

SITUATIONAL ASSESSMENT OF MONITORING &
EVALUATION SYSTEMS OF STATE HEALTH SECTOR:
FOCUS ON MINISTRIES OF HEALTH SUPPORTED BY
PATHS2 IN NIGERIA

REPORT OF ASSESSMENT OF JIGAWA STATE

25 – 29 JULY 2010



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Assessment Team

Consultant	Company and position	Official Contact	Team Role
Dr. Osahon Ogbeiwi	FACTfinders CSL, UK Director & Executive Consultant	Tel: +44 7999444545 Email: director@factfinderscsl.com osahonjio@yahoo.co.uk Web: www.factfinderscsl.com	Lead Consultant

TABLE OF CONTENTS

Abbreviations and Glossary.....	4
Executive Summary.....	5
1. Introduction.....	7
1.1 Background of Jigawa State	7
1.2 Jigawa State Health Sector	7
1.3 Jigawa State M&E System.....	8
1.4 Background of the Assessment	8
2. Methodology	9
2.1 Assessment Methods.....	9
2.2 Target Population and Study Areas	9
2.3 Sampling/Selection of Key Informants	9
2.4 Components of M&E System Assessed	10
2.5 Assessment Design.....	11
2.6 Assessment Team.....	12
2.7 Data Storage and Analysis.....	12
3. Findings and Analysis.....	13
3.1 Number of Respondents and Analysis.....	13
3.2 Strengths and Weaknesses of the State M&E Plan	13
3.3 Data Management Capabilities of SMOH.....	15
3.4 Strengths and Weaknesses of Program Data Collection and Reporting Systems.....	18
3.5 Functional Linkage between the State M&E System and HMIS.....	20
3.6 Collaboration between Programmes M&E and State M&E System/HMIS	22
3.7 Stakeholder Assessment of the Current Status of the M&E System.....	23
4. Discussion – The Implications of Findings.....	25
4.1 Limitations	25
4.2 Strengths and Weaknesses of the Current M&E Framework in the State	25
4.3 Data Management Capabilities of the SMOH.....	26
4.4 Strengths and Weaknesses of Data Collection and Reporting Systems of Programme Areas.....	26
4.5 Linkages between M&E, HMIS and Programmes	27
4.6 Stakeholders’ Assessment of Strengths and Weaknesses of the M&E Framework..	27
5. Conclusions	27
5.1 General Conclusions	27
5.2 Summary of Key Strengths and Weaknesses in the Current M&E Framework	28
6. Recommendations.....	29
6.1 Develop an M&E System	29
6.2 Build Human Resource Capacity for M&E	30
6.3 Improve Government Funding for M&E	31
6.4 Improve Quality of Reporting	31
6.5 Improve Data Feedback.....	31
Appendix 1: List of Key Informants.....	32

ABBREVIATIONS AND GLOSSARY

DFID	- Department for International Development
DD	- Deputy Director
DPPRS	- Director Policy, Planning, Resource Mobilisation and Statistics
DPRM&E	- Director, Planning, Research, Monitoring and Evaluation
DSNO	- Disease Surveillance and Notification Officer
Epid	- Epidemiology
FMOH	- Federal Ministry of Health
HDCC	- Health Data Consultative Committee
HIV/AIDS	- Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HMIS	- Health Management Information System
HSB	- Health System Board
HSP	- Health Services Programme
IDSR	- Integrated Disease Surveillance and Response
ISS	- Integrated Supportive Supervision
KM	- Knowledge Management
LGA	- Local Government Area
M&E	- Monitoring and Evaluation
MESST	- Monitoring and Evaluation System Strengthening Tool
NYSC	- National Youth Service Corps
PATHS2	- Partnership for Transforming Health Systems Phase II
PHC	- Primary Health Care
PM	- Programme Manager
PRRINN	- Partnership for Reviving Routine Immunization in Northern Nigeria
SMOH	- State Ministry of Health
SPO	- State Programme Officer
SSHDP	- State Strategic Health Development Plan
STL	- State Team Leader
WHO	- World Health Organization

EXECUTIVE SUMMARY

Introduction

This assessment was conducted in August 2010 to analyse the current situation of the M&E system of the Jigawa state health sector and the operational framework of M&E activities. The assessment identified the strengths, weaknesses and gaps in the M&E system as well as recommendations for strengthening the system. Its findings will serve as baseline information for the future development and strengthening of the M&E system as part of the Partnership for Transforming Health Systems Phase II (PATHS2) technical assistance for health system strengthening in Jigawa. The assessment was carried out by a team of two M&E consultants who adapted and used the M&E System Strengthening Tool (MESST) of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Structured interviews of 12 state health sector M&E stakeholders were carried out, focusing on five components, including: the existing plan or framework for M&E in the State Ministry of Health (SMOH); the data management capabilities of the SMOH and the data collection and reporting systems of selected SMOH health programmes; linkages between M&E, HMIS and the SMOH health programmes; and the stakeholders' perspectives of the strengths and weaknesses of the current M&E framework and their recommendations for its strengthening. The latter two components were assessed using a qualitative checklist designed by the assessment team.

Findings

Strengths and Weaknesses of the State M&E Plan or Framework for M&E

Jigawa State has a State Strategic Health Development Plan (SSHDP) with a results framework of goals, objectives and output targets, but it has no M&E policy, M&E plan, M&E unit or a designated state M&E officer. There is therefore no formal state M&E system and so any current implementation of M&E activities lack strategic and structural bases. Presently the state uses data management frameworks related to the national health management information system (HMIS), national integrated disease surveillance and response (IDSR) and different programmatic information systems for the data collection, capture and monitoring. However, there is a process underway to develop an M&E plan and the state has already officially requested PATHS2 technical assistance to facilitate it. This demonstrates government interest in developing a functional state-level M&E system. However, the government budget for M&E activities is insufficient and the SMOH lacks a matching political commitment and support to sustain the practice of health sector M&E.

Data Management Capabilities of the SMOH

The SMOH has a unit responsible for HMIS and a unit for IDSR, but there is no state-level unit responsible for oversight of M&E other than designated M&E officers of individual programmes. There is a basic capacity for and experience in data collection and analysis, which indicates some capacity for data processing of reports received from these lower levels. However, the respondents report that the SMOH does not produce regular and quality technical M&E reports and does not give systematic feedback on programme performance. This suggests a low level of capacity to aggregate and process the data into information that is meaningful for strategic or operational decision making. The SMOH has some capacity to review, verify and assure the quality of reports received from the LGA level, and thus is able to identify lapses in quality of these reports. However, it lacks procedures for addressing the inconsistencies found in the reports verified, and therefore is unable to provide quality-assured data for M&E purposes. While there are monthly data review meetings with local government area (LGA) M&E officers to allow for feedback on the submitted reports, but their usefulness for improving the quality of reported data is limited. Some training of relevant staff in data management processes has been done and three of the 15 persons involved in the state data management system have had basic training in M&E, but these are very senior staff, two at director level; that is, there is M&E capacity only at the apex of the state data management Organogram. Based on the responses of key informants, the SMOH has a low overall average rating score of 1.9 out of a maximum of 4.0 points for its current data management capabilities.

Strengths and Weaknesses of Data Collection and Reporting Systems of Programmes

The average rating score of the data collection and reporting systems of selected programme areas suggests that the SMOH has a fair capacity at programme level to produce valid and useable data.

Functional Data Flow Linkages

Individual programmes run mainly their own data collection and reporting systems parallel to one another and non-harmonised with the mainstream state HMIS data system. As a result of an inadequate workforce for M&E (and other health interventions) in Jigawa State, the same staff serve multiple official purposes and programmes, which results in a burdensome workload of data collection and reporting. The Health Data Consultative Committee (HDCC), which should be a vital mechanism for coordination, harmonisation and information sharing, is functionally moribund.

Stakeholders' Assessments and Recommendations

In spite of its many limitations, the available data management framework has some strengths. Stakeholders see the resources available in the form of staff, partner support, a government control system and the existing HMIS structure as opportunities for effective planning and sustainability of the desired state M&E system. The main weaknesses are the parallel, non-harmonised information systems, inadequate human resource capacity and failure to process the data that are generated. In general, they find no formal and functional framework for M&E and so their recommendations mainly rest on the need for a systematic development of a state-level M&E.

Key Recommendations

The SMOH should:

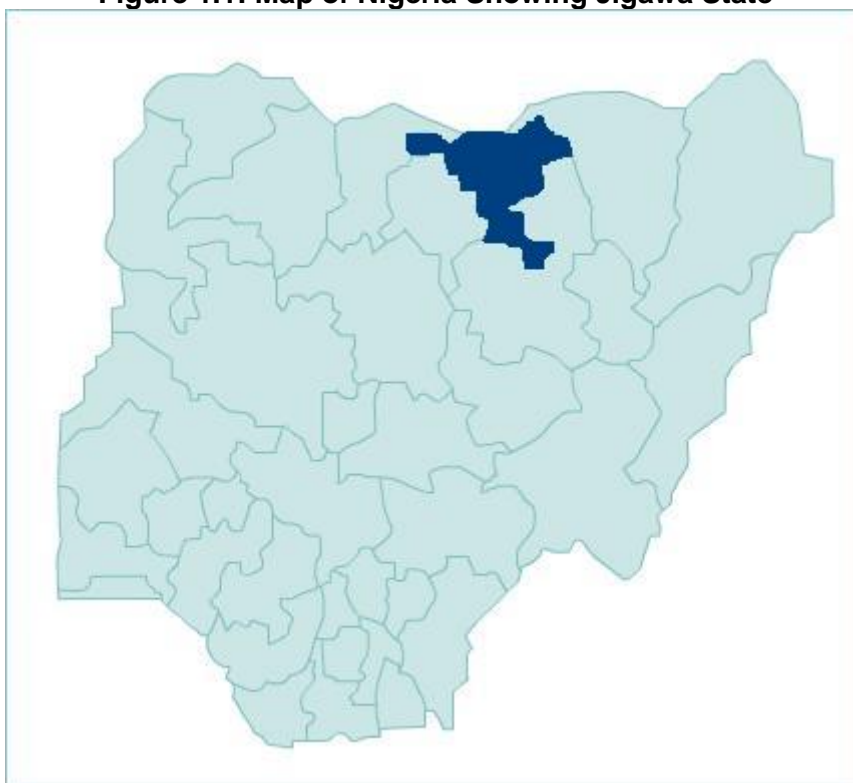
- Establish a central M&E unit with a team of capable staff led by an officially designated and empowered state M&E officer to oversee monitoring and evaluating the performance, progress and achievements of SMOH health interventions, coordinate departmental and programme-level M&E activities and harmonise the parallel data management processes and tools of different stakeholders in the state health sector.
- Develop a detailed M&E plan that will provide a result-oriented state framework for implementation of M&E activities based on the existing Logical Framework of goals, objectives, indicators and targets in the SSHDP.
- Outline in the M&E plan the policy, rationale, goals, objectives, outputs, strategies, approaches, activities, structure, regularity, resources and budget for implementation of progress monitoring and achievement evaluation of all major health interventions in the state.
- Organise a stakeholder workshop to discuss the various issues surrounding the implementation of M&E plan in the state health sector, setting up of a state M&E unit to centrally coordinate and harmonise the information systems at the state and programme levels.
- Reactivate the Health Data Consultative Committee as the meeting point of state, programmes and partners to encourage information sharing and collaboration in the execution of M&E activities in the state health sector.
- Commit government political and financial support to the state M&E system through provision of adequate budget and funding to the operations of the state M&E unit and the implementation of M&E activities in the state.

