JICA Technical Cooperation Project For
Strengthening Pro-Poor Community Health Services in
Lagos State

Half-Year Progress Report

for the Period of January – June 2018

31 July 2018

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01 Introduction

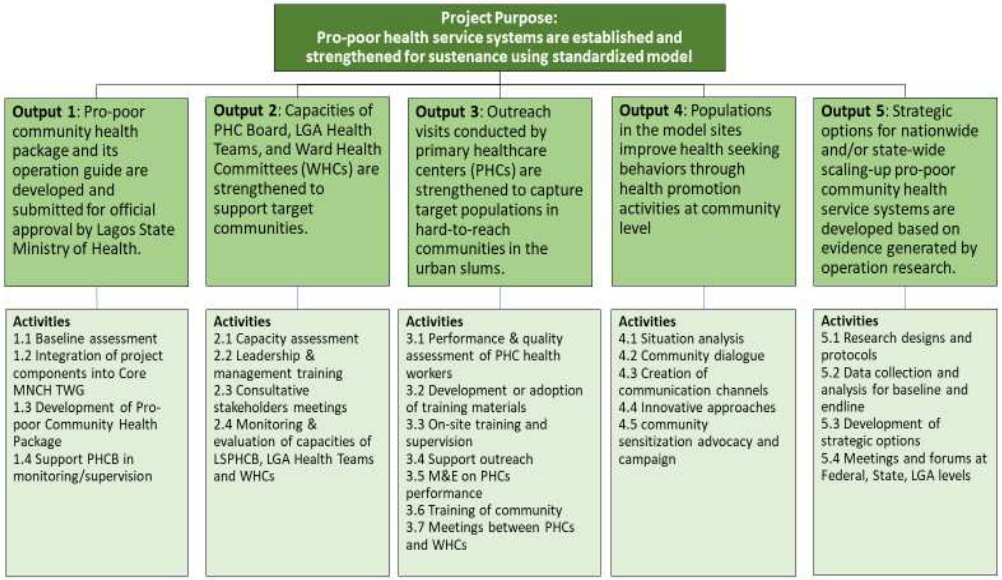
1.1. Background

- In Lagos State, the rapid population growth, which is not coping with the capital investment including health sector, has resulted in increasing number of population living in slum areas where basic services such as infrastructures, electricity, safe drinking water.
- It is noteworthy that disproportionate disease burdens exist among the poor who have limited access to health services due to geographic and financial barriers. As a result, the health coverage and utilization of health services is still limited among the indigent population.
- Lagos state set the revitalization of primary healthcare centres (PHCs) as one of the policies to improve the health at the community level. Delivery of health services at the community level has been enhanced by the establishment of 24-hour-7-day PHCs, recruiting more doctors, midwives, nurses, community health officers (CHOs) and community health extension workers (CHEWs).
- Given this context, to support the policy for strengthening primary health care at the community level is meaningful.
- Japan International Cooperation Agency (JICA) provided technical and financial support to Lagos State Ministry of Health (LSMOH) for implementation of a project namely "Project for Improving Maternal, Newborn and Child Health in the Lagos State" for the period of 2009 – 2014.
- The project intervened in capacity development of improving knowledge and skills of health workers at PHCs in antenatal care, delivery and postnatal care, hospital management by 5S approach, community health promotion activities and monitoring and evaluation (M&E).
- As an extension of the said project, to further address the needs of indigent people in urban slum areas, another 4-year technical cooperation project, namely "Project for Strengthening Pro-poor Community Health Services in Lagos State" was initiated in May 2014 based on the agreement made between Lagos State Ministry of Health (LSMOH) and Japan International Cooperation Agency (JICA) in February 2014.
- The project aims at establishing an evidence-based model of community health services for the indigent population in urban slums in Lagos State.
- The project started with Eti-Osa Local Government Area (LGA) and expanded its project area to Lagos Mainland LGA and Yaba Local Council Development Area (LCDA) in January 2017.
- With this expansion, the project period was also extended up to December 2018.

1.2. Project Design

- The project was designed to improve equitability, affordability and accessibility of maternal and child health services for indigent population in urban slum communities. A Project Design Matrix (PDM) was developed as an annex to the document, which lays out the project design by summarizing the project elements in a logical way: Project Goal, Purpose, Outputs and Activities with verifiable indicators and means of verification. The Project Goal and Purpose stated in the PDM is as follows:

Figure 1. Project Design



- Project Goal equitable, affordable and accessible maternal and child health services for indigent population in urban slum communities are improved.
- Project purpose: Pro-poor health service systems are established and strengthened for sustenance using standardized model
- The following five outputs were set in order to achieve the above project purpose:
  - Output 1: Pro-poor community health package and its operation guide are developed and submitted for official approval by Lagos State Ministry of Health.
  - Output 2: Capacities of Lagos State Primary Health Care Board (LSPHCB), Local Government Health Authorities (LGHA) and Ward Health Committees (WHCs) are strengthened to support target communities.
  - Output 3: Outreach visits conducted by primary healthcare centers (PHCs) are strengthened to capture target populations in hard-to-reach communities in the urban slums.
  - Output 4: Populations in the model sites improve health seeking behaviors through health promotion activities at community level.
  - Output 5: Strategic options for nationwide and/or state-wide scaling-up pro-poor community health service systems are developed based on evidence generated by operation research.
- Activities were planned to achieve each of the above outputs. Figure 1 on the next page depicts the project design.

1.3. Pro-Poor Community Health Model

Based on the results from a needs assessment conducted in Eti-Osa LGA at the initial stage of the project, a conceptual framework namely "Pro-poor Community Health Model" was developed. The model is for making health services accessible to the indignant population in urban slum communities in Lagos State. It is comprised of three pillars: 1) Accessibility Improvement, 2) Quality Improvement, and 3) Creation of Conducive Environment. Most of the project interventions fall under the pillar #1 that sets the target population into four categories as follows:

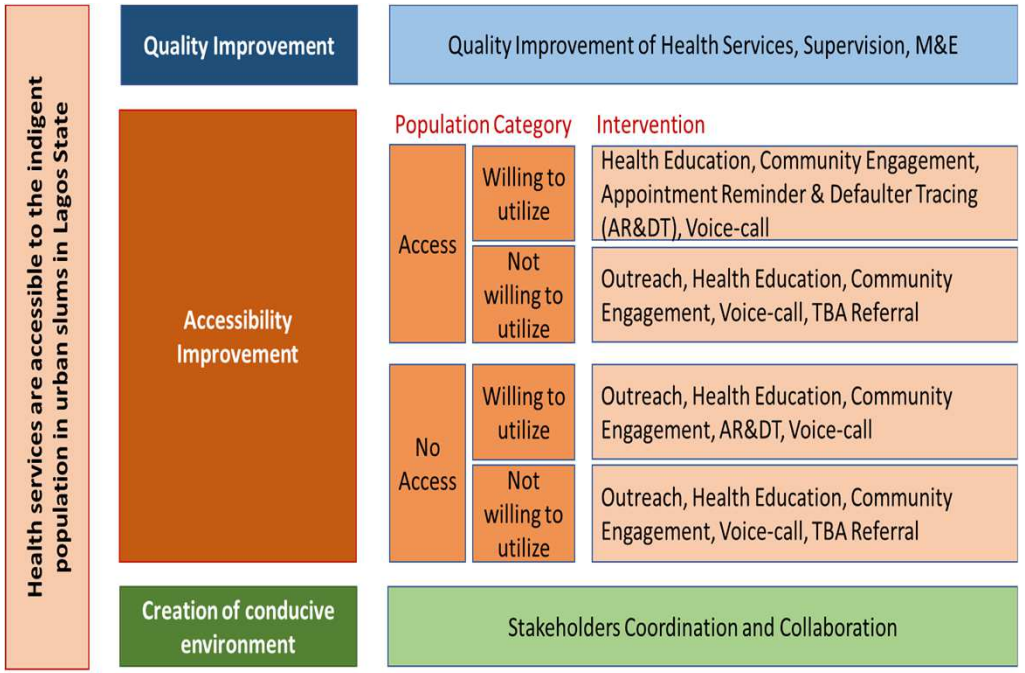
a. People who have easy access to a health facility and willingness to utilize the health services at the facility;
b. People who have easy access to a health facility but no willingness to utilize the services at the facility;
c. People who have difficult access to a health facility but willingness to utilize the health services at the facility; and
d. People who have difficult access to health facility and no willingness to utilize the services at the facility.

