilities assessed could not provide records of 2020 second round coverage.
- Health workers reported that volunteers rather than OIC were engaged to deliver VAS in the facilities hence no facility records were available and as such reported treatment cannot be validated.
- 13% of respondents reported poor social mobilization, 10% reported poor funding, 13% poor commodity logistics and 3% insecurity, inadequate capacity building and poor planning as reasons coverages were not met in the May/June and November / December of 2020 MNCHW.
- 46.7% of health facilities assessed do not carry out routine VAS.
- 50% of health facilities who carry out routine VAS do not have records of the supplementation.
- General low routine VAS coverages across all facilities apart from May 2021.
- Only 10% reported support for Advocacy, State level training and post implementation review meeting for 2020 implementation.

Therefore, even though the state reported an admin VAS coverage of over 80%, this could not be validated in the field based on the above and the fact that follow up conversations at the state level

revealed very low VAS coverage in the hard to reach and security compromised LGAs which covers a large area of the state. However, there is support in the State from NI and UNICEF.

6.4 Taraba –

All facilities assessed in the state also reported that MNCHW was not conducted in 2020. As such, there was no support for advocacy, resource mobilization, Microplanning, planning meeting, state level training, LGA level training, ward level training, health workers training, community sensitization, demand creation, community dialogues, town announcers training, SBCC materials printing, monitoring, supportive supervision, data collection and management, daily evening review meeting, data aggregation, data analysis, data reporting, post event coverage survey, post implementation review meeting and volunteers training. Largely due to the absence of both government and partner support, but also due to COVID-19/inadequate supply of VAS capsule and lack of funding as opined by 86.7% and 70% of respondents respectively. Consequently, the state achieved 0% coverage on VAS in 2020.

Routine VAS is being carried out in the state in 2021, but this is marred by low supplementation coverage and poor reporting.

6.0 CONCLUSION AND RECOMMENDATIONS

7.1 General Recommendations

The assessment has revealed gaps and challenges in implementing MNCHW in the states. Adamawa, Akwa Ibom and Taraba do not have partner support for the MNCHW and also have very low routine supplementation figures. On the other hand, although Katsina implemented MNCHW and have a there are still lots of gaps in the interventions as revealed by the assessment.

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

- Share findings with NI and UNICEF so that they can fill the identified gaps in Katsina State while we direct our efforts to other states without partners.
- Initiate planning meetings and engagements towards the next MNCHW intervention in Adamawa, Katsina and Taraba states
- 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.
- Provide technical support for MNCHW implementation in the context of COVID-19.
- Support the implementation of a robust social mobilization intervention tailored to context and need.
- 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.

7.2 Specific Recommendations

7.2.1 Katsina -

Helen Keller to share details of identified gaps with NI and UNICEF to carry out effective MNCHW especially in the eight (8) LGAs (Sabuwa, Dandume, Batsari, Dan Musa, Safana, Jibia, Faskari, and Kankara) currently having security challenges.

7.2.2 Adamawa, Akwa Ibom and Taraba -

Helen Keller to lead the reintroduction and/or support for the following MNCHW activities in the states:

- Advocacy to key stakeholders for timely and adequate allocation and release of resources.
- Planning / microplanning meetings.
- Trainings at the State, LGA, ward and facility levels for health workers, state, LGA and ward level officials.
- Demand creation, community mobilization/sensitization using jingles, town announcers and SBCC materials.
- Comprehensive / real-time monitoring of implementation using standard monitoring checklists and sampling/deploying independent monitors to ensure that every area is covered.
- Support for the quantification and distribution of vitamin A and deworming commodities.
- Data collection, aggregation, and management.
- Daily evening review meeting.
- Post event coverage survey (PECS) after implementation in the State to validate administrative VAS coverages.
- Post implementation review meeting.
- Support for commodity availability, technical support for quantification and distribution of commodities based on targets to ensure effective coverage at all levels.
- Statewide training of the LGAs nutrition officers and M&Es on data management to ensure proper data aggregation and management.
- Deploying technical strategies from lessons learnt on implementation in security compromised LGAs to carry out effective MNCHW in the security challenged LGAs.

8.0 Conclusion

This assessment gives a brief snapshot of the quality of the VAS campaign implementation across 120 primary health care facilities in 4 states. Findings from the assessment reveal that funding is unavailable in three states, and in Katsina state where there is funding and partner support , 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 a gap of poor documentation at the PHC level, even though the health facility admin coverage was available at the State level. These factors were found to affect the quality of the campaign and ultimately VAS coverage as well.

Given these challenges, there is the need to implement the recommended interventions to bridge the gaps.