1. INTRODUCTION

1.1 Background of Jigawa State

Jigawa State is one of the seven states in the northwest geo-political zone of Nigeria. It was carved out of Kano State, which borders it to the northwest. The other neighbouring states include, Kaduna, Bauchi and Yobe. Jigawa also shares an international border with the Niger Republic (see Figure 1.1). The state has a population of about 3.6 million people living in 27 local government areas (LGAs). It is mainly rural and ranks among the states in Nigeria with the poorest and worst health and socio-economic health indicators. According to the contributors to Wikipedia, “The overall literacy rate was about 37% in 2002 (22 percent for women and 51 percent for men). School enrolment ratio is fairly high with very good improvements in the last few years, even though there is still clear disparity between boys and girls.” The main ethnic group in the state is the Hausa Fulani. Their major occupation is farming, with up to 80% of the population living on subsistence farming and animal husbandry.¹

Figure 1.1: Map of Nigeria Showing Jigawa State



Source: <http://www.fusioncharts.com/maps/GalleryMap.asp?mapName=Nigeria>

1.2 Jigawa State Health Sector

The State Ministry of Health (SMOH), under the headship of the Honourable Commissioner for Health, is responsible for ensuring that appropriate health care services and interventions are available to meet the health needs of the people of Jigawa State through policy development, strategic planning and coordination of health care services. Its core role is policy making and coordinating state-level secondary/tertiary care services and management of the services at the gunduma (district) and LGA levels through the Gunduma Health System Board (HSB). Delivery of health care services is structured to be compatible with the State Strategic Health Development Plan (SSHDP), which is aligned with the National Strategic Health Development Plan. The state

¹ http://en.wikipedia.org/wiki/Jigawa_State. Accessed 11 Oct. 2010.

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

government collaborates with a number of development partners for efficient delivery of health services to the population in Jigawa State, especially international agencies such as the U.K. Department for international Development (DFID), United Nations Development Program (UNDP), UNICEF, World Bank, International Fund for Agricultural Development (IFAD), and African Development Foundation (ADF).²

1.3 Jigawa State M&E System

The SMOH has a draft SSHDP with a results framework of goals, objectives, outputs and indicators that is useable for M&E purposes, but there is no M&E plan, budget or unit specifically assigned to monitoring and evaluation (M&E) of health activities in the state health sector (Table 1.1). Responsibility for state-level M&E in health is presently designated to staff at the Gunduma HSB, specifically to the director of the Department of Planning, Research and M&E (DPRM&E) and his team of deputy directors, epidemiologist and state disease surveillance and notification officers (DSNOs); the M&E coordinators at the gunduma council level; and the M&E officers at the LGA level. (Officers assigned to M&E activities at all levels are actually DSNOs.) Besides monitoring the trend of notifiable and epidemic diseases in the state using the National IDSR system, the main role of the DSNOs at all levels is in the handling of the data related to National Health Management Information System (HMIS) and the information systems of individual health programmes in the state. The SMOH has a HMIS unit within the Department of Policy, Planning, Resource Mobilisation and Statistics (DPPRS), which is responsible for collecting and analysing the HMIS data received from the Gunduma HSB using the applicable NHMIS software or database.

Table 1.1: Status of the State M&E System

SSHDP	M&E Framework in SSHDP	State M&E Policy	State M&E Plan	State M&E Budget	State M&E Unit	M&E	M&E Activities
Draft. Excel spreadsheet copy available	No M&E framework. SSHDP has only a results framework	NIL	NIL	NIL	NIL.	Role officially assigned to the Gunduma HSB	Collection of IDSR and HMIS data from peripheral facilities

1.4 Background of the Assessment

1.4.1 Rationale

PATHS2 is extending its support for strengthening of the health systems of state-level programmes to include technical assistance for improvement of M&E systems at the federal and state levels of Nigeria's health sector. There is therefore a need for a situational assessment and needs analysis of the M&E system in the health sector in Jigawa State, one of the five states supported by PATHS2, in order to provide a basis for the development of a functional and effective M&E system for the SMOH, along with a strengthened M&E capacity.

1.4.2 Purpose

The overall purpose of the assessment is to determine the current status of the M&E system of the state health sector, with a focus on the Jigawa SMOH, to identify the strengths, weaknesses and gaps. The assessment will provide recommendations for improving the M&E system in the state. The recommendations will be used to develop an action plan for M&E system strengthening, in later consultation with stakeholders. The assessment will use an adapted version of the M&E

² http://en.wikipedia.org/wiki/Jigawa_State. Accessed 11 Oct 2010.

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

System Strengthening Tool (MESST) of the Global Fund to Fight AIDS, Tuberculosis and Malaria, with the framework customized to fit the Nigerian context and to cover the state health system.

1.4.3 Scope

The scope of this assessment covers the following areas.

1. Strengths and weaknesses of the state M&E plan (if there is one) and how it relates to the SSHDP and its results framework. In the absence of an M&E plan, we will assess the degree to which an informal framework for M&E data collection already exists, and whether steps are being taken to develop an M&E plan.
2. Data management capabilities (to collect, analyse and report on programme implementation data) of the DPRS M&E section, as the management unit with oversight responsibility for M&E of the work of the entire SMOH. Where there is no clear M&E section or where the DPRS is not leading M&E for the ministry, the assessment will focus on the section of the ministry that is the M&E lead.
3. Strengths and weaknesses of the data collection and reporting systems of each SMOH programme area, in terms of its ability to report valid, accurate and high quality data.
4. Functional relationship or linkage between the M&E system and HMIS in the respective states.
5. Identify and propose recommendations for strengthening the state M&E system, based on stakeholder consultations.
6. Any other matter relating to M&E system in the health sector.

2. METHODOLOGY

2.1 Assessment Methods

This assessment is a cross-sectional descriptive analysis of the current situation of the M&E systems of the Jigawa SMOH using the adapted framework of the Global Fund's MESST. The MESST checklists were reviewed and re-structured and statements updated to adapt them to the data requirements of this assessment. The original MESST was designed to be used in a workshop-style group discussion of stakeholders of Global Fund-related programmes and management units. The statements in the adapted tool were revised for individual stakeholder assessment of the M&E and data management systems of the SMOH as a management unit of the health sector as a whole. The assessment also used SWOT (strengths, weaknesses, opportunities, threats) Analysis to identify strengths and weaknesses or gaps in the M&E systems as well as outline the possible external factors in the wider SMOH environment and beyond that influence the current state M&E systems or framework.

2.2 Target Population and Study Areas

The target population are the stakeholders of the M&E system at the state level of the Jigawa health sector.

2.3 Sampling/Selection of Key Informants

The study subjects included all persons with direct responsibility for M&E and data management of the state health sector. The selection of 12 study subjects for interviews was based on who are the

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

key informants on the state M&E system and the HMIS in five areas of the state health sector (Table 2.1).

Table 2.1: Key Informants and Their Affiliation with the Jigawa Health Sector

SMOH	Gunduma Health Systems Board	Selected Programme Areas	PATHS2 Jigawa State	Development Partners: DFID-Health Projects
1. Director, PPRS 2. State HMIS officer 3. Asst procurement officer II	4. Director PRM&E 5. Deputy Director (DD) Planning/HMIS 6. DD Planning M&E 7. State epidemiologist 8. State DSNO	- M&E Malaria (state HMIS officer) - M&E Health Systems Project (asst procurement officer II) - M&E Primary Health Care (PHC) (DD PM&E)	9. M&E/Knowledge Management (KM) officer 10. HMIS officer	11. Partnership for Reviving Routine Immunization in Northern Nigeria (PRRINN) – State team leader 12. PRRINN – State programme officer (Immunisation)

2.4 Components of M&E System Assessed

The assessment topics were divided into five components. These are listed in the Table 2.2, along with definitions of each component.

Table 2.2: Components and Their Measurements

Components	Working Definition	Measurement Parameter(s)
1. Strengths and weaknesses of the state M&E plan, if any	Characteristic components of the State M&E plan and how it relates to the SSHDP	Structure, content and results framework of the state M&E plan, Relationship of the state M&E plan to the SSHDP
2. Data management capabilities of SMOH	Capability of the M&E section to collect, analyse and report on SMOH programme implementation data	<ul style="list-style-type: none"> Competencies available in the M&E section for the design, collection, analysis and reporting of data, and feedback relating to the work of the SMOH Quantity and quality of resources available for M&E Availability and completeness of the implementation of the M&E plan Effectiveness and progress of M&E activities in relation to expected results stated in the M&E plan
3. Strengths and weaknesses of the data collection and reporting systems of selected SMOH programme area	Ability of each selected programme area to collect and report valid, accurate and high quality data relating to its work in the SMOH	<ul style="list-style-type: none"> Quality of reported data of/from each programme area: validity, accuracy and completeness of reported data
4. Functional linkage between state M&E system and state HMIS	Interrelations and inter-working between the SMOH M&E and HMIS sections	<ul style="list-style-type: none"> Functionality of collaboration between the sections responsible for M&E and HMIS in the SMOH Functionality of collaboration between the M&E section and M&E units of key programme areas of the SMOH
5. Stakeholders' recommendations for the development of SMOH M&E system	Stakeholders suggestions for the development and strengthening of the health sector M&E system	<ul style="list-style-type: none"> Stakeholders' perceptions or opinions of the next steps for developing the M&E system in the light of their understanding of the current situation or context

2.5 Assessment Design

2.5.1 Data Collection Techniques and Tools

Data were obtained from the key informants through a combination of quantitative and qualitative approaches. The adapted MESST tools were used as semi-structured checklists nos. 1, 2 and 3 for the quantitative individual key informant interviews, while a separate checklist no. 4 was prepared by the assessment team and used as a tool of open-ended questions for the qualitative individual interview of all 12 key informants. Table 2.3 shows the list of interviewees to whom the checklists were applied.