Six key interventions are employed for the model:

1) Strategic Outreach by health care providers
2) Community Health Education by CORPs
3) Community Engagement through WHC
4) Automatic Appointment Reminder and Defaulter Tracing SMS Delivery
5) Automatic Voice-call Message Delivery
6) Coordination for strengthening TBA Referral & Reporting

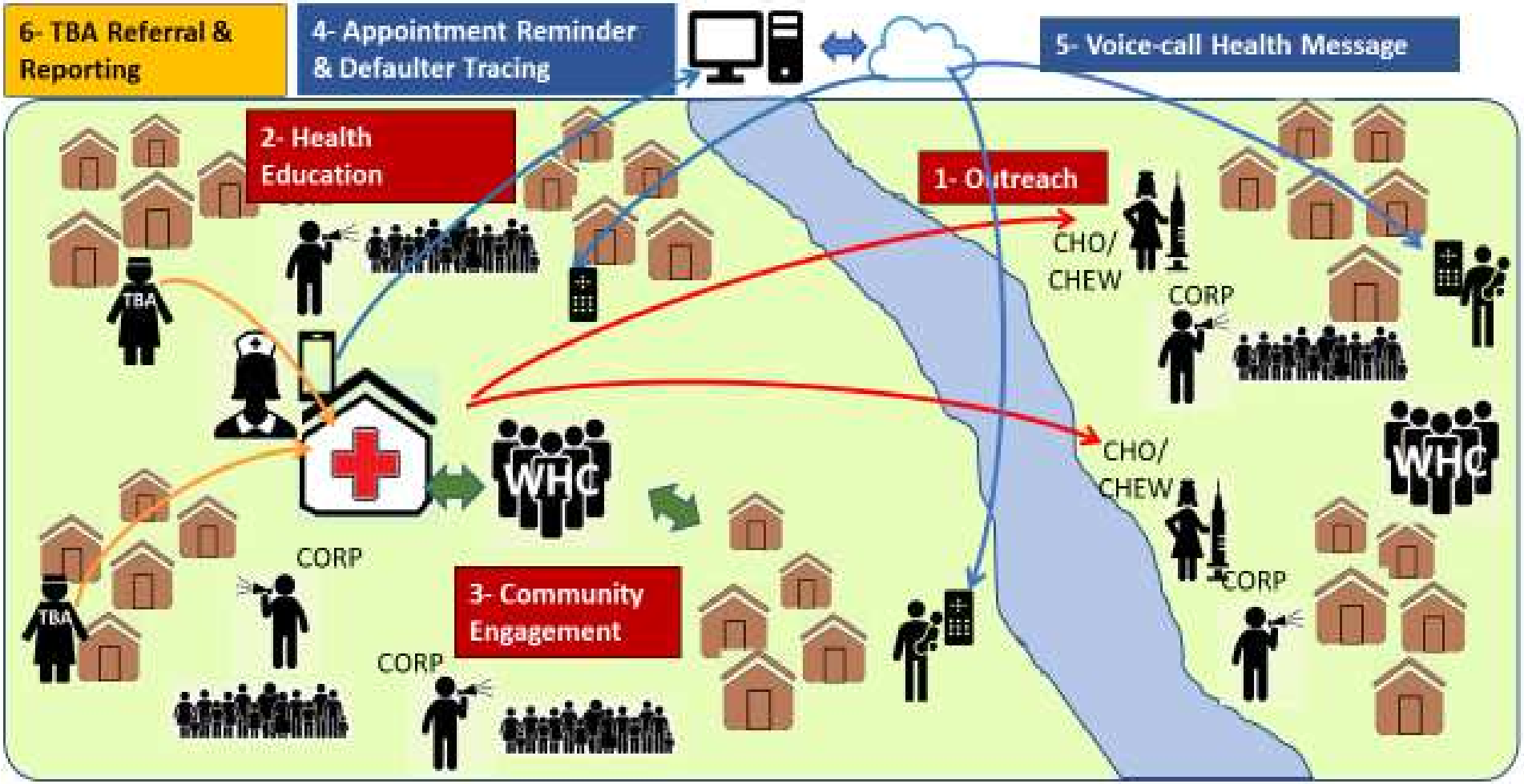
These six interventions are combined to fit for each target category as depicted in Figure 2 and 3.

Figure 2. Pro-poor Community Health Model



Provision or installation of equipment at health facilities, support for quality assessment of health facilities fall under the pillar #2 (Quality Improvement). Other activities regarding stakeholder coordination and collaboration including campaign support fall under the pillar #3.

Figure 3. Pro-Poor Community Health Model (Pictorial)



02 Progress, Achievements, Issues and Looking Ahead by Interventions

4th JCC Meeting on 12 Jan 2018

2.1. Strategic Outreach by Health Workers

2.1.1. Activities Undertaken and Plan (Figure 4)

2.1.2. Progress and Challenges

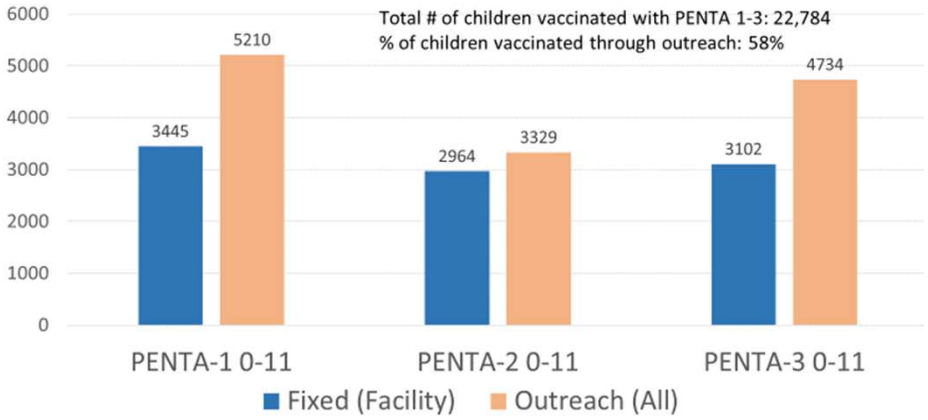
- Eti-Osa LGA finally submitted a list of HTR in Feb 2018, which was expected in Oct 2017, and started HTR outreach in the same month. HTR outreach visits however could not continue in March 2018 due to health workers' heavy engagement in the Measles Campaign 2018. Outreach data for Feb 2018 was submitted by LIO in the middle of Mar 2018, but quarterly data review meeting was not conducted due to the same reason. HTR outreach resumed in Apr 2018 and has been on-going although the outcome has not been encouraging.
- HTR outreach in Lagos Mainland has been undertaken as planned for the reporting period despite the Measles Campaign. Monthly data review meetings have been regularly conducted except in April 2018 when the LIO was on leave. A quarterly data review meeting also was held in March 2018 in the face of the Measles Campaign.
- There were several national campaigns taking place during the reporting period, which heavily engaged government health workers: Measles Campaign in March 2018, National Immunization Plus Day (NIPD) Week in April and June 2018.
- Eti-Osa has been sharing only HTR outreach immunization data with the Project. Consequently, the Project was able to do only partial analysis/comparison of immunization data. On the other hand, Lagos Mainland has been sharing monthly routine immunization reports capturing both facility-based, routine outreach and HTR outreach data with the project for deeper analysis.

2.1.3. Looking ahead

- Support HTR outreach visits up to October 2018 and monthly data review to November 2018.
- Prepare a joint quarterly data review meeting with both Eti-Osa and Lagos Mainland in July and another one in September 2018.
- Advocate for sustaining HTR outreach visits to those settlements, which have been bearing good outputs with the evidence.

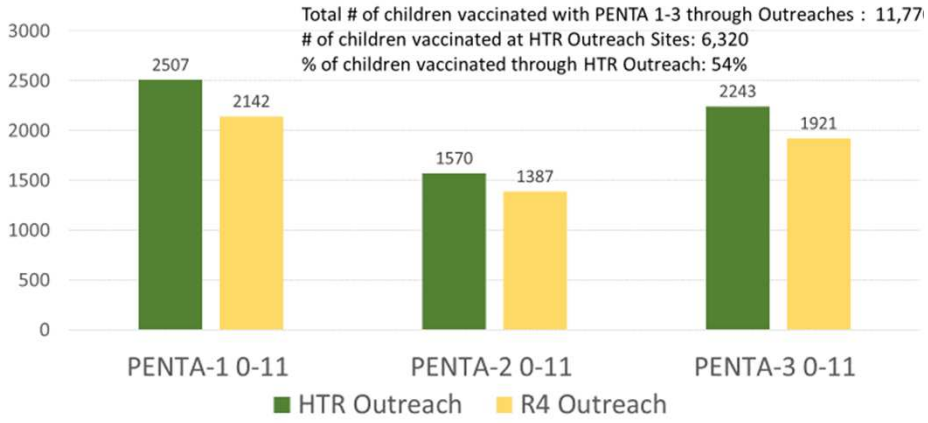
2.1.4. Achievements of Hard-to-Reach Outreach during Jan – Jun 2018

Figure 5. # of Children Vaccinated with PENTA 1-3 by Modes of Service for the period of January - June 2018



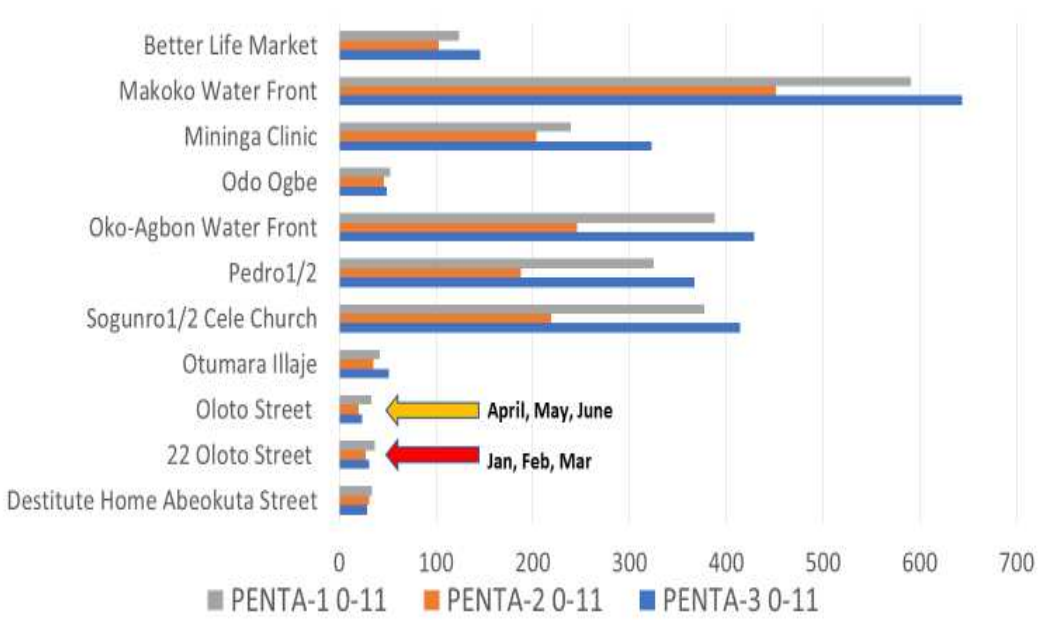
Data Source: L/Mainland Monthly RI Report Submitted to the State by LIO (Soft Copy) for the period of Jan – June 2018

Figure 6. Output Comparison between 4-Routine and HTR Outreach Sites for the period of January - June 2018



Data Source: L/Mainland Monthly Outreach Reports for the period of Jan – June 2018

Figure 7. Output Comparison by HTR Outreach Sites for the period of January - June 2018



Data Source: L/Mainland Monthly Outreach Report for the period of **Jan – June 2018**

2.2. Community Health Education by Community Resource Persons (CORPs)

2.2.1. Activities Undertaken (Figure 8)

2.2.2. Progress

- Community Resource Persons (CORPs) have conducted community health education talk sessions as planned during the reporting period. The numbers of CORPs in Eti-Osa, Lagos Mainland and Yaba are 9, 39 and 59 respectively. Lagos mainland and Yaba outnumber Eti-Osa due to ward coverage and population density.
- Monthly performance review meetings have also been undertaken as planned in all Eti-Osa, Lagos Mainland and Yaba Local Governments
- Constant supervision visits was provided to CORPs by the LGA team members. A WhatsApp group was created for LGA team members (supervisors) and the project to share the up-to-date supervision activity with photos and has been well utilized.