Annex

1.0 Health Facilities (HF) Visited:

1.1 Adamawa;

Yola North

1. PHCC Jambutu,
2. PHCC Nassarawo,
3. A.A. Namtari Yelwa PHCC

Girei

4. PHCC Vunoklang,
5. PHCC Sangere,
6. PHCC Girei B PHC Ungwan Yara,

Fofure

7. PHCC Fufore,
8. Ribadu PHCC,
9. PHCC Gurin PHC

Jada

10. PHCC Jada,
11. PHCC Jada 2,
12. PHCC Wurokuna

Song

13. PHCC Sigire,
14. PHCC Clinic A,
15. PHCC Morke

Yola South

16. PHCC Nana Asamau,
17. PHCC Lamido Aliyu
18. PHCC Wuro Hausa,

Demsa

19. Demsa PHCC,
20. Nasarawo PHCC
21. Dong PHCC,

Mayo Belwa

22. Mayo Belwa PHCC,
23. Mayo Farang PHCC
24. Jereng PHCC

Numan

25. Gweda Mallam PHCC,
26. Bamtato PHCC
27. Makera PHCC

Ganye

28. Yelwa PHCC,
29. Sangasumi PHCC
30. Sugu PHCC

1.2 Akwa Ibom;

Abak

1. Primary health centre (PHC) Operational Base, Poly Clinic Abak,
2. PHC Afaha Obong
3. PHC Mbidim,

Nsit Ibom

4. Primary Health Centre OP Base Afaha Offiong,
5. PHC Afaha Abia,
6. Model PHC, Mbiokporo 1

Ibesikpo Asutan

7. PHC Base Nung Udoe,
8. Health Center Ikot Akpa Edung
9. PHC Ikot Iko

Eket

10. Primary Health Centre (OP Base Ikot Ebok),
11. Health Post Ikot Usoekong
12. PHC Idua

Mkpat Enin

13. PHC OP Base, Mkpat Enin,
14. PHC Ikot Akpaden
15. PHC Ukam

Uyo

16. PHC Operational Base Uyo,
17. PHC Mbiabong Anyanya Uyo,
18. Primary Health Centre Aka Offot Uyo,

Etim Ekpo

19. Primary Health Centre operational Base Uruk Ata Ikot Ekpor,
20. Health Centre Obong Ntak,
21. Health Centre Atan Eka Uruk Ehiet

Etinan

22. PHC OP Base Etinan,
23. PHC Ndon Utim Etinan,
24. HC Ekpene Ukpa

Oruk Anam

25. PHC Ikot Ibratim Oruk Anam,
26. Health Centre Ekparakwa,
27. Health Post Ntak Ibesit Oruk Anam

Ikot Ekpene

28. PHC Operational Base Ikot Ekpene,
29. Health Centre Uruk Uso Ikot Ekpene,
30. Health Centre Ikot Uto

1.3 Katsina;

Katsina

1. CHC Kofar Kaura,
2. MCHC Kofar Marusa
3. MCHC Kofar Guga

Dutsinma

4. MPHC Shema,
5. PHC Karofi
6. PHC Bagaggadi,

Matazu

7. MCHC Karadua,
8. MPHC Sayaya
9. MPHC Kogari

Kankara

10. PHC Kankara,
11. PHC Yargoje
12. PHC Tudu,

Malumfashi

13. CHC Malumfashi,
14. PHC Karfi
15. PHC Dayi

Kurfi

16. Comprehensive Health Care Kurfi,
17. Modern Primary Health Care Barkiya
18. Modern Primary Health Care Birchi

Charanchi

19. Primary Health Care Radda,
20. Maternal Child Health Care Charanchi
21. Maternal Care Health,

Kankia

22. PHC Kankia (Galadima A Ward),
23. PHC Kafin –Soli (Kafin-Soli Ward),
24. CHC Rimaye (Rimaye Ward)

Danmusa

25. PHC Danmusa (Danmusa A Ward),
26. PHC Yantumaki (Yantumaki Ward),
27. PHC Teshar Kadanya (Kadanya Ward),

Batagarawa

28. Primary Health Care Batagarawa,
29. Comprehensive Health Care
30. Maternal and Child Health Care.

1.4 Taraba;

Gasso

1. PHCC Gunduma,
2. PHCC Tella
3. PHCC Mutun Buyi B.

Bali

4. PHCC Maihula,
5. PHCC Bali B,
6. PHCC Gajabu

Sardauna

7. PHCC Gambu B,
8. PHCC Nguroje,
9. PHC Titon

Ussa

10. PHCC Rufi 1,
11. PHCC Costine,
12. PHCC sabon Gida

Donga

13. PHCC Kumbo,
14. PHCC Nyita,
15. PHCC Akate

Jalingo

16. Township PHCC,
17. Kona PHCC
18. Mafindi PHCC

Ardo Kola

19. Sunkani Primary Health Care Centre,
20. Iware Primary Health Care Centre,
21. Kofai Primary Health Care Centre

Kurmi

22. Ba Issa PHC, Cottage Hospital,
23. First Referral, Sabon Gida
24. Tukura Primary Health Care Center,

Takum

25. Gen. TY Danjuma PHC Centre,
26. Rogo Primary Health Care Center,
27. Mbakpa Primary Health Care Center

Wukari

28. Wukari Town PHCC
29. Pwadzu PHCC
30. Wapan Nghaku PHCC