Table 2.3: Application of the Data Collection Tools

Tool	Key Informant	Aspect Assessed
Adapted MESST checklists no. 1	1. DPPRS (SMOH), 2. DPRM&E (Gunduma), 3. State DSNO (Gunduma), 4. M&E/KM officer (PATHS2)	Component 1: Strengths of the SMOH M&E plan
Adapted MESST checklists no. 2	1. DPPRS (SMOH) 2. DPRM&E (Gunduma) 3. DD PHMIS (Gunduma) 4. DD PM&E (Gunduma) 5. State HMIS officer 6. State epidemiologist 7. State DSNO 8. PATHS2 M&E/KM officer	Component 2: Data management capacity of the SMOH and Gunduma HSB
Adapted MESST checklist no. 3	1. M&E officer, Health Systems Project (HSP) 2. M&E officer, Malaria Control 3. DDPM&E, PHC 4. State program officer, Immunisation (PRRINN)	Component 3: Quality of the data reporting systems of the implementation programmes
Checklist no. 4	All 12 key informants	Component 4: Linkages between programme area and overall sector M&E and between M&E and HMIS systems Component 5: Strengths and weaknesses of the M&E system, stakeholders suggestion for improving the M&E system

2.5.2 Structure and Administration of Data Collection Tools

1. Unlike the default administration of MESST for assessment of M&E systems of Global Fund projects, the MESST checklists nos. 1, 2 and 3 are not self-administered or workshop based, but rather are used as interviewer-administered questionnaires.
2. The MESST checklists were reviewed and re-structured and questions updated to adapt them to the data requirements of this assessment.
3. The adapted MESST checklists have numbered rows of questions or statements to which the respondent chooses one of the four answer options: Yes, completely; Mostly; Partly; and No, not at all.
4. Where the answer is not 'Yes, completely,' the respondent is asked to explain the reason why and the interviewee's comments are recorded verbatim into the adjacent second answer column of the relevant row.
5. Where the answer given by the respondent requires verification by documentary evidence, the interviewer's observations of the evidence are recorded in the third answer column of the relevant row.
6. The checklist no. 4 is a topic guide to be used with open-ended questions for the collection of purely qualitative in-depth data.
7. The tools were not pre-tested but were scrutinized by the relevant PATHS2 technical staff. Only tools approved by PATHS2 were used for the assessment exercise.

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

2.5.3 Data Sources

The main sources of data for the measurement of the five components in section 2.5 are the M&E stakeholders listed in Table 2.1. Additional documentary data sources were examined for background information or for verification of respondents' answers. The documents proposed for review and those that were actually available to be reviewed are listed in Table 2.4.

Table 2.4: List of Documents Reviewed

Intended	Actual
<ul style="list-style-type: none">- State M&E plan- SSHDP- National Strategic Health Development Plan- M&E periodic progress and situation reports- M&E activity completion reports- M&E annual programme reports (statistical and narrative)- Programme data collection and reporting formats- M&E staff nominal role- M&E office inventory- State annual M&E budgets and financial reports- PATHS2 HMIS assessments	<ul style="list-style-type: none">- SSHDP- HMIS quarterly reports- Data collection and reporting tools and instructional manuals of the National HMIS (produced by Jigawa SMOH and Gunduma HSB)

2.6 Assessment Team

The assessment in Jigawa State was carried out by the lead consultant of the assessment team commissioned by PATHS2 for the nationwide exercise. He received data collection support from the assistant to the PATHS2 M&E/KM officer, Miss Ify Elmas Oli, who is a Public Health graduate of the National Youth Service Corps (NYSC) in Jigawa State. The data collection was performed and completed according to the terms of reference using the checklists approved by PATHS2. The support data collected provided assistance to the interviewer in some of the interviews conducted. To assure the validity of data collected, the support interviewer was trained by the lead consultant on the application of the data collection tools. The lead consultant also crosschecked all checklists filled by the support interviewer for correctness and completeness.

2.7 Data Storage and Analysis

The adapted MESST checklists are based on the MS Excel application. Each completed checklist was saved as a separate Excel file according to the respondent interviewed. During analysis, the five answer options for each statement in the adapted MESST checklists were given numerical codes or score from 0 to 4 to enable quantitative analysis and graphical representation of results:

- Yes, completely = 4
- Mostly = 3
- Partly = 2
- No, not at all = 1
- Not applicable (NA) = 0

A separate state summary checklist was prepared for each of checklists nos. 1-3. The answers entered in the state summary checklists were derived from the arithmetic means (averages) of the scores given to the responses given in the corresponding checklists by the individual key informants. For this, the average of respondents' scores (excluding NA) for each statement was approximated to the lower whole number if a decimal. The mean scores for each statement and weighted averages for the different sections of the state summary checklists were used to rate the status of the M&E or data management systems in the state. The in-depth answers, comments and observations collected with the checklists nos. 1 to 4 were transcribed and subjected to qualitative analysis and narrative presentation of results. The data presented as the results of the assessment in the next chapter is based on the average values in the state summary checklists.

3. FINDINGS AND ANALYSIS

3.1 Number of Respondents and Analysis

Four key informants gave responses to statements about the strength of the available M&E framework in the SMOH (adapted MESST checklists no. 1). Eight key informants gave responses to statements about the data management capacity of the SMOH (adapted MESST checklists no. 2) while four key informants (three programme M&E officers and one partner programme officer) working in four programmes (Immunization, Malaria, PHC and Health Services Programme [HSP]), responded to the statements about the strengths and weakness of the reporting systems of programme areas (adapted MESST checklist no. 3). For each statement in checklists nos 1, 2 and 3, the code or score of the responses given by all individual key informants were summed and the arithmetic mean calculated as the overall response for the state; they are presented in the statistical tables and graphs in this chapter. All NA responses were excluded from the calculation of state arithmetic means.

All 12 individual key informants were interviewed for the functional linkages of M&E, HMIS and programmes, as well as stakeholders' perception of current strengths and weakness of the available framework for M&E and their recommendations (designed checklist no. 4). Their responses are analysed by qualitative categorisation to produce the state summary.

3.2 Strengths and Weaknesses of the State M&E Plan

3.2.1 General

Table 3.1 and its graphical representation in Figure 1.1 show the state summaries of the coded responses of the four key informants interviewed with adapted MESST checklist no.1. The distribution of the answer categories shows that the respondents completely agreed with 11 (19%) of the 58 statements in the checklist, while a total of 26 (44.8%) responses are either 'mostly' or 'partly'. Statements that are not applicable to the context of M&E in Jigawa state health sector (or unknown to respondents) totalled 14 (24%). The overall average rating score in Table 3.1 is 2.6 out of a maximum score of 4.0. The range of rating scores is from 0.0 in the aspects of availability of goals, objectives and baselines of indicators to 3.0 in the aspect of availability of quantifiable targets in the existing framework.

Table 3.1: Distribution of Responses to Statements Assessing the M&E Plan (in adapted MESST checklist no. 1)

a) Sections Assessed	No. of Statements	Number of Answers					Average Score*
		Yes, completely	Mostly	Partly	No, not at all	NA	
I. State strategy and state M&E plan are available and linked	6	0	1	0	2	3	1.6
Where no M&E plan, there is a process of interest to plan; or M&E activities and indicators are available	5	1	1	2	0	1	2.8
II. Goals and objectives in M&E plan are SMART	4	0	0	0	0	4	0.0
III.1 Indicators are relevant, quantifiable and standard	14	2	5	4	1	2	2.6
III.2 Data sources are available, usable and appropriate	15	5	5	3	2	0	2.9
III.3 Baselines are available	3	1	0	0	0	2	0.0
III.4 Targets are available and quantifiable	6	2	1	0	1	2	3.0

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

IV. Data dissemination plan is available and transparent	3	0	0	3	0	0	2.0
V. M&E budget is available and sufficient	2	0	0	1	1	0	1.5
OVERALL	58	11	13	13	7	14	2.6
Percentage	100%	19.0%	22.4%	22.4%	12.1%	24.1%	

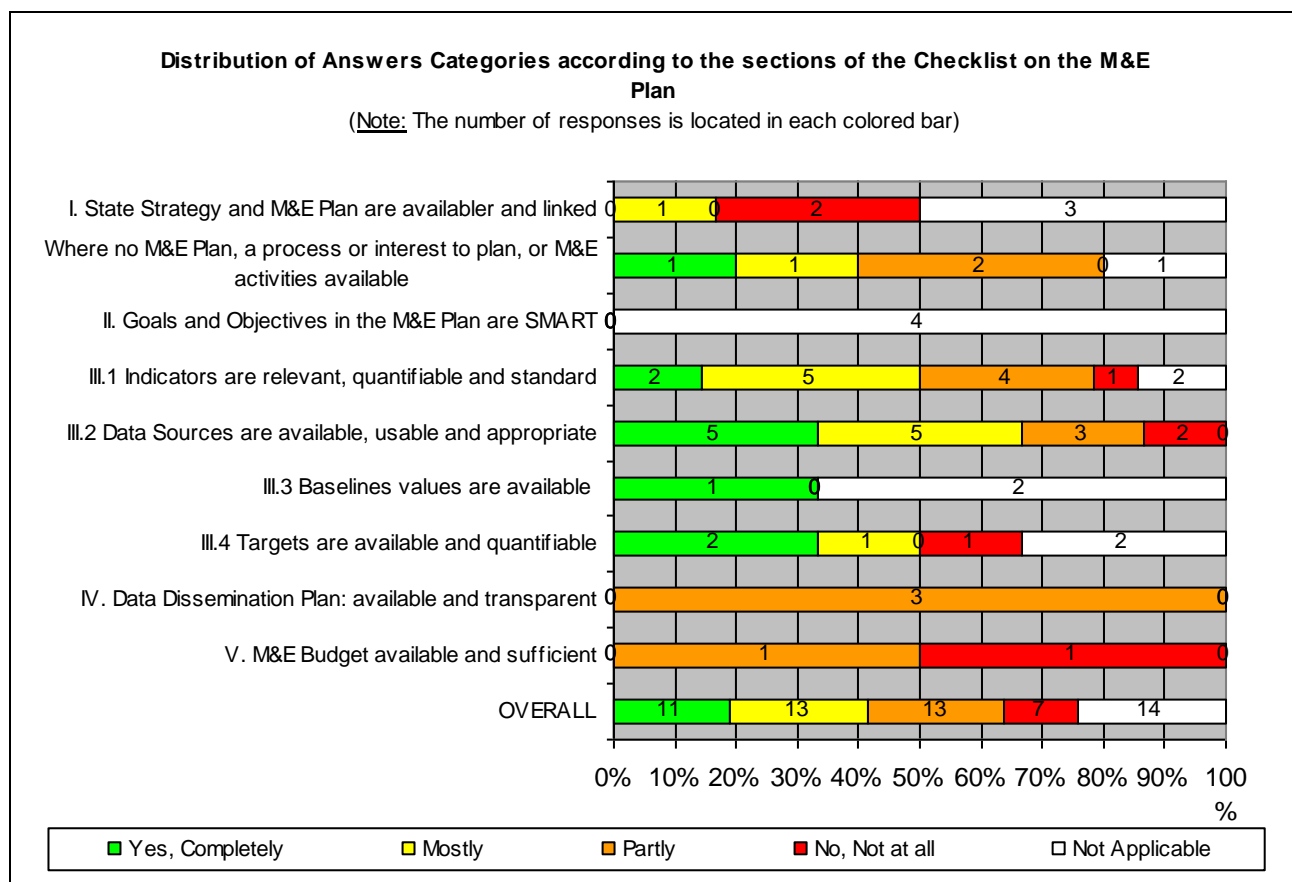
*Based on the codes of the answer categories: Yes, completely = 4; Mostly = 3; Partly = 2; No, not at all = 1; NA = 0