2.2.3. Challenges

- CORPs are paid for transportation after conducting health education sessions based on their performance (number of verifiable reports submitted for the previous month). The support motivates them to deliver education sessions to the community; however, transportation support poses a big challenge for the LGAs to maintain them although the transportation fee was reduced from NGN 1,000 to 750 per session in May 2018 due to budget constraint by the JICA headquarters.
- In addition, to check and verify the CORP daily registers and calculate the transportation fee based on their performance is a tedious work, which is difficult for the LGA teams to sustain.

2.2.4. Looking Ahead

- Knowledge-level test for CORPs is being planned during the performance review in August 2018.
- Organize a refresher training for CORPs in September 2018 in consideration of the knowledge test results.
- Continue support for transportation to CORPs until the end of September 2018 and the performance review meeting until October 2018.
- Encourage the LGA teams to devise a mechanism to sustain or utilize the trained CORPs for improvement of community health after the end of the project.

2.1.5. Achievements

- Figure 9 depicts the number of caregivers reached out through the sessions reported by CORPs. Each individual CORP is encouraged to reach out minimum 10 persons through one session and conduct 10 sessions in a month so as to achieve 10,000 monthly target in the aggregate. The monthly target has been achieved except February 2018. In March, the number reached 12,000.
- Figure 10 illustrates average number of caregivers reached by one CORP. In terms of individual CORPs' achievement in quantity, Eti-Osa is higher than others. CORPs' performance seems affected in Eti-Osa and Yaba in May 2018 since transport fee reduction was announced in April 2018, but recovered in June 2018. Lagos Mainland has steadily been increasing since January 2018.
- Constant supervision by the LGA teams (mainly Health educators) has contributed to the recovery and the improvement of the CORPs performance.

Figure 9. Number of caregivers reached through Health Education Sessions

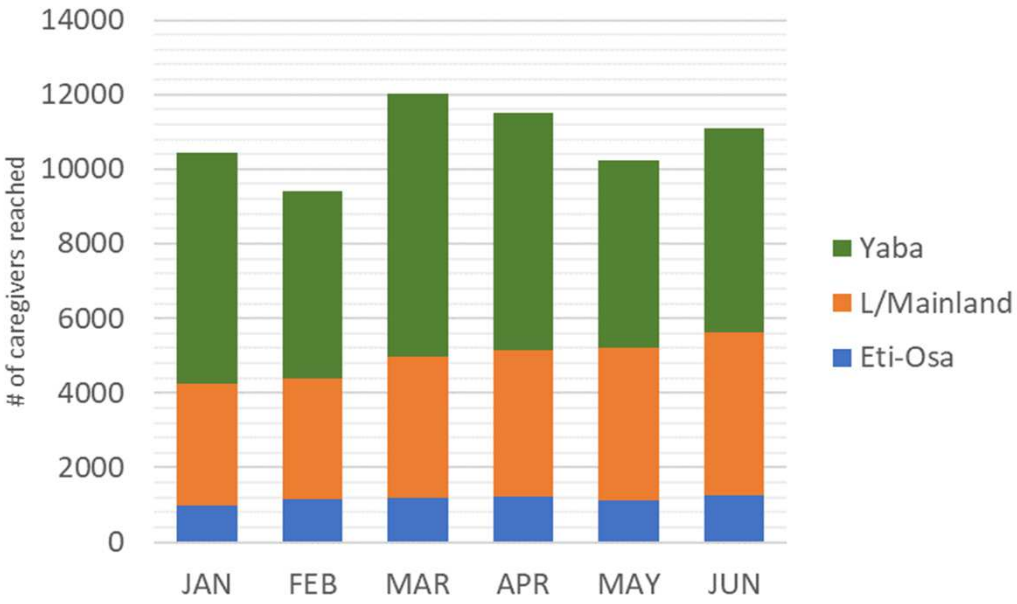
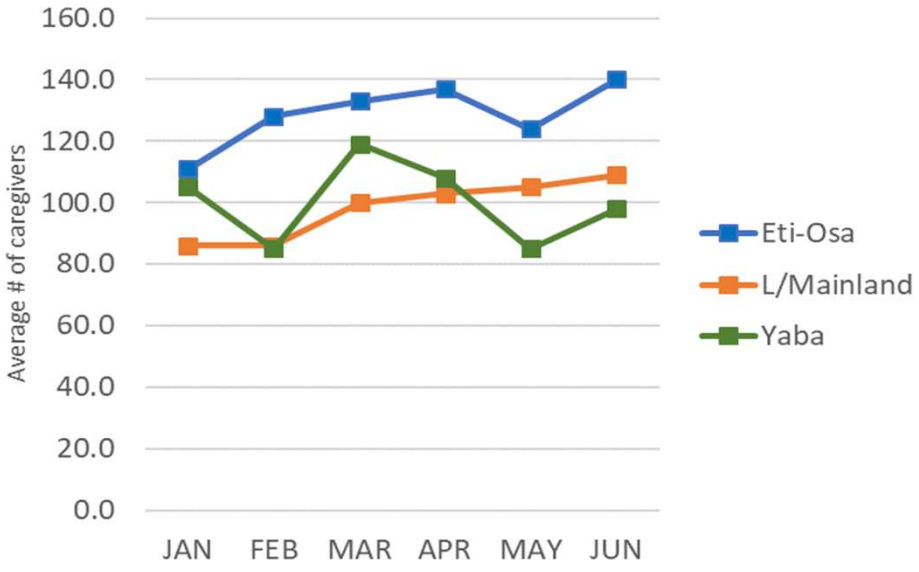
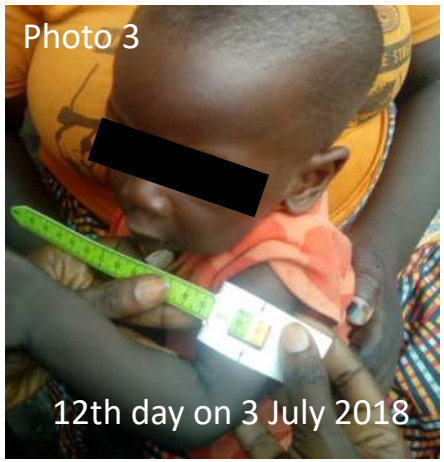


Figure 10. Average number of caregivers reached through Health Education Sessions per CORP



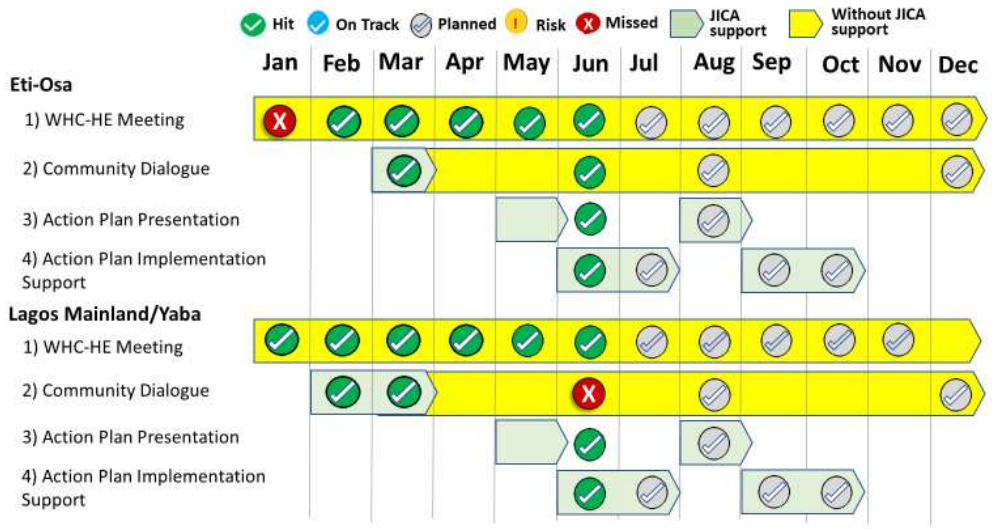
2.1.6. Good Practices

- Several children with suspected severe acute malnutrition have been identified through MUAC measurement and reported by CORPs. During May and June 2018, 9 cases out of other cases were enrolled for close follow-up by the Lagos Mainland MOH. One of them became lost-to-follow-up after MUAC turns yellow because the mother travel with the child and had not returned. The other 8 cases have been closely followed up.
- The photos 1-5 illustrate the recovery process of one of the malnourished boy.
- His mother residing in Okobaba was not sure about child's age but further investigation on visiting her house revealed that the child was estimated about 11 months of age. He was so severely malnourished that he was referred to Mercy Children's Hospital first to rule out any metabolic diseases. He commenced food supplement. He weighed only 4.6kg at the time of enrollment. He was fed twice daily with food supplement and milk apart from the regular meals for 2 weeks. The mother was also taught how to make affordable complementary feeds. After one month, he weighed 8 kg as indicated in Photo 5.
- Six out of other 7 other babies have successfully recovered from red to green. One of them is still in a state of yellow despite the one month feed of food supplement due to some episodes of malaria and diarrhea.