3.2.2 State Structure/Framework of M&E: Availability and Linkage of the M&E Plan to the SSHDP, Current M&E Structure, If No M&E Plan

The Jigawa SMOH has a draft SSHDP that is based on the National Strategic Health Development Plan. The SSHDP has a framework of goals, objectives and targets, but lacks a specific framework for M&E of health activities. The SMOH does not have M&E policy or M&E plan that should form the strategic basis of M&E activities in the health sector. However, there is a process underway to develop an M&E plan with a formal government request for PATHS2 technical support. According to respondents, the key stakeholders of this process are the DPPRS, DPRM&E (gunduma) and state epidemiologist.

The respondents believe the SMOH currently performs some M&E activities, which are reported to be disease surveillance and monitoring of health facilities under the integrated supportive supervision (ISS). Some indicators that currently are monitored include those of disease trends and rates of case mortality and fatality, related to the indicators of the HMIS and IDSR.

Figure 3.1: Assessment of the Jigawa State Health Sector M&E Plan



3.2.3 Goals, Objectives and Indicators in M&E Plan: Availability and Structure

As there is no M&E plan in Jigawa, the statements in the section of goals and objectives were not applicable.

The indicators and other sections assessed by respondents in the MESST checklist no. 1 are entirely related to contents of the SSHDP and the HMIS and IDSR information systems. The responses in the state summaries show that these information systems use technically sound data sources. According to respondents, the frequency of data collection is stated and is 'partly' feasible. Even though not routinely collected, respondents also reported that data are partially available for monitoring the quality of services, training and client satisfaction, but not available for monitoring drug resistance to treatment. The SMOH occasionally works with coordinators of large-scale household surveys and regularly updates its health data. The respondents are sure that the SMOH makes use of data from the state health information system. However, public accessibility to health data is said to be partial, and data dissemination and sharing occurs mainly through the Health Data Consultative Committee (HDCC) meetings.

According to respondents, all programme-level indicators have baseline values, but only some of them have annual targets, which are always expressed numerically. A budget that is clearly linked to M&E activities is only partly available, and is less than 7% of the total budget of the SMOH.

3.2.4 Summary of Findings

M&E is practised only as it pertains to HMIS and IDSR, even though the SSHDP has a results framework. There is no M&E policy or M&E plan, but the SMOH has initiated a process that demonstrates there is government interest in developing an M&E policy and plan. Respondents report that data sources relating to the HMIS are technically sound with stated and feasible data collection frequency. The respondents believe the government uses data generated by the state information systems. A budget for M&E activities is partially available in the SMOH though less than 7% of the SMOH total budget. The overall average rating score of the strength of existing framework is 2.6 out of maximum of 4.0 points.

3.3 Data Management Capabilities of SMOH

3.3.1 General

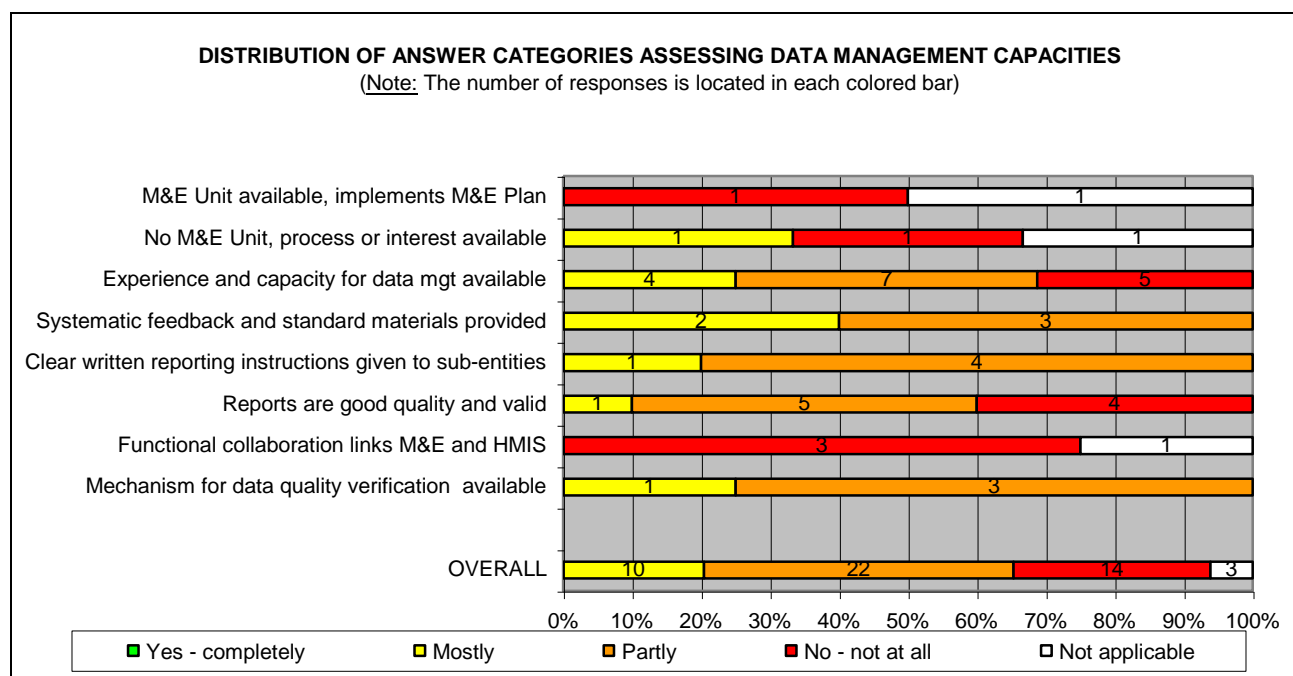
Table 3.2 and Figure 2 show the distribution of answer categories to the statements in the adapted MESST checklist no. 2, which assesses SMOH data management capabilities according to the state summaries of responses from eight key informants. Respondents partially agreed with a total of 32 (65.3%) out of the total 49 statements and disagreed with 14 (28.6%). No statement in the checklist received a 'yes, completely' response. The overall average rating score was 1.9 (Table 3.3), with a range from 1.0 in the sections about the availability of a state M&E unit and functional collaboration between M&E and HMIS, to 2.4 in the section of availability of systematic feedback and recording and reporting materials. Table 3.2 shows that the average score was less than 2.0 in four of the eight sections assessed, namely: availability of a state M&E unit, experience and capacity for a data management system, quality and validity of reports, and availability of functional links between M&E and HMIS.

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

Table 3.2: Distribution of Responses to Statements about SMOH Data Management Capabilities (in MESST checklist no. 2)

Sections Assessed	No. of Statements	Number of Answers					Average Score
		Yes, completely	Mostly	Partly	No, not at all	NA	
M&E unit available and implements M&E plan	2	0	0	0	1	1	1.0
Where no M&E unit, process or interest is available	3	0	1	0	1	1	2.0
SMOH has experience and capacity for quality data collection, reporting and analysis	16	0	4	7	5	0	1.9
Effective systematic feedback and standard recording and reporting materials provided	5	0	2	3	0	0	2.4
Clear written reporting instructions given to sub-entities	5	0	1	4	0	0	2.2
Reports are good quality and valid	10	0	1	5	4	0	1.7
Functional collaboration links M&E and HMIS	4	0	0	0	3	1	1.0
Mechanism for data quality verification at service points available	4	0	1	3	0	0	2.3
OVERALL	49	0	10	22	14	3	1.9
Percentage	100%	0%	20.4%	44.9%	28.6%	6.1%	

Figure 3.2: Distribution of Responses about Data Management Capacities



3.3.2 State M&E Unit: Availability

According to the respondents, there is no state M&E unit in the SMOH responsible for oversight M&E of all SMOH health activities, but there is evidence that individual programme areas have designated M&E officers who perform mainly data collection, collation and analysis duties for their

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

respective programmes. The SMOH has a HMIS unit under the director of the DPPRS, and puts M&E responsibilities on the director of the DPRM&E at the Gunduma HSB and his deputies. However, the latter coordinate primarily the collation of periodic HMIS reports from the gunduma councils that oversee health facilities in the state, and transmission of the same to the SMOH HMIS unit. In addition, he also oversees state the DSNO (unofficially the state M&E officer) who only collects data related to the IDSR system under the coordination of the state epidemiologist. There is no process underway to establish a state M&E unit, but the respondents believe the SMOH authorities are to a large extent interested in setting up one.

3.3.3 Data Management Experience and Capacity: Collection, Reporting, Analysis, Feedback and Use of Data

In most cases, there is experience in collecting and analysing programme data in the SMOH, and to a less extent, experience in producing regular reports on programme progress and results. The SMOH produces some reports on time, but according to respondents, they are not of good technical quality. Staff definitely lack experience in designing formats for data collection and reporting because the HMIS tools used in the health sector are national materials designed by the Federal Ministry of Health (FMOH). The SMOH occasionally produces standard data recording and reporting materials. Some staff have received training in HMIS data management processes and tools, but there is lack of capacity in M&E, strategic information and data systems management. Capacity to resolve inconsistencies in reported data as well as methodology to address missing data in reports are only partially available. The SMOH has an organogram that shows some positions with data reporting / management responsibilities. It has a designated staff who review the quality of data submitted by sub-reporting entities and there is a designated programme manager for ensuring strategic use of M&E data for decision making.

3.3.4 Quality of Data Reporting

According to respondents, the SMOH has a documented process for meeting its reporting requirements. It also has partly documented terms of reference with sub-reporting entities on reporting requirements and deadlines and has partly provided clear written instructions on what, how, when and to whom to report. Reports received are mostly verified for timeliness, completeness and accuracy. Based on this, some reports by sub-reporting entities are submitted on time and complete, but no report is mistake-free. Still, there is no written procedure to address late, incomplete or inaccurate reporting and the SMOH provided no evidence that a systematic process is in place to follow up quality of data issues. The ministry has in place only partial procedures for verification of reported health services and data and to demonstrate that site visits to the data collection points for quality verification have occurred.

3.3.5 Feedback

The SMOH is said to mostly provide systematic feedback on quality of reports to sub-reporting entities, and only partly on programme performance. However, respondents claim to have evidence that feedback improves programme performance.

3.3.6 Quantity and Quality of Resources Available for M&E

As the SMOH does not have an M&E unit, there are presently no staff or non-staff resources that are specifically allocated to state-level M&E responsibilities, besides the resources for HMIS Unit at the SMOH. Table 3.3 shows the list of state staff with data management duties in both the SMOH and the Gunduma HSB, the qualifications and responsibilities. At least 15 staff are involved in HMIS and IDSR activities, with none performing roles of progress or results-oriented M&E of health activities. Only three persons among these 15 have received any training specifically on M&E (Table 3.3) and these are officials in the most senior cadres.

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

Table 3.3: State Officials with Data Management-related Responsibilities in the SMOH and Gunduma HSB

Job Title	Unit	Qualification	Key Responsibilities	Trained in M&E?
DD HMIS	HMIS, gunduma	Dip Envir. Health	Demand creation	No
Sen. statistical officer	HMIS, gunduma	Dip Statistics	Data capture	No
DD Planning	Planning, gunduma	BSc Nutrition		No
State DSNO	IDSR, gunduma	CHEW	Surveillance	No
Deputy state DSNO	IDSR gunduma	HND Public Health	Surveillance	No
Epidemiologist	IDSR, gunduma	HND Public Health	Outbreak investigation and control	No
DPRM&E	Planning, gunduma M&E	B.Pharm	Director state M&E	Yes
DPPRS	SMOH	MBBS	Director policy	Yes
State officer* HMIS	HMIS, SMOH	HND Statistics	Data collection, process, analysis and presentation	Yes

*The HMIS unit in the SMOH has six staff members, including the state HMIS officer.

3.3.7 Summary of Findings

The SMOH does not have a state M&E unit, but individual programmes have M&E officers and there are DSOs at LGAs designated as M&E officers. These perform mainly data collection and reporting relating to national tools of HMIS and the IDSR system. Responsibility for M&E and data collection from the health facilities at peripheral levels is assigned to the Gunduma HSB. There is no process underway to establish a state M&E unit. The respondents believe the SMOH has some experience of data collection, analysis and producing regular reports, but the reports are not of good technical quality. Reports from sub-reporting entities are verified for quality and some reports are reported to be timely and complete but most are not accurate. While they report that reports are not followed up for quality, they believe the ministry gives them some feedback on the quality of reports, less on programme performance. Only three senior staff have been trained in M&E. The overall average rating of the data management capabilities in the SMOH is only 1.9 out of a maximum of 4.0 points.

3.4 Strengths and Weaknesses of Program Data Collection and Reporting Systems

3.4.1 General

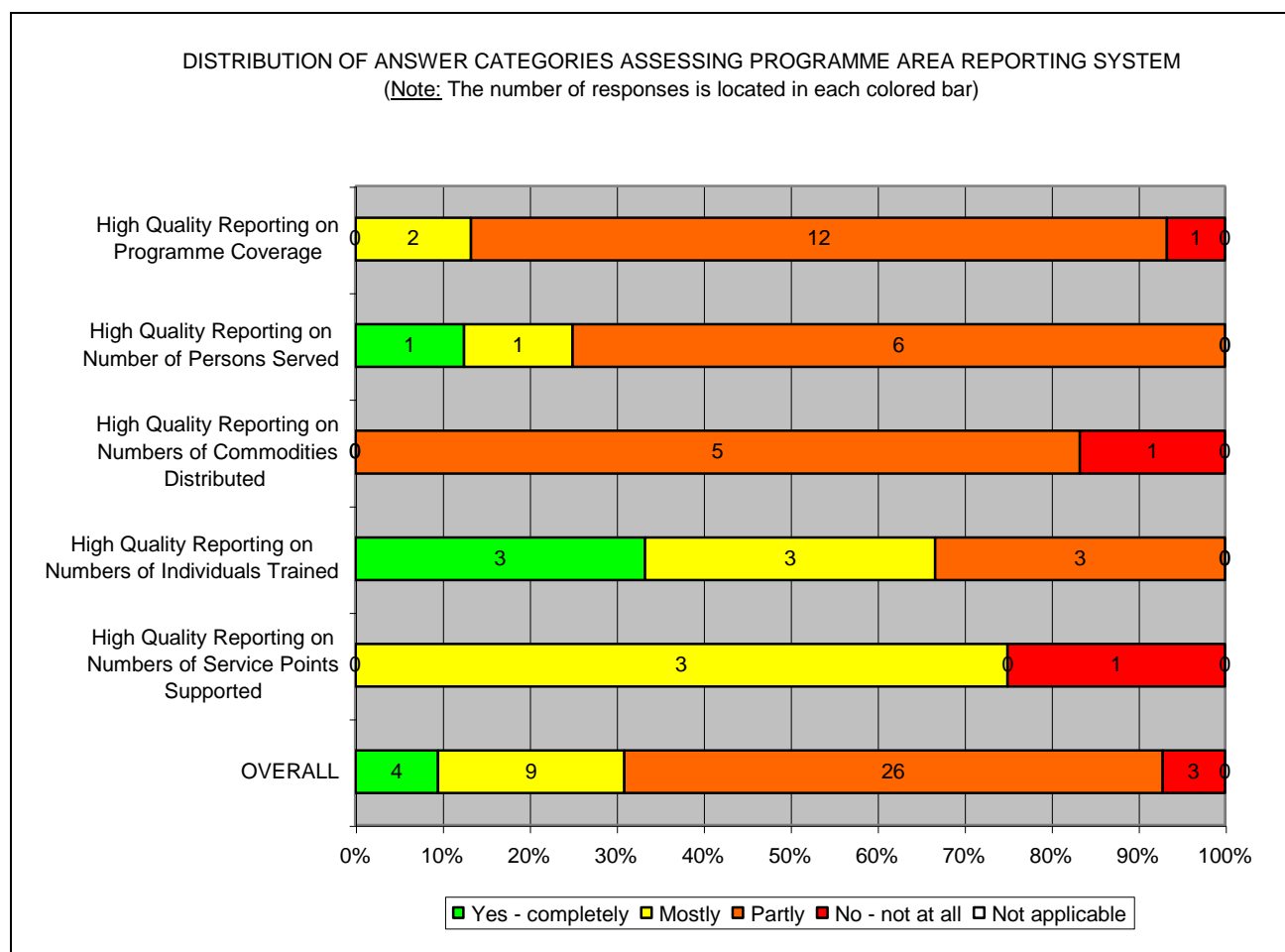
Table 3.4 and Figure 3.3 show the state summary (average) of the responses of the four programme officers interviewed about the 42 statements in adapted MESST checklist no. 3, on the reporting systems of their programme areas. The programme areas covered were Immunisation, Malaria Control, PHC and HSP. A total of 35 (83%) of the 42 statements in the checklist were believed to be either mostly or partly true. Only four (10%) statements were agreed to be completely true. The overall average rating score was 2.3, with a range from 1.8 in the reporting of the number of commodities to 3.0 in the reporting of the number of staff trained. In all aspects of the programme reporting systems, the source documents are available at the various levels for auditing purpose.

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

Table 3.4: Distribution of Responses to Statements Assessing the Reporting Systems of Programme Areas

Sections Assessed	No. of Statements	Number of Answers					Average Score
		Yes, completely	Mostly	Partly	No, not at all	NA	
I.1 High quality reporting on programme Coverage	15	0	2	12	1	0	2.1
I.2 High quality reporting on number of persons served	8	1	1	6	0	0	2.4
II. High quality reporting on numbers of commodities distributed	6	0	0	5	1	0	1.8
III. High quality reporting on numbers of individuals Trained	9	3	3	3	0	0	3.0
IV. High quality reporting on numbers of service points supported	4	0	3	0	1	0	2.5
OVERALL	42	4	9	26	3	0	2.3
Percentage	100%	10%	21%	62%	7%	0%	

Figure 3.3: Responses on Programme Area Reporting Systems



3.4.2 Data Collection and Reporting on Programme Coverage and Number of Persons Served

Data on aggregated numbers of people served are partly reported through a single channel of reporting. National forms are partly used for data collection of programme information systems. So according to the state summaries, the list of definitions of data collected and reported only partly meet national and international standards and used in health facilities

Clear instructions are partly available on how to fill data collection and reporting forms. The responsibility for data collection and reviewing reports to be submitted are also partly designated to staff in the service points. The reporting systems avoid double counting of people served within the same service points, but not across service points. Relevant staff are partly designated at LGA and gunduma council levels to be responsible for reviewing and verifying the quality of reports from facilities. A mechanism for reconciling discrepancies in reports and carrying out data quality assurance at the service points is also only partly in place.

3.4.3 Reporting on Numbers of Commodities Distributed

According to respondents, the use and verification for completeness and accuracy of distribution log sheets for reporting on the number of commodities supplied and received are partially done in the programmes assessed. But there are no quality controls in place for computerised data entry of distribution log sheets.

3.4.4 Reporting on Numbers of Individuals Trained

A mechanism is partly in place to ensure that people counted as trained have completed the entire training and that learning objectives have been reached. The respondents reported that training reports are systematically verified for completeness and mistakes and procedures to reconcile discrepancies in training reports are fully available.

3.4.5 Reporting on Numbers of Service Points Supported

According to respondents, the SMOH has a list of service points is partly updated. Mechanisms that help to avoid double counting of service points and to track inventory levels and stock-outs at the service point are only partly available. The service points are not identified by any national system of ID or code numbers.