2.3. Community Engagement through WHCs

2.3.1. Activities Undertaken (Figure 11)



2.3.2. Progress

- Monthly WHC Chairmen Meetings with the Health Educator have been regularly conducted in both Eti-Osa and Lagos Mainland without support from JICA.
- Community dialogue meetings have been implemented in February – March 2018 by all wards and in June by Ikate Ward in Eti-Osa. Community needs in terms of health service improvement were identified through the community dialogue.
- Each ward developed an action plan to improve health services at the PHC covering the ward based on the needs identified during April - May 2018.
- A meeting for all wards to present and share their action plans was successfully conducted in June 2018. All the action plans presented were assessed by judges (LSPHCB and LGA team members) and 12 out of 23 wards were selected for action implementation.
- Guidelines for the ward action plan implementation was developed and shared with the wards selected. Guidelines describe how procurement should be documented and accountably presented.
- Procurement by the 12 WHCs has started in June 2018.

2.3.3. Challenges

- Some wards in Eti-Osa have not grasped the importance of the action plan development cycle and perceive it as a nuisance work.

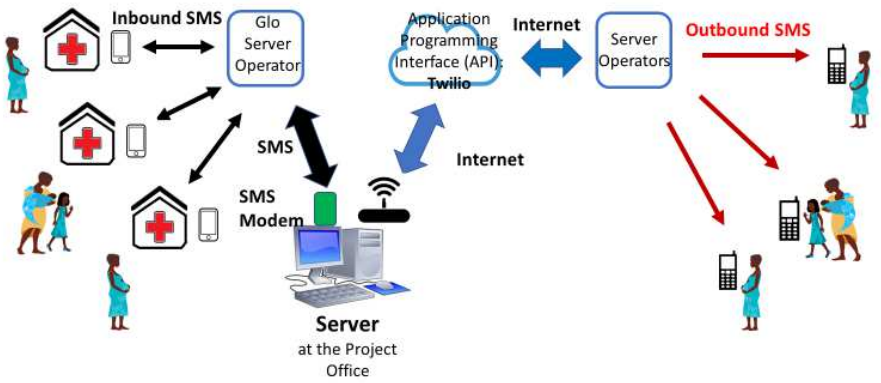
2.3.4. Looking ahead

- Implementation of the action plans should be monitored by each LGA team.
- Implementation is expected to be completed by the end of July 2018.
- Second round of the cycle will be conducted in August and September 2018.
- The sequence of the activities for action plan development and implementation is a practical training for WHCs, starting from needs identification, problem analysis, action plan development, advocacy (presentation), implementation of action plan and submission of all accounting documents. WHCs must have been equipped with the practical knowledge and skills for their active pursuance in their roles even after the project.

2.4. Automatic Appointment Reminder and Defaulter Tracing SMS Delivery

2.4.1. System Design (Figure 12)

Appointment Reminder and Defaulter Tracing SMS Communication Design



2.4.2. Activities Undertaken (Figure 13)

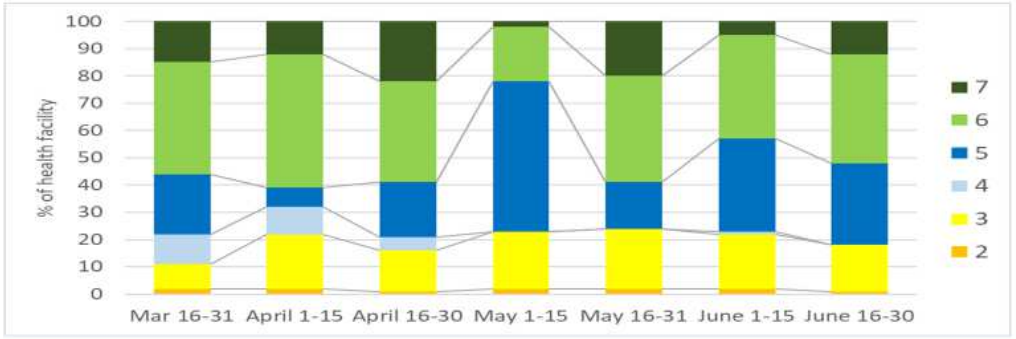
2.4.3. Progress and Challenges

- PHCs are supposed to input appointment information on the mobile application and transmit the data to the server. The server allocate the appointments into a control group and 6 intervention groups, then automatically send reminder SMSs to clients according to the groups they belong to. PHCs should confirm clients' return on the appointment day so that the server can recognize defaulters and send another reminder SMS to them. PHCs should confirm those defaulters when they return on a later day. Defaulters who don't show up are then notified to each PHC for further follow-up.
- Re-orientation training was conducted to improve performance of PHCs on 29th Jan and 1st Feb, inviting all staff engaged in the operation at 100 PHCs and MOHs.
- Supervision visits and telephone mentoring have been carried out throughout the reporting period.
- Expansion training originally planned in March and June wasn't taken place because the effectiveness of the intervention was yet to be demonstrated due to lack of data amenable to analysis. Therefore, no supervision or telephone mentoring was made to those 192 PHCs that have not started the intervention.
- budget constraint has also affected the plan for expansion.
- Weekly review meeting had been conducted except when the LSPHCB focal person was not available due to other engagements.
- Biweekly monitoring report was suspended during the period from mid February to the end of March 2018 due to data discrepancies between the data on the server and on the mobile phones, which was detected in the course of data analysis. The issue was immediately reported to the program developer for their investigation. They concluded that the low capacity of SMS modem and slow internet caused the data loss that caused the discrepancy.

2.4.3. Progress and Challenges (Cont'd)

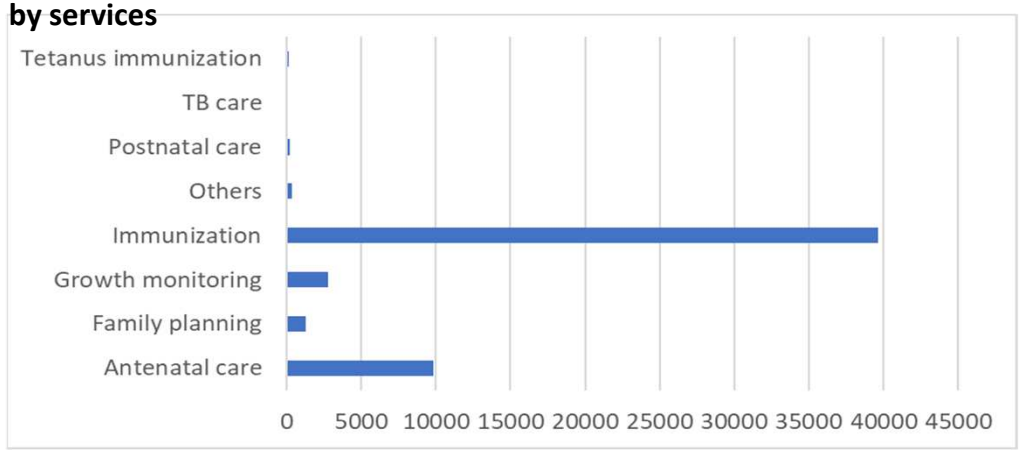
- Therefore, the modem was switched to high capacity modem (GoIP) that can handle large quantity of SMSs at a time and internet was replaced with a high speed and dedicated band-with internet service (CobraNet) in March 2018. A high spec server with auto-backup system was also purchased in line with the recommendations made by the Ministry of Science and Technology for smooth operation of the intervention.
- The data discrepancy issue seemed minimized at the beginning of April 2018 and biweekly reporting resumed and continued.
- Figure 14 illustrates PHCs' performance in line with the standard procedure. Dark green denotes percentage of PHCs trying to confirm both clients and defaulters return, which accounts for less than 20% every month. Light green indicates PHCs confirming clients returned but not defaulters returned.
- Based on the available data, number of appointments uploaded by 100 PHCs to the server was collated by service types (Figure 15). There were 54,300 appointments uploaded, of those 39,594 accounting for 72.9% was immunization appointments and 9,853 (18.1%) antenatal care.
- Among the appointments, 3,333 appointments were uploaded after the scheduled appointment days, which implies that no reminder SMSs were delivered to those clients.
- Figure 16 is a bar chart displayed on the dashboard on 1st June 2018. It clearly illustrates that confirmation of clients' and defaulters' return has not been done well. Negligence in the confirmation resulted in a lot of created appointments falling under pending status (refer to the blue bars in Figure 16). Another negligence in confirmation of defaulters' return resulted in a lot of defaulters falsely remaining as defaulters. The grey bars are supposed to appear as number of defaulters returned.
- All the above issues have been shared with MOHs at a monthly MOHs meeting organized by LSPHCB and held on 30th May 2018, urging their attentions and actions to rectify the issues.

Figure 14. Biweekly monitoring of PHC's performance in line with operating procedure



Color	Score	Situation
	7	Appointment register recorded, data entry consistent, uploaded data confirmed at the server, clients' receipt of reminder messages confirmed, returned client confirmed and defaulter returned clients' confirmed by PHC
	6	Appointment register recorded, data entry consistent, uploaded data confirmed at the server, clients' receipt of reminder messages confirmed and Returned clients confirmed by PHC
	5	Appointment register recorded, data entry consistent, uploaded data confirmed at the server and clients' receipt of reminder messages confirmed
	4	Appointment register recorded, data entry consistent and uploaded data can be confirmed at the server but clients' receipt of reminder messages have not been confirmed yet
	3	Appointment register recorded and data entry consistent but uploaded data cannot be confirmed at the server for the past 2 weeks
	2	Appointment register recorded and data entry started but inconsistent for the past 2 weeks
	1	Appointment register recorded but data entry not started
	0	Appointment register not recorded. Nothing started.

Figure 15. # of appointments uploaded to the server during Jan-Jun 2018 by services



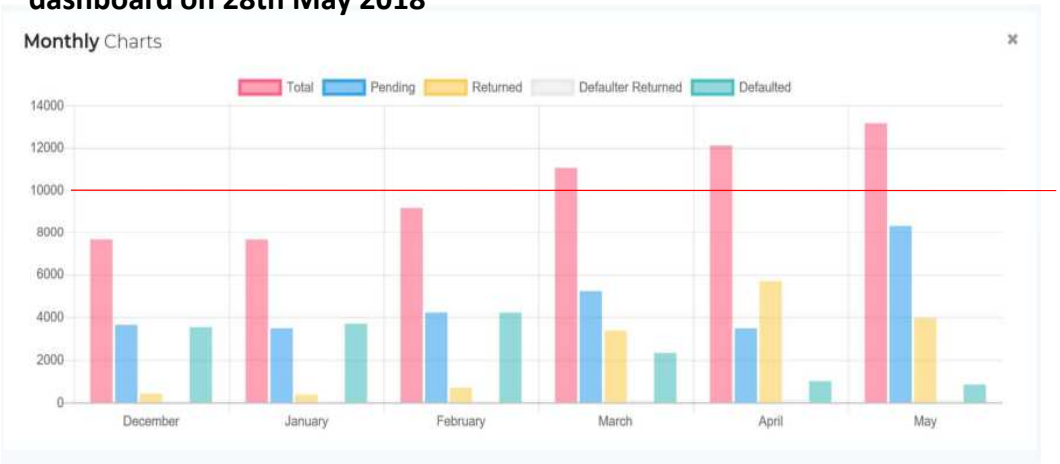
- It was revealed at the end of May 2018 that the data discrepancy issue had not been rectified. In addition, the bar chart displayed on the dashboard of the portal site was highly volatile and showing precarious data. Figures 16 and 17 are the bar charts displayed on 1st June 2018 and 28th May 2018 respectively. Two graphs were just 4-day apart, yet the figures changed drastically in quantity for April and May within the 4 days.
- Aggregation of blue, yellow, grey and green should be equal to pink, but the logic is defied in May in Figure 16.
- Moreover, there was a sudden unexplainable sharp decline of appointments in June 2018. The software developer tried to troubleshoot but could not identify the cause. While troubleshooting on this issue during the first and second weeks of June 2018, the interface was unable to be updated.

2.4.4. Looking Ahead

- Continue encouraging PHCs for better data entry operation and keep on monitoring the data generated under the current system with 100 PHCs.
- Urge the program developer to improve data extraction program that can produce data set amenable to analysis.
- Try to analyze the data to demonstrate the effectiveness of the intervention.
- Concurrently develop a concept on rebuilding the system to make its operation simpler and more manageable at PHC level, make the system generate more reliable data and simplify data collation, analysis and interpretation. Discuss the concept with all the stakeholders and have a consensus on the basic operation flow and architecture design.
- Develop the simplified system in line with the concept and pilot-test the system with a few PHCs to assess its operability and database functionality.
- Replace the current system with the new system as many PHCs as possible within the available budget that was affected by the budget constraint.
- The State to devise a way to sustain the intervention by allocating budget.

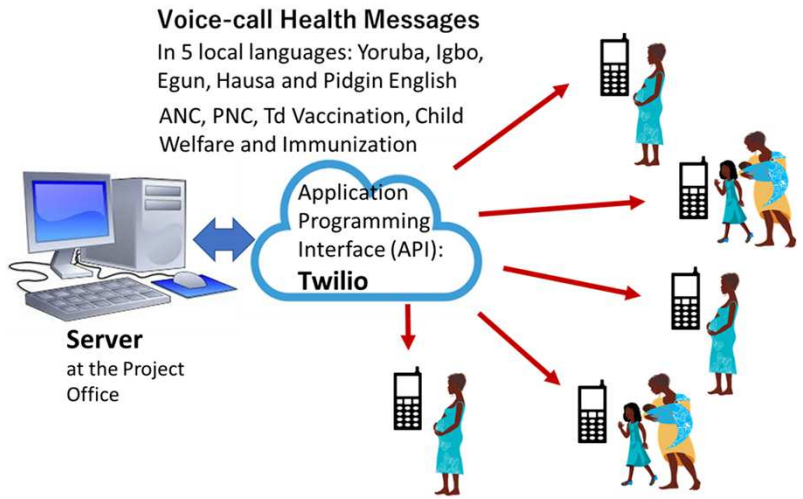
Figure 16. # of Appointments and Defaulters appeared on the portal dashboard on 1st June 2018

Figure 17. # of Appointments and Defaulters appeared on the portal dashboard on 28th May 2018



2.5. Automatic Voice-call Health Message Delivery

2.5.1. System Design (Figure 18)



- This intervention is designed to directly and automatically deliver health messages to antenatal, postnatal and caregiving women in their preferred local language.
- Twenty-three messages are sequenced and programmed in accordance with stages of pregnancy and age of newborn baby: five messages for antenatal period and eighteen for post delivery period. One message is delivered every other week until nine months after delivery.
- The first voice message contains a few questions regarding the mother's pregnancy status or delivery date to determine the most appropriate message to start with. The mothers who responded to the questions could proceed to the second message next time.
- The messages are translated into 5 local languages: Yoruba, Igbo, Hausa, Egun and Pidgin English. Target audience is 1,500 women who were interviewed in the Baseline Survey (then-pregnant) conducted in February 2017 and were interested in receiving the voice-call messages.

2.4.2. Activities Undertaken (Figure 19)

2.5.2. Progress and Challenges

- Delivery of automatic voice-messages started at the end of December 2017 although it should have started long before.
- The delay has seriously affected the intervention since the most of the pregnant women participated in the baseline survey in Feb 2017 had already delivered their babies by Oct 2017 and missed the opportunities to listening to health messages tailored for antenatal and postnatal period.
- At the beginning of January 2018, the project was reported by the program developer that the majority of the mothers hung up the initial voice call. An action was immediately undertaken to make a reminder call to every targeted mother one by one, encouraging them to accept the voice calls and listen to the messages.
- In January, 1,738 completed calls* were made to the mothers. Despite the above efforts, number of mothers who fully responded to the questions in the initial message didn't increase as expected.

*Completed calls means calls picked up even for a second

- The program developer took too long time to develop a WEB portal site for the project to monitor the progress, which was supposed to be ready by the end of 2017. The portal site was finally opened at the beginning of May 2018 and the data stored in the database has become accessible since then for monitoring.
- Figures 20 illustrates number of completed calls and call duration based on the data in the database. Nearly half of the calls were hung up the phone within 1 minute before fully responding the questions in January 2018. Considering the fact that It takes more than 2 minutes to fully respond the questions, the graph indicates that majority of the mothers didn't respond to the questions.
- The project initiated the initial voice-call message to those mothers who didn't either pick up or fully respond to the questions several times during January, February, March and May 2018 as indicated in Figure 21.
- With the introduction of a high spec server with a high speed internet service at the office in March 2018, the voice data was transferred from a cloud server to the ground server. It was debunked however that the internet service the project was using was not capable enough to transmit a heavy data such as voice data and failed to do so. It was not until end of April 2018 that the program developer reported it to the project. The voice data was immediately transferred back to the cloud server.
- As of 30th June 2018, only 78 mothers proceeded to the educational messages, 65 of those still hung up the phone within one minute (Figure 22).
- The voice messages have not reached the target audience widely enough.
- The program is designed for research purpose, targeting only those women interviewed for baseline survey conducted in Lagos Mainland in February 2017, with random allocation of target audience into intervention and control groups. This means that not every women who expressed their willingness to receive the messages actually receive them.

2.5.3. Looking Ahead

- Continue message delivery and monitoring of call duration of the mothers until November 2018
- Number of mothers who have benefited is so limited that other ways of utilization of voice messages should be urgently discussed with LSPHCB. If the ideas generated could be implementable within the project budget and period, then swiftly substantiate the ideas before the end of the project.

Figure 20. Call duration of mothers in January 2018

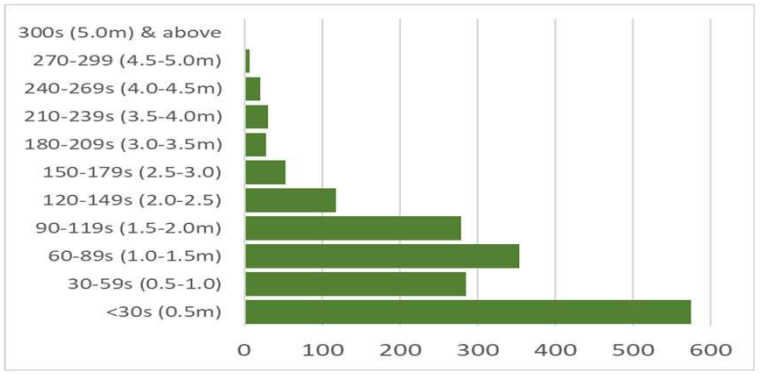


Figure 21. Number of completed calls (picked up by mothers even for 1 second

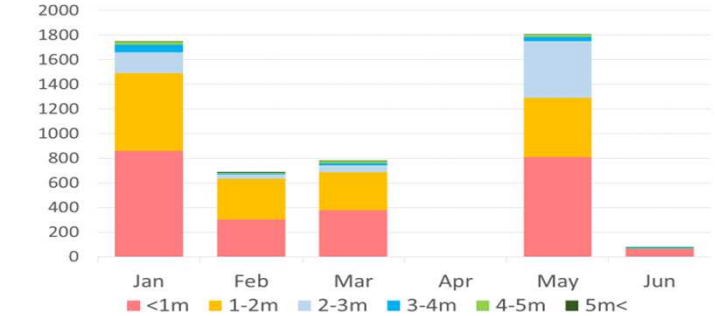
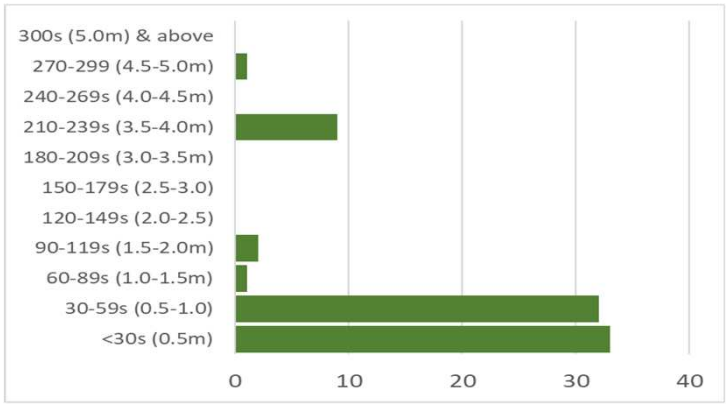


Figure 22. Call duration of mothers in June 2018



2.6. Coordination for TBA Referral & Reporting

2.6.1. Activities Undertaken (Figure 23)

2.6.2. Progress and Challenges

- A consultant was recruited to facilitate the development of TBA reporting and referral system.
- A technical working group (TWG) was formulated to coordinate and oversee the development process and provide technical input at each stage of the development. Six TWG meetings have taken place as of 5th July 2018.
- TBA tally sheet and reporting formats were drafted for pilot testing.
- As part of pilot testing. 2-day training of trainers (TOT) was conducted at Cedar Centre (Yaba) in May 2018.
- Sequel to the TOT, 3-day step-down training was held in Eti-Osa and Yaba respectively and concurrently.
- Field testing of reporting and referral tools took place immediately after the step-down training for one month. The testing period became short due to some delay in the development process.
- Data supervision and validation meeting was held in June 2018 to assess the usage of submitted reporting and referral tools and data quality.
- Community Health Management Information System (CHMIS) Database software was developed and installed at the M&E office of LSPHCB. M&E staff were trained on the database.
- Final draft was submitted at the end of June 2018.

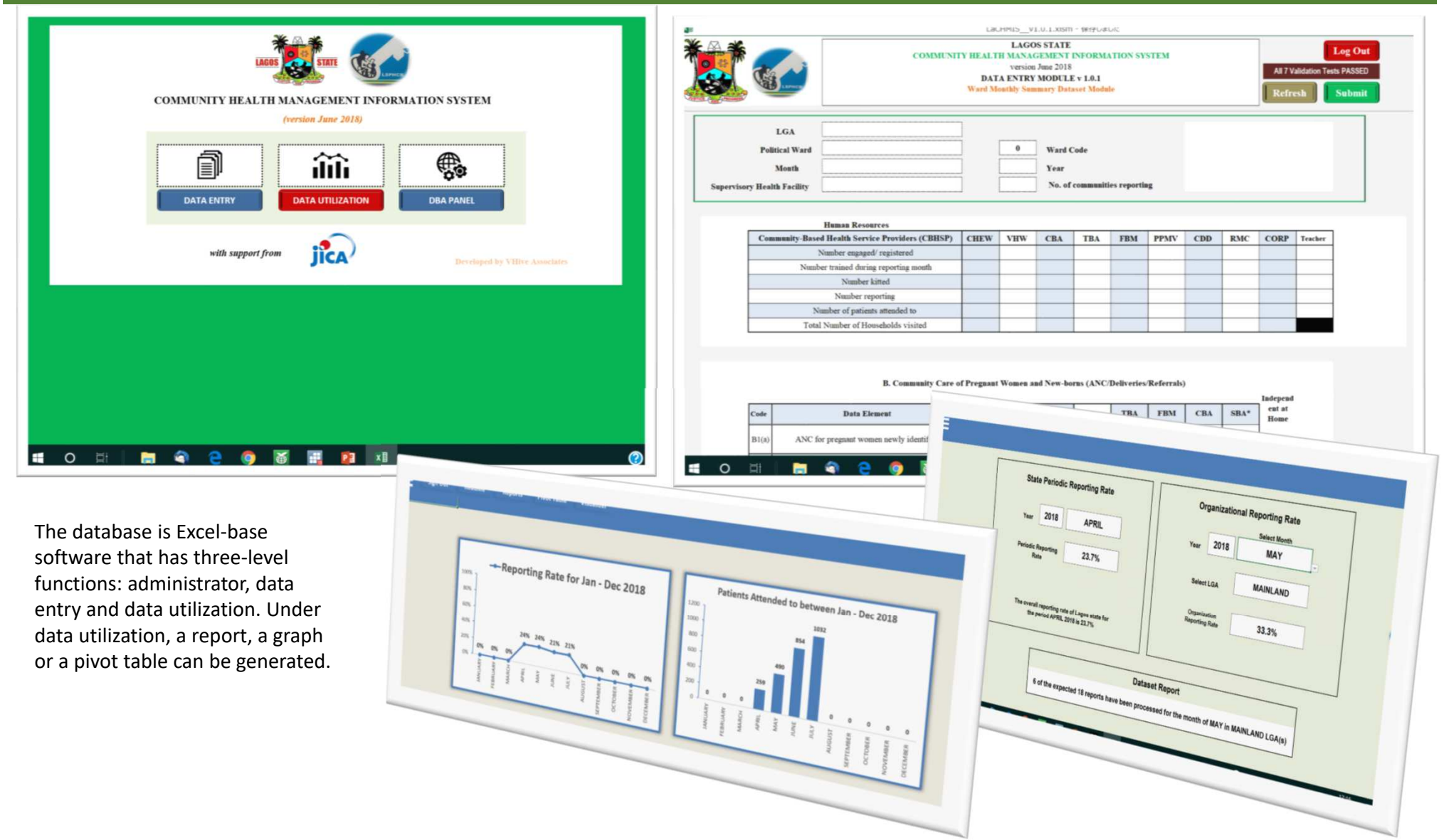
2.6.3. Achievements

- Number of TOTs trained: 11 State-level and 19 LGA-level personnel in Eti-Osa, Lagos Mainland and Yaba
- Number of TBAs trained: 11 in Eti-Osa and 25 in Lagos Mainland/Yaba
- Final Draft of Community-level Health Information Management System Reporting and Referral Tools developed:
    1) Two-way referral slip
    2) Referral register
    3) Community-based Health Service Provider Tally Sheets (Pregnant Women and Delivery, Childhood Illnesses, HIV, Maternal and Child Mortality)
    4) Community Monthly Summary Form
- Data for April and May 2018 was entered into the CHMIS database.

2.6.4. Looking Ahead

- Hold the 6th TWG meeting on 5th July 2018 to share the final draft of the documents, results of data validation and supervision and data for April and May 2018.
- Continue to support for CHMIS monthly data validation meetings until September 2018 to monitor the data flow from TBAs to CHOs, LGA and LSPHCB.
- Print the CHMIS tools for the next one year use for the pilot LGAs.
- Encourage LSPHCB to maintain the TWG to make a follow-up even after the pilot period.
- The State to devise a way to expand the intervention by allocating budget.

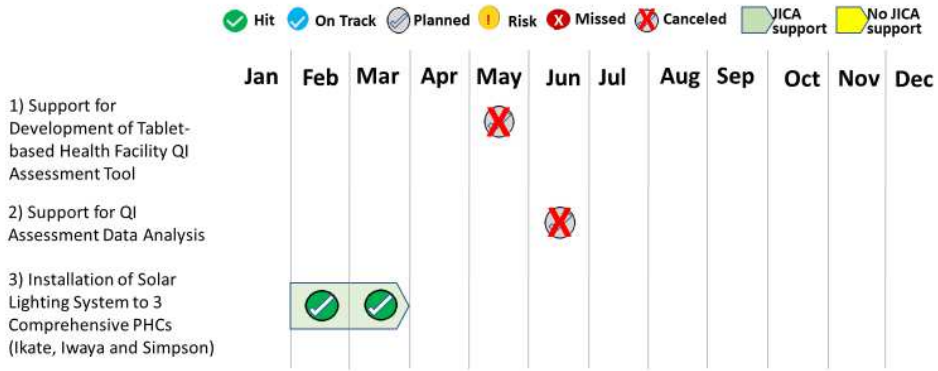
2.6.5. CHMIS Database (Figure 24)



The database is Excel-base software that has three-level functions: administrator, data entry and data utilization. Under data utilization, a report, a graph or a pivot table can be generated.

2.7. Quality Improvement

2.7.1. Activities Undertaken (Figure 25)



2.7.2. Progress, Issues and Achievements

- Support for development of mobile QI assessment tool and data analysis were canceled due to the budget constraint.
- Solar lighting system was installed at three comprehensive PHCs, namely Ikate PHC in Eti-Osa LGA, Simpson PHC in Lagos Mainland and Iwaya PHC in Yaba LCDA in March 2018. These PHCs frequently encounter difficulties to provide maternal and child health services at night due to the intermittent electric power supply. The issue had been repeatedly raised during community dialogues. Initial assessment was done and the concept was agreed with the LGA health teams and the LSPHCB in February 2018.

Photo 6. Ikate PHC staff with Solar Switch Board, Controller and Batteries

Photo 7. Solar panels installed on the roof of Iwaya PHC

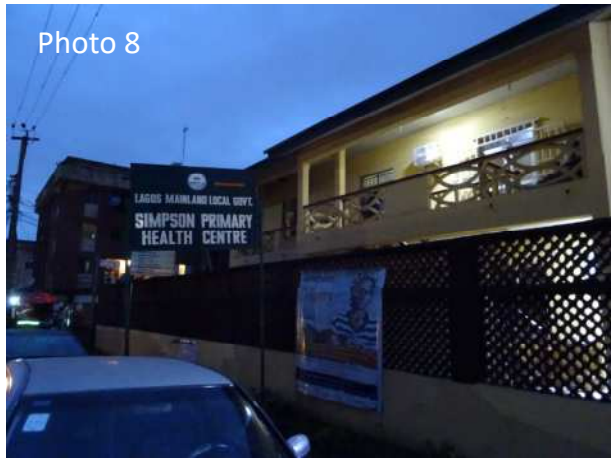


Photo 8. Solar light operating at night at Simpson PHC

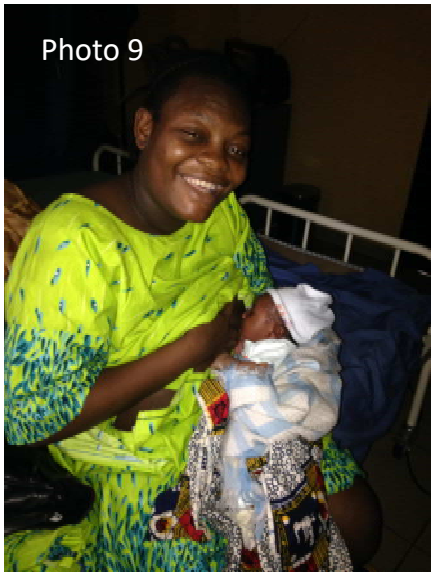
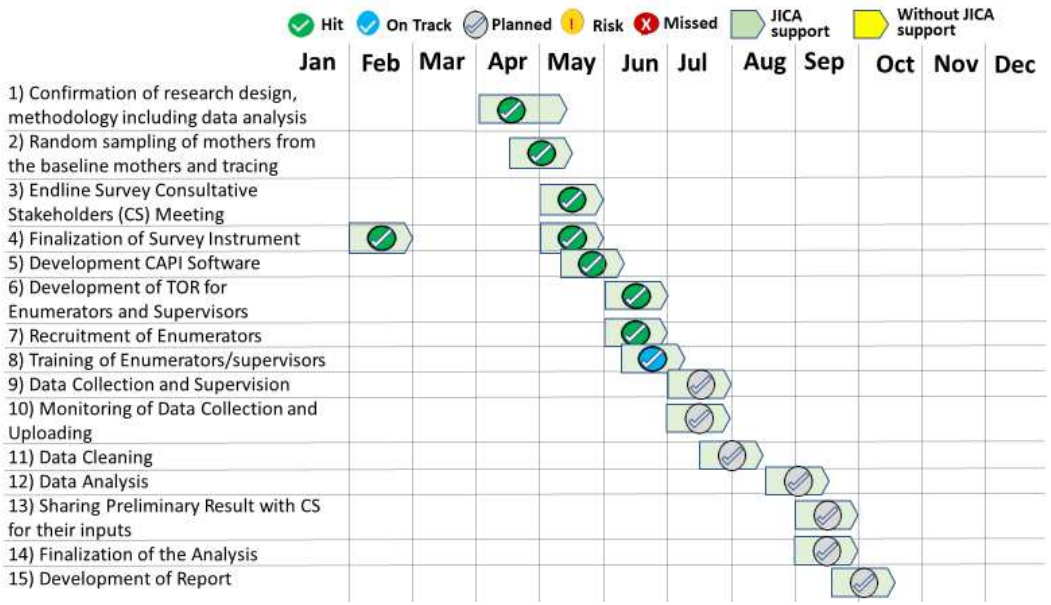


Photo 9. A woman delivered under the solar light at Simpson PHC

2.8. End-line Survey

2.8.1. Activities Undertaken (Figure 26)



2.7.2. Progress, Issues and Achievements

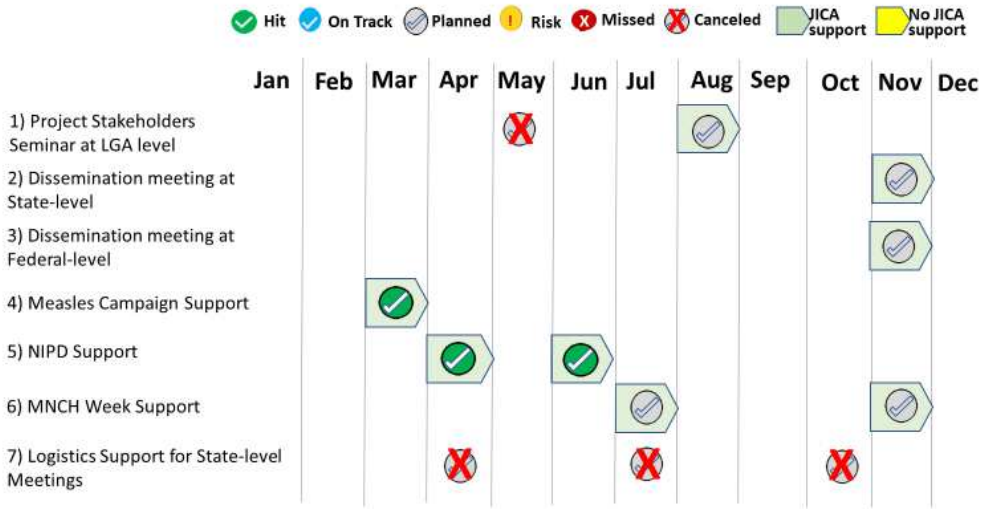
- In February 2018, the draft end-line survey questionnaire was reviewed and pretested through mock interviews in the field. Representatives from LSMOH and LSPHCB participated in the pre-test.
- Results of the pretest and methodologies to identify the same mothers who participated in the baseline survey were shared in a consultative stakeholder meeting for the end-line survey held after the pre-test in February 2018.
- In March 2018, the project was informed that the budget allocated for the end-line survey and related activities had been completely expunged.
- Vigorous negotiation with the headquarters had been done and some amount of budget has been recovered, with which the data collection and analysis could not be outsourced to a research institution and was switched to insourcing in collaboration with LSMOH and LSPHCB.
- In addition, sampling size was reduced from 2,112 to 1,000 due to the limited budget. 1,000 mothers have been randomly sampled from the original sample. They are being traced by telephone calls, CORPs and geographic coordinates.
- The research design and methodology has been shared in a consultative stakeholders meeting attended by representatives from LSMOH, LSPHCB and Lagos Mainland and Yaba local governments on 1st June 2018.
- Based on the resolutions made during the meeting, 30 enumerators were recruited from N-power staff working in Surulere, Mushin, Somolu, Lagos Island, Lagos Mainland and Yaba in June 2018.
- End-line questionnaire was finalized in the middle of May 2018 and sent to an agent to transform it to Computer Assisted Personal Interview (CAPI) tool. The draft tool was reviewed several times before use at the end of June 2018.
- Supervisors have been nominated and trained in June 2018 with the CAPI tool.

2.7.3. Looking Ahead

- Train the enumerators on their roles and responsibilities, how to trace and interview mothers with the CAPI tool.
- Dispatch the enumerators, supervise them and monitor uploaded data and clean the data.
- Collate, analyze and interpret the data and share the results with stakeholders.
- Compile the report.

2.9. Stakeholder Collaboration and Advocacy

2.9.1. Activities Undertaken (Figure 27)



2.9.2. Progress

- The project supported the implementation of the Measles Vaccination Campaign 2018 in March 2018 by providing 13 LGAs with transportation cost for outreach to hard-to-reach settlements, purchase of megaphones for community mobilization and development of jingles for community announcement.
- The project also supported National Immunization Plus Days (NIPD) in April and June 2018 with radio jingles.
- A project stakeholder seminar and financial support for state-level meetings were canceled.
- TWG and Apex CHOs Meetings due to the budget constraint.

2.9.3. Looking Ahead

- Organize a LGA-level project stakeholders seminar to share the end-line results.
- Organize dissemination meetings at the state and the federal levels to share the project outcomes
- Provide support for Maternal, Neonatal and Child Health Week to be held in July and November 2018.

Photo 10. Hand-over of megaphones to LSPHCB on 14th March 2018

Photo 11. Community mobilization for measles campaign in March 2018

2.10. Other Notable Events

Jan Feb Mar Apr May Jun

Photo 12. 10th January: A visit by a team of Japanese Government High-level Officials to Okobaba Destitute Home to observe outreach and health education session

Photo 13. 12th January: 4th JCC Meeting held to review the progress for the period of Jun-Dec 2017 attended by HCH, SA, Representatives from Federal MOH, LSMOH, LSPHCB, Local Governments and Wards

Photo 14. 12th April : A visit by a Special Advisor to the President of JICA to Ilaje community in Lagos Mainland

Photo 15. 17th May: 5th JCC Meeting held to review the progress, the budget constraint situation and its impact on the implementation of planned activities attended by HCH, SA, a representative from Federal MOH, LSMOH, LSPHCB, Local Governments

03 Progress in line with the Project Design Matrix (PDM*)

*PDM is an annex of the official document (Record of Discussion) signed by both Nigeria Government and JICA for implementation of the project. It is a matrix laying out the project design that summarizes the project elements in a logical way: goal, purpose, outputs and activities with verifiable indicators and means of verification.

Output 1: Pro-poor community health package and its operation guide are developed and submitted for official approval by Lagos State Ministry of Health.

No.	Activity described in PDM	Actual activity conducted or to be conducted	Implementation Status	
1-1	Conduct, analyze, and share baseline assessment on geographical, demographic, economic, social, and health aspects in target communities	Needs Assessment in Eti-Osa	Completed in Dec 2014	
		Baseline Survey in Eti-Osa	Completed in Aug 2015	
		Baseline Survey in Lagos Mainland	Completed in Apr 2017	
1-2	Integrate pro-poor community health components into the responsibility of the Core Technical Working Group on MNCH	Sharing project progress in MNCH CTWG Meetings, Routine Immunization TG Meetings and Social Mobilization WG Meetings	On-going	
1-3	Jointly develop, pro-poor community health package, and operation guide and, if needed, revise them based on field-testing	Development of operation guides (Outreach, CORPs' Health Education, WHC Empowerment, Appointment Reminder and Defaulter Tracing, Voice-call Message Delivery and TBA Referral and Reporting)	To be conducted	
1-4	Support PHCB in monitoring and supervision	Support for Quality Assessment of PHCs	Conducted in Jul 2017	
		Monitoring and supervision on AR&DT operation, CORPs health talks, Outreach	On-going	
		Monitoring on Voice-call message delivery	On-going	

Completed | On-going and on track | To be conducted | To be conducted with delay or no concrete plan | Not conducted and no plan to conduct

Output 2: Capacities of PHC Board, LGA Health Teams, and Ward Health Committees (WHCs) are strengthened to support target communities.

No.	Activity described in PDM	Actual activity conducted or to be conducted	Implementation Status	
2-1	Conduct capacity assessment for effectively implementing project's activities (LSPHCB, LGA Teams and WHCs)	Pre- and post-test of Leadership and Management Training and WHC training/refresher training	Completed in Jun 2015, Jul 2015, Feb 2017 and Dec 2017	
2-2	Conduct basic training on leadership, management, and governance according to the assessment results	Training on leadership, management and Governance for LSMOH, LSPHCB and Eti-Osa LGA Team TOT for C-IMCI (CORPs) Training, WHC Training, AR&DT Training	Completed in Jun 2015	
2-3	Regularly conduct consultative stakeholder meetings for pro-poor community health services among relevant organizations	Consultative stakeholders meetings with LGA Teams	On-going	
2-4	Conduct monitoring and evaluation (M&E) of capacities of PHC Board, LGA Health Teams, and Ward Health Committee (WHC)	No activities conducted or planned for monitoring and evaluation of capacities of PHCB and LGA Team	Not done and no plan to do	
		Conduct monitoring and evaluation of capacities of WHCs	On-going	

Completed | On-going and on track | To be conducted | To be conducted with delay or no concrete plan | Not conducted and no plan to conduct

Output 3: Primary health centers (PHCs) are functioning enough to provide pro-poor community health services through improvements of performance of community health officers (CHOs), community health extension workers (CHEWs), other PHC workers and Ward Health Committee (WHC) members

No.	Activity described in PDM	Actual activity conducted or to be conducted	Implementation Status	
3-1	Conduct and review performance and quality assessment for CHOs, CHEWs, other PHC workers and WHC members	Support for Quality Assessment of PHCs	Conducted in May-Jul 2017	
3-2	Develop pro-poor community health training materials through reviewing and adopting the existing training materials	Adoption of Training Material on C-IMCI for CORPs	Completed in 2015	
		Adoption of WHC Training Material	Completed in Nov 2017	
		Development of AR&DT Training Material	Completed in Jul 2017	
		Modification of AR&DT Training Material	On-going	
3-3	Conduct on-site training on community health services	On-site Supervision to PHCs on AR&DT	On-going	
		On-site Supervision to Immunization Outreach	On-going	
		On-site Supervision to CORPs' health education sessions	On-going	
		Support for Quality Assessment of PHCs	Conducted in May-Jul 2017	
3-4	Support implementing bi-monthly outreach activity	Support for implementation of monthly outreach to hard-to-reach sites	On-going	

Completed

On-going and on track

To be conducted

To be conducted with delay or no concrete plan

Not conducted and no plan to conduct

Output 3: Primary health centers (PHCs) are functioning enough to provide pro-poor community health services through improvements of performance of community health officers (CHOs), community health extension workers (CHEWs), other PHC workers and Ward Health Committee (WHC) members

No.	Activity described in PDM	Actual activity conducted or to be conducted	Implementation Status	
3-5	Conduct monitoring, evaluation and supervision (ME&S) of PHCs' performance	Telephone mentoring & on-site supervision on AR&DT	On-going	
		Support for Quality Assessment of PHCs	Conducted in May-Jul 2017	
		Development of Community HMIS (CHMIS) System	Completed in Jun 2018	
		Data validation and supervision of CHMIS	On-going	
3-6	Conduct training on community health for Ward Health Committee members	Initial Training of WHCs for Eti-Osa	Completed in Jul 2015	
		Initial Training of WHCs for Lagos Mainland	Completed in Feb 2017	
		Refresher training of WHCs	Completed in Nov-Dec 2017	
		Initial Training of CORPs in Eti-Osa	Completed in Nov 2015	
		Initial Training of CORPs in Lagos Mainland	Completed in Mar 2017	
		Refresher training of CORPs	To be conducted	
		Support for TBA registration and training	Completed in 2015	
		Training of TBAs and CHOs/CHEWs on CHMIS and referral	Completed in Jun 2018	
3-7	Organize joint regular meetings between PHCs and WHCs to strengthen their linkage	WHC monthly meetings with Health Educators	On-going	
		Problem analysis and action plan development in WHC refresher training with Facility In-Charges	Completed in Nov-Dec 2017	
		Quarterly meeting for developing a proposal for improvement between PHC and WHC	1st round to be completed in July and 2nd round in September 2018	

Completed | On-going and on track | To be conducted | To be conducted with delay or no concrete plan | Not conducted and no plan to conduct

Output 4: Populations in the model sites improve health seeking behaviors through health promotion activities at community level

No.	Activity described in PDM	Actual activity conducted or to be conducted	Implementation Status	
4-1	Conduct situation analysis for current status of health promotion	Problem identification, analysis and action plan development by WHC	Conducted in Feb-March 2018 and another one to be conducted in Aug 2018	
4-2	Open a strategic dialogue on community health between community leaders and stakeholders	Problem identification, analysis and action plan development by WHC	Conducted in Feb-March 2018 and another one to be conducted in Aug 2018	
4-3	Create multiple communication channels at community level (eg: Between community health volunteers and mothers' group, School health activity)	Support CORPs to conduct health education sessions in their communities	On-going	
		Empower WHCs to act as a mediator between their communities and PHCs/LGAs	On-going	
		Delivery of appointment reminder and defaulter tracing SMSs to PHC clients	On-going	
		Delivery of voice-call messages to pregnant women and mothers	On-going	

Completed | On-going and on track | To be conducted | To be conducted with delay or no concrete plan | Not conducted and no plan to conduct

Output 4: Populations in the model sites improve health seeking behaviors through health promotion activities at community level

No.	Activity described in PDM	Actual activity conducted or to be conducted	Implementation Status	
4-4	Develop and conduct innovative approaches for promoting community health services	Development and operationalization of appointment reminder and defaulter tracing SMSs system	On-going	
		Development and operationalization of voice-call message delivery system	On-going	
		Development of Standardized TBA referral and reporting mechanism	On-going	
4-5	Conduct community sensitization, advocacy, and campaigns for community health services	Support CORPs to conduct health education sessions in their communities	On-going	
		Empower WHCs to act as a mediator between their communities and PHCs/LGAs	On-going	
		Courtesy visits to LGA Chairmen	On-going	
		Support MNCH Week, Measles Campaign, NIPD	Support for Measles Campaign and NIPD completed. Support for MNCH Week to be supported	

Completed | On-going and on track | To be conducted | To be conducted with delay or no concrete plan | Not conducted and no plan to conduct

Output 5: Strategic options for nationwide and/or state-wide scaling-up pro-poor community health service systems are developed based on evidence generated by operation research.

No.	Activity described in PDM	Actual activity conducted or to be conducted	Implementation Status	
5-1	Develop research designs and protocols for approval by the authorities for research clearance	Develop operational research design and protocol for the research in Eti-Osa and get approval by the LSMOH and the Lagos State Univ. Teaching Hospital Health Research Ethics Committee	Completed in Apr 2016	
		Develop research designs and protocols for the research in Lagos Mainland and get approval by the LSMOH and the Lagos State Univ. Teaching Hospital Health Research Ethics Committee	Completed in Jun 2017	
5-2	Conduct data collection and analysis through baseline and end-line surveys	Baseline Survey	Completed in Mar 2017	
		Endline Survey	On-going	
5-3	Develop strategic options for the state-wide and/or nationwide scaling-up strategies in an evidence-based manner	Develop operation guides (Outreach, CORPs' Health Education, WHC Empowerment, Appointment Reminder and Defaulter Tracing, Voice-call Message Delivery and TBA Referral and Reporting)	To be conducted	
5-4	Conduct regular meetings and forums with Federal Government Authorities, State Government Authorities, Local Government Authorities, and Development Partners to share project achievements and lessons-learned.	Sharing project progress in MNCH CTWG Meetings, Routine Immunization TG Meetings, Social Mobilization WG Meetings and SOLM Steering Committee Meetings	On-going	
		Sharing project progress at the Federal Level	To be conducted	

Completed

On-going and on track

To be conducted

To be conducted with delay or no concrete plan

Not conducted and no plan to conduct

Project Purpose: Pro-poor health service systems are established and strengthened for sustenance using standardized models

Indicators described in the PDM	Indicators specified	Means of verification
1. Pro-poor community health package and its operation guide are in the official approval process for their state-wide scale up.	Availability of Pro-poor Community Health Model and its Operation Guide for state-wide scale-up	Document JCC