3.4.6 Summary of Findings

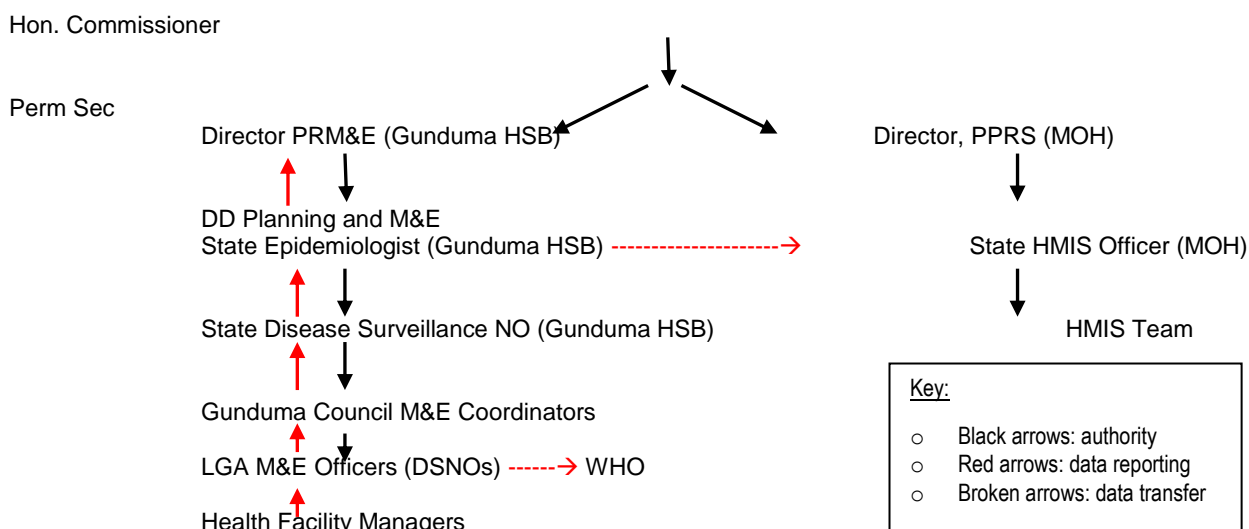
The information systems of programme areas are mainly parallel to the mainstream of the state information system: they partly use national tools for data collection and reporting, which avoids double counting of people served within the same service points, but not across the number of service points and mechanism for data verification, validation and reconciliation is only partly in place. The overall average rating score of the quality of the data collection and reporting systems at programme level is 2.4 out of a maximum of 4.0.

3.5 Functional Linkage between the State M&E System and HMIS

3.5.1 Organizational Structure of the State M&E System

The organogram in Figure 3.4 shows the structural organisation of data management responsibilities in Jigawa State.

Figure 3.4: Structural Organisation of Data Management Responsibilities in Jigawa State



3.5.2 Data Collected by State M&E System

Table 3.5 shows the details of the main data collection process in the Jigawa State HMIS and programmatic structures. Health workers at the LGA and facility levels are the collectors and aggregators of routine data at frequencies that vary from daily to quarterly. The uses of data given by most respondents suggest that data are processed and the state government uses the information for planning and decision making. However there is also the contrary view that the state does not use the data.

Table 3.5: Data Collection Process in Jigawa State Health Information System

b) Type of Data Collected	Entity Responsible for Data Collection	Frequency	Data Sources	Use of Data
Out-patient Attendance, Maternal deaths, and, immunization, disease surveillance	Health workers	Monthly	Facility	Compare outpatient coverage, maternal and child health Assess disease burden over time
HMIS list of Essential Data Set (EDS): total 32	Health workers	Monthly	Facilities	Use at different levels
Routine immunisation, disease surveillance, Drug Revolving Fund	Health workers	Monthly, weekly	Health facilities, Community/ Pharmacy	NA to the state
Quarterly report	LGA M&E	Quarterly	Facilities	Planning and decision making
Health data	Health workers	Daily	Facilities	Decision making

3.5.3 Areas of Collaboration or Linkage between M&E System and HMIS

According to some respondents, no person is designated as M&E officer in the SMOH, but there are programme M&E officers. In some situations, the same persons do both M&E and HMIS activities at the state and council levels. For example, the HMIS unit staff also act as programme M&E officers. According to one respondent, “HMIS and M&E are synonymous. It is a one-man system for both HMIS and M&E at programme level.”

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

Some respondents believe that collaboration is mainly on data collection, as it is the M&E officers at the LGA and gunduma councils who are responsible for collecting, collating and channelling HMIS data from the facilities to the state level. At the state level, collaboration may also occur in the areas of planning, data analysis, reporting and data use. But there is no evidence that this happens routinely other than at the monthly review meetings of the HDCC.

3.5.4 Use of Data from the State HMIS by the M&E System

The key informant responses in Table 3.6 show there is no formal M&E system at the state level, but it may exist at the programme level, where it is integrated with the HMIS and the role performed by the state HMIS officers: the M&E uses show a relationship between HMIS data and strategic and decision-making purposes at the programme level. But no evidence of this was provided for verification.

Table 3.6: Responses on M&E /HMIS Collaboration

Utilisation of HMIS Data for M&E	M&E / HMIS Collaboration
<ul style="list-style-type: none"> ○ Rational use of drugs, free maternal services ○ Outpatient records, antenatal care and deliveries and nutrition status ○ Expansion of maternity services ○ Planning of the year's budget ○ Expansion / improvement of facilities 	<ul style="list-style-type: none"> ○ Since we do not have a single M&E unit, the HMIS staff are also M&E officers for one programme or the other. ○ The same person does HMIS and M&E activities. Both have a common source. Same M&E collects, one person collects and send data for M&E, HMIS Epid, World Health Organisation (WHO). This is too much work. Each function supposed to have a particular focal person. ○ Same staff do both HMIS and M&E activities.

3.5.5 Responsibilities of staff of M&E and HMIS Units

With the performance of "M&E" by state HMIS officers at the programme level, some respondents stated that, "Until now there is no clear distinction between HMIS and M&E system in the State." "There is no clear demarcation between the two functions." Others are able to differentiate the general responsibilities of staff operating the two information systems, which are listed in Table 3.7

Table 3.7: Duties of M&E and HMIS Staff (often done by the same person)

M&E Staff	HMIS Staff
<ul style="list-style-type: none"> ○ Track programme progress and target ○ Collect/transport data ○ Monitor project and evaluate impact of project ○ Monitor quality of data ○ Design data collection tools ○ Perform quality assessment 	<ul style="list-style-type: none"> ○ Collect data ○ Enter data into database software (captures the data) ○ Do simple analysis and presentation ○ Advise on use of information ○ Act as custodian of health data ○ Train lower-level M&E staff in LGA and health records office ○ Deal with data, relate to health information system

3.5.6 Challenges of Collaboration

According to respondents, M&E staff and the HMIS unit staff fight to keep the data they generate and the HDCC has been irregular in its meetings, so there is no functional coordination and linkages between the programme M&E staff and the state HMIS staff.

3.6 Collaboration between Programmes M&E and State M&E System/HMIS

3.6.1 Use of Same Staff

There is of the same staff for both programme and M&E activities; often the same person is involved, especially at the gunduma council level where gunduma M&E officers are involved in the data validation of programme data and collaborate in data analysis, collation and analysis.

3.6.2 Information Sharing

The HDCC serves as a collaboration forum for coordination of all state health data, but it does not work as effectively as it should. It is where information sharing should occur, as the HDCC is constituted by all data stakeholders in the SMOH, Gunduma HSB and partners. However, while some of them attend meetings, most programmes hold on to their data and don't share. This may be because the programmes feel they are answerable to their donors.

3.6.3 Independent Data Systems

Programmes do not feed information into the state M&E system. Programmes are supposed to feed data to the central HMIS but every programme has its own data system. According to respondents, programmes, especially the World Bank-assisted ones, use parallel data collection and reporting tools. Such programmes have their own structure and staffing. As a respondent said, "Most of the programmes are stand-alone and in this respect are never part of the state HMIS system." For example, "the immunization programme does not generate its own data but uses what other units already generate. But a lot of its activities are not captured by HMIS. Other programs such as malaria, HIV, onchocerciasis, TB etc. are not captured at all."

Table 3.8 shows the opinions of respondents on the possibility of role overlap of between the M&E systems of the programmes and the state and resultant duplication of data in the state health information system. The conflicting opinions of respondents suggest there may be no overlap or duplication despite the parallel systems and the use of the same staff.

Table 3.8: Respondents' Opinions about Role Overlap and Data Duplication

c) Overlap?	Duplication of data?
No state M&E, so no overlap	Parallel data collection and reporting tools, every programme introduced new tools
Immunization has no M&E officer, the SMOH M&E take charge of data aspect	Different programmes collect different, their own data. Different from routine HMIS collected by the state. Good example is immunisation, programme collects immunisation data, and the state HMIS collects routine immunisation data. At times there are differences in data collected.
Yes, things are not yet clear as to what function gunduma and SMOH perform	No. All data emanated from the facility using a standardised data collection tools.
Not applicable. No state M&E mandate	No duplication. In Jigawa we have or use HMIS at LGA. They are reporters for M&E, HMIS, HIV, malaria, etc. The same people. Too burdensome.

3.7 Stakeholder Assessment of the Current Status of the M&E System

3.7.1 Strengths

Some respondents believe there can be no strengths in a system that does not exist. Their responses included the following: "Does it exist? No strengths identified. No M&E system, so no strengths." Others identified some current strengths, as Table 3.9 shows. Obviously the availability and commitment of staff as well as partners support are seen as key strengths.

Table 3.9: Current Strengths of the State M&E System in SMOH, according to Respondents

Category	Responses
1. Staff capacity	<ul style="list-style-type: none"> Capacity available at the SMOH and gunduma board for M&E with fairly trained and hard-working staff, looking at the volume of work
2. Staff motivation	<ul style="list-style-type: none"> Good commitment by the staff
2. Partners' support	<ul style="list-style-type: none"> Presence of development partners such as PATHS2, PRRINN, UNICEF and WHO
3. Political support	<ul style="list-style-type: none"> Political will of the government good will of the management in the ministry – a major strength.

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

		Political commitment
4.	Existing structure	<ul style="list-style-type: none"> ○ A good system at the state level, there is a structure on the ground. There is a structure in place for M&E programme. Specific M&E is being done in each programme. ○ There are opportunities for M&E: The SSHDP has an M&E matrix with indicators to be reached in 2015.

3.7.2 Weaknesses

Table 3.10 shows four categories of weaknesses identified by the key informants. The most problems are seen to be those of the existing low level of performance of M&E, if any structure exists at all. There are also problems of lack of technical capacity and lack of coordination of the different and multiple problems.

Table 3.10: Current Weakness in the State M&E System in SMOH, according to Respondents

Categories	Responses
1. Data management problems	<ul style="list-style-type: none"> ○ Data are generated but not reported, not documented. Records keeping is poor
2. Organisation / coordination problem	<ul style="list-style-type: none"> ○ Programmes run parallel M&E systems ○ The lower level of the system is weak ○ M&E system is not combined. Combination will not be an easy task. M&E is fragmented
3. Technical / limited capacity	<ul style="list-style-type: none"> ○ Lack of capacity ○ Lack of trained people to operate the real M&E work ○ Lack of material resources
4. M&E performance	<ul style="list-style-type: none"> ○ M&E unit does not exist, no central M&E. No M&E system – only a combination of Epid and HMIS collaboration. Still at rudimentary stage – not well established. No M&E framework ○ No harmonised monitoring checklist. Poor supervision of lower level from the higher level ○ No constant supervision – supervision is erratic. ○ Lack of crystal structure for M&E. M&E system is very weak. No free hand to operate ○ The M&E is not functioning as it's supposed to be

3.7.3 Suggestions for Improving/Developing M&E System

Table 3.11 shows the suggestions of M&E stakeholders in the SMOH and the Gunduma HSB. The ones mentioned most frequently are those requesting the development of a state M&E unit as well as building staff capacity and data management.

Table 3.11: Stakeholders' Recommendations for the Development of the State M&E System

Category	d) Responses
1. M&E development	<ul style="list-style-type: none"> ● Establish M&E unit ● Develop M&E policy and M&E framework in the state health sector. Raise the structure: identify a framework for M&E. The M&E framework should be aligned with the state strategic plan (structured from the state strategy). Align framework to specific indicators ● Institutionalisation of supervision plan – monthly supervision ● The M&E system should be strengthened and its capacity built to enable it function and give results ● Design M&E framework and policy in the state ● Provide an M&E system for the SMOH and gunduma health system for effective M&E of health activities ● A clear and well-established M&E system in the state will certainly enable the gunduma health system to evaluate the effectiveness of the new health system
2. Staff capacity building	<ul style="list-style-type: none"> ● Basic training in M&E ● Identify and train M&E staff: Identify the personnel and train them

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

	<ul style="list-style-type: none"> • Improve M&E capacity • An umbrella for M&E – find an entry point such as HDCC • Service delivery points getting the right tools and training on the usage of tools: build a lot of capacity
3. Data management	<ul style="list-style-type: none"> • Emphasise data use at all levels • HDCC should be regular with its (review) meetings • Analyse and feed back data brought in and express appreciation for job well done • Look at the big opportunity to strengthen the HMIS at the lower level
4. Resource support	<ul style="list-style-type: none"> • Provide continuous support to the M&E unit • Provide working tools – standard working tools
5. Political commitment	<ul style="list-style-type: none"> • Need for advocacy to the top government • Allow the system to function – needs political commitment, solicit for political spinal cord for its sustainability
6. Structural reform	<ul style="list-style-type: none"> • Both SMOH and gunduma should have a central M&E unit to track progress towards achieving Millennium Development Goals • A separation of functions between SMOH and gunduma should be clearly demarcated in respect of M&E in the state
7. Donor coordination	<ul style="list-style-type: none"> • Weekly / monthly meeting with all programmes and partners
8. Stakeholder support	<ul style="list-style-type: none"> • Change paradigm of stakeholders to reverse their fear of M&E

3.7.4 Linkage between the State and the National M&E Systems

The state HMIS unit forwards an annual HMIS report to the FMOH, but receives no feedback.

4. DISCUSSION – THE IMPLICATIONS OF FINDINGS

4.1 Limitations

While use of a data collection assistant enabled timely completion of the data collection exercise, use of the assistant, even though briefly pre-trained, could be an important limitation of this M&E assessment. In addition, the conflicting responses to some of the statements in the adapted MESST checklists suggest a likely inadequate understanding of the statements by some key informants. In a few instances an apparent exaggeration of the actual situation may have happened, albeit inadvertently. While documentary evidence was also provided in some cases, it was absent for most responses. Such responses were therefore difficult to justify. Nevertheless, every effort was made to ensure the most valid data possible were used for the analysis done.

4.2 Strengths and Weaknesses of the Current M&E Framework in the State

On the whole, the absence of both an M&E policy and M&E plan implies a lack of strategic basis for M&E in the Jigawa State health sector. The availability of an M&E framework in the SSHDP could serve as a platform from which to begin the planning of an operational M&E system. The process underway to develop an M&E plan through the requested technical assistance of PATHS2 shows a real government interest in developing a functional and effective state-level M&E system. However, the lack of sufficient budget for M&E activities suggests an inadequate state government commitment to M&E in the health sector.

The low average rating score given to the existing M&E framework is essentially attributable to the lack of an M&E plan with relevant organizational goals, objectives, indicators and targets, tools the SMOH needs for monitoring the progress of health activities and to evaluate their outcomes. Currently, the range of the M&E activities performed in the ministry shows that the framework

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

available for M&E relates directly to the data monitoring activities of the HMIS and IDSR systems. Without performance of project outcome evaluation activities, the current framework is essentially a structure for national data management and so an incomplete package of M&E. In this vein, therefore, the assessment team agrees with the stakeholder opinions that, for now, there is no functional M&E system in Jigawa State.

4.3 Data Management Capabilities of the SMOH

The overall average rating score of 1.9 out of 4.0 indicates an availability of generally low data management capabilities in the Jigawa SMOH. The findings of this assessment show that while there is a unit responsible for HMIS, a unit for the IDSR and programmatic M&E responsibilities, there is no unit responsible for oversight performance of M&E at the state level. There is therefore no unit with formal responsibility for coordination and harmonisation of the different and parallel information systems currently operational in the state health sector. This assessment finds that in spite of the presence of staff titled with M&E at all levels of the health sector, there is no single person who wears the hat of state M&E officer. The delineation of the roles of DPRS and the Gunduma HSB with regards to functional responsibility for the state M&E system is unclear. Who really is responsible for the Jigawa State M&E system? The DPRS or the Gunduma HSB?

The SMOH has limited experience in designing data collection and reporting materials, due to the availability of the nationally designed tools of the HMIS and programme information systems. This experience suggests the presence of some capacity for processing data reports received from lower levels. However, this assessment found no evidence of this, as the SMOH reportedly does not produce regular and quality technical reports. Similarly, despite the report that the SMOH makes use of data from the state information system for strategic decision making, the lack of constructive feedback on programme performance indicates otherwise. While these show the incongruence of some key informants' responses, they also indicate a limited ability to complete the whole range of the data management process, which begins with data collection and reporting of raw data and ends with feedback and utilisation of processed data. It is noteworthy that the SMOH has in place some capacity to review, verify and assure the quality of reports received from the LGA levels, and thus the government is able to identify lapses in report quality. However, even though feedback on the quality of reported data is reportedly given to data aggregators, the assessment found that the SMOH is unable to address or follow up the inconsistencies found and therefore unable to provide quality-assured data for M&E purposes. Thus while the monthly data review meetings with LGA M&E officers allow for feedback on submitted report, its usefulness for improving the quality of reported data is limited.

There is evidence that some training of relevant staff in data management processes has been done. One-fifth of all persons involved in the data management system at the state level has had basic training in M&E, but the seniority of the staff trained shows that M&E capacity is with the policy and decision makers at the apex of the state data management organogram, rather than with the operational level where practical M&E capabilities are actually needed. This probably explains the reported lack of capabilities in M&E and strategic information management, which require skills beyond those for routine data collection and reporting that exist in the SMOH. Nevertheless the training of policymakers in M&E would ensure political support for the proposed state M&E system.

4.4 Strengths and Weaknesses of Data Collection and Reporting Systems of Programme Areas

The average rating suggests that the SMOH has a fair capacity at the programme level to produce valid and useable data at levels considered similar to that in the state level data management system. The capacity for valid data is found to be highest in the systems for reporting training data and lowest in the systems in the systems of reporting logistics and commodities.

4.5 Linkages between M&E, HMIS and Programmes

Programmes are shown to run mainly non-HMIS data collection and reporting systems, individualised and non-harmonised, running parallel to one another and to the mainstream state data system. The report of programmes not sharing information suggests the absence of any functional linkage between programmes together on one hand, and between programmes and the state HMIS on the other. In this circumstance, the possibility of duplication of data collected or reported is unavoidable, even though many stakeholders reported this does not happen. With the situation in Jigawa State, where the same staff serve multiple official purposes and programmes, the non-harmonised programmatic information systems have an implication of a creating burdensome workload of data collection and reporting for the M&E workforce at all levels in the state. The HDCC is therefore a vital mechanism for coordination, harmonisation and information sharing, if it is functional. However, there is evidence from this assessment to suggest the HDCC may be functionally moribund. There is therefore an ineffective state coordination of the different partner or programme driven information systems in the Jigawa state health sector.

There is a weak linkage between the DPRS, the unit of the state HMIS unit responsible for processing data into useable technical reports, and the Gunduma HSB, where senior staff are responsible for M&E and oversight of data collection and reporting from the facilities and LGA through the gunduma councils. This inadequate collaboration by the two sides of state data management raises a question on the reported government utilisation of data generated by the state information systems. Despite this, the use of state HMIS staff for programme-level M&E duties suggests that the distinction between the M&E and HMIS structures is impossible within the existing data management framework.

4.6 Stakeholders' Assessment of Strengths and Weaknesses of the M&E Framework

In spite of its many limitations, stakeholders find some strengths and purpose in the data management framework available in Jigawa State. On their score sheet, all resources available in the form of staff, partners' support, government control system and the existing HMIS are opportunities for effective planning and sustainability of the desired state M&E system. The main weaknesses they listed are the parallel programmes, low human resource capacity and data generation with no processing into reports. In general, they find no formal and functional framework for M&E and their main recommendations therefore are for a systematic development of a state-level M&E.

5. CONCLUSIONS

5.1 General Conclusions

There is presently no formal state M&E system and no strategic framework for the implementation of M&E activities in Jigawa State. The M&E activities reported done are within the data management framework of the national HMIS, the IDSR and the mostly independent and apparently partner-driven non-harmonised information systems at the programme level. The range of data management process presently implemented is considered incomplete and inadequate for a full implementation of M&E at the state level that would perform oversight functions covering M&E of all health activities. There is evidence of state government interest in the development of an effective state structure for M&E that would provide the needed linkage between the functionally isolated state departments, programmes and related partners, but there is insufficient government commitment and support to sustain it.

5.2 Summary of Key Strengths and Weaknesses in the Current M&E Framework

5.2.1 Strengths

- Available M&E framework in the SSHDP that could serve as a platform for planning of an operational M&E plan
- A process is underway to develop an M&E plan through the technical assistance of PATHS2
- Low data management capabilities in the Jigawa SMOH
- Availability of the nationally designed tools of the HMIS and programme information systems
- Basic experience of data collection and analysis exists in the SMOH; presence of some capacity for data processing of reports received from these lower levels
- Some SMOH capacity to review, verify and assure the quality of reports received from the LGA levels, and thus the government is able to identify lapses in quality of these reports.
- Some training of relevant staff in data management tools and processes
- One-fifth of all persons involved in the data management system at the state level has had basic training in M&E
- The monthly data review meetings with LGA M&E officers allow for feedback on submitted report
- SMOH has a partial capacity at programme level to produce valid and useable data

5.2.2 Weaknesses

- Absence of both M&E policy and M&E plan implies a lack of strategic basis for the practice of M&E
- No performance of project outcome evaluation activities
- No state M&E unit responsible for oversight of M&E at the state level - no functional state M&E system
- There are different and parallel information systems currently operational in the state health sector.
- No single person who wears the hat of state M&E officer.
- SMOH does not produce regular and quality technical reports
- Lack of constructive feedback on programme performance – reported utilization of data is questionable
- Limited ability to complete the whole range of the data management process
- SMOH currently lacking in the required technical capacity to completely execute M&E activities
- SMOH incapable of addressing or following up the inconsistencies found in the reports verified - unable to provide quality-assured data for M&E
- M&E capacity focused at the policy and decision makers at the apex of the state data management organogram, rather than with the operational level
- Programme data collection and reporting systems individualised and non-harmonised, running parallel to one another and to the mainstream state data system.
- Absence of any functional linkage between programmes together on one hand, and between programmes and the state HMIS on the other
- Limited manpower in the state health sector - the same staff serve multiple official purposes and programmes
- A burdensome workload of data collection and reporting for the M&E workforce at all levels
- Weak functional linkage between the DPRS and the Gunduma HSB

5.2.3 Opportunity

- Palpable government interest for the development of a functional and effective state-level M&E system
- There is a unit responsible for HMIS, a unit for the IDSR and programmatic M&E responsibilities
- Training of policymakers in M&E would ensure political support for the proposed state M&E system
- HDCC is a vital mechanism for coordination, harmonisation and information sharing

5.2.4 Risks

- A lack of sufficient budget for M&E activities suggests an inadequate state government commitment to the practice of M&E in the health sector.
- The HDCC is functionally moribund.
- There is no state coordination of the different partners' data operations.

6. RECOMMENDATIONS

6.1 Develop an M&E System

M&E system means a structure of inputs, processes and expected outputs.

Table 6.1: Structure of an M&E System

Component	Content
Inputs	<p>M&E unit: Staff, equipment, logistics and budget</p> <p>M&E tools: SSHDP M&E framework, M&E policy, M&E plan, M&E work plan and M&E budget</p> <p>Programme materials: Project logical framework and plans, goals, objectives, indicators, targets, strategies and activities, etc. for M&E</p>
Process	<p>Progress and quality monitoring activities: Supervision, implementation review meetings, performance appraisal, data management (collection, statistical reporting, verification, validation, reconciliation, analysis, report-writing, dissemination and feedback, utilisation of information for operational decision making)</p> <p>Achievement evaluation activities: External, internal, peer, participatory; formative and summative evaluation</p> <p>M&E cycle activities: Preparation for exercise, stakeholders planning meeting, terms of reference, commissioning, data collection, analysis and report-writing and dissemination, feedback and post-M&E action to implement recommendations, use of the M&E reports for strategic decision making</p>
Outputs	<p>Expected immediate results of M&E activities and deliverables on programme quality, performance and development including higher productivity of health workers, increased effectiveness of project implementation, efficiency and judiciousness in terms of management of project resources</p>
Outcome and impact	<p>Expected short-term and longer-term effects of M&E on the programmes' target population, users, clients, etc., including improved success and value of public health services rendered by the SMOH and clarity, accountability and transparency for the state government's expenditures on health</p>

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

The SMOH should...

1. With the joint action / collaboration of the DPRS and the DPHC/DC, establish a central M&E unit that has oversight responsibility for developing a state-level M&E system as outlined in Table 6.1 and coordinating and harmonising the departmental and programme-level M&E systems.
2. For implementation of recommendation #1, appoint, officially designate and empower a capable staff with the relevant experience and training in M&E and data management as the state M&E officer.
3. Develop a detailed M&E plan that will provide a results-oriented state framework for implementation of M&E activities in the state health sector and guide the oversight functions of the state M&E unit. The M&E plan should be based on the existing Logical Framework of goals, objectives, indicators and targets in the SSHDP and should outline the M&E policy, rationale, goals, objectives, outputs, indicators strategies, approaches, activities, structure, regularity, resources and budget for implementation of monitoring progress and evaluating achievements of all major health interventions in the State.
4. For implementation of recommendation #3, organise a stakeholder workshop facilitated by PATHS2 technical assistance to discuss the various issues surrounding the implementation of M&E in the SMOH and prepare the state M&E plan to address them.
5. Have the state M&E unit implement the full range of M&E processes as outlined in Table 6.1, not only data management activities, but also routine progress and quality monitoring, periodic indicator-based statistical trend analysis, routine supportive supervision of implementation of health services and periodic evaluation of health outcomes in the state health sector and impacts on the people of Jigawa State.
6. Develop the capacity of key functionaries in the state M&E system through both routine and special training programmes to enable the full implementation recommendation #5.
7. The state government should demonstrate and improve its commitment to the development of a state M&E system by budgeting and providing adequate (up to 10% of the SMOH budget) funding to directly support and sustain the M&E activities and the state M&E unit in particular.
8. The directors of DPRS and of PHC/DC, as the main stakeholders of M&E processes in the SMOH, should ensure that the periodic analysis of collated data, production of related M&E reports based on analysed data, dissemination and feedback of M&E results/reports and appropriate utilisation of data for operational and strategic decision making at both policy and operational levels in the state health sector become the performance deliverables of the functional state M&E unit.

6.2 Build Human Resource Capacity for M&E

- Manpower development for M&E in the state must be vigorously pursued starting with a detailed plan on the staff skills mix and training needed for efficient output and performance.
- The SMOH should organise an in-house M&E workshop for all relevant staff in the ministry and the Gunduma HSB to development their capabilities in M&E and broaden their knowledge and skills for results-oriented performance of M&E at the state ad programme levels.

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

- The SMOH with the assistance of PATHS2 should consider organising a skills acquisition workshop on data processing and technical report writing.

6.3 Improve Government Funding for M&E

- It is important to appropriate adequate funding for M&E staff, infrastructure, planning and documentation development by government and its partners.

6.4 Improve Quality of Reporting

- The capacity needs of the LGA M&E officers and facility-level health workers who are responsible for data collection and collation should be reviewed and the appropriate training held on the data aggregation, verification, validation and reporting skill they need to improve the quality of reports submitted. This should be extended to health facilities as soon as it is completed for the LGAs.

6.5 Improve Data Feedback

- Credible data management requires that state-level operatives to whom data has been submitted process that data and give regular and systematic feedback on programme performance both to the staff at data collection and reporting levels and those at the policy- and decision-making level
- The monthly LGA M&E meetings should be used as an effective forum for delivering not only feedback on quality of reports, but feedback for the data collectors and reporters on the results of analysis of the data they submit as well as the core interpretation, conclusions and recommendations for programme improvements.
- Where funding allows, the SMOH should regularly carry out Data Quality Assurance of data and services reported by the data aggregators. This could be done during the ISS visits to the data source facilities.

REPORT OF ASSESSMENT OF JIGAWA STATE | JULY 2010

Appendix 1: List of Key Informants

Respondent	Position	Work Area	Checklist No. Applied	Email Address	Telephone
1. Yusuf Yusufari	PRRINN State Team Leader,	State Immunisation Programme	4 only	yusufyusufari@yahoo.co.uk	08036176776
2. Nasiru Ilallah	PRRINN – MNCFI State Programme Officer	State Immunisation Programme	3 and 4	dr_mnas@yahoo.com	08036434750
3. Auwal Shehu	M&E/ Asst Procurement Officer, SMOH,	State M&E, Health System Project	3 and 4	auwalone1@yahoo.com	08069299329
4. Abdullahi Kainuwa	Director Policy, Planning, Resources Mobilisation and Statistics	State HMIS	1, 2 and 4	mkainuwa@yahoo.com	08035961532
5. Adamu G. Abubakar	State HMIS Officer	State HMIS/ M&E Malaria Control	2 and 4	ada_mu2003@yahoo.co.uk	08032079444
6. Ismail Mamuda	State Epidemiologist, Gunduma HSB	Surveillance / State M&E	2, 3 and 4	samkah1@yahoo.com	08034864266
7. Abdullahi Magama	Deputy Director Planning, M&E, Gunduma HSB	M&E PHC, Programmes	2, 3 and 4	ai_magama@yahoo.com	08065944635
8. Zanna Omar Ali	PATHS HMIS Officer	State HMIS	4 only	damaturu2005@yahoo.com	08036832435
9. Ibrahim A. Umar	State DSNO, Gunduma HSB	Surveillance / State M&E	1, 2 and 4	aiminu35@yahoo.com	08036440522
10. Sale Ibrahim	Deputy Director, Planning Gunduma HSB	State HMIS	2, 4	saledanbinta@yahoo.com	08036919621
11. Pharm. Usman Tahir	Director PRM&E	State M&E	1, 2 and 4	alhajindo@yahoo.co.uk	08036919848
12. Mohammed M. Shehu	PATHS2 M&E/KM	State M&E	1, 2 and 4	mohmustysh@yahoo.com	07068746242

<p>ABUJA No 37 Panama Street, Off Ibrahim Babangida Boulevard, Maitama - Abuja</p>	<p>ENUGU No 1, Coal City Gardens Estate, Off Okpara Avenue, GRA, Enugu State Team Leader Dorcas Edeani d.edeani@paths2.org</p>	<p>JIGAWA Plot No. 212 Nuhu Muhammed Sanusi Way, Dutse, Jigawa State Team Leader Abubakar Kende a.kende@paths2.org</p>	<p>KADUNA 1st Floor, Wema Bank Building, No. 22 Bida Road, Off Yakubu Gowon Way, Kaduna. State Team Leader Dr. Zainab Mohammed Idris z.muhammadidris@paths2.org</p>	<p>KANO No 9 Suleiman Crescent, after Ni'ima Guest Palace Hotel, Nasarawa - Kano. State Team Leader Dr Abubakar Izge a.izge@paths2.org</p>	<p>LAGOS Desiree House, No 2 Sheraton/Opebi Road, Beside Afrijet Building, Ikeja - Lagos.</p>
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National Programme Manager
Mike Egboh
m.egboh@paths2.org

Technical Programme Coordinator
Benson Obonyo
b.obonyo@paths2.org

State Programme Coordinator
Dr. Garba Safiyanu
g.safiyanu@paths2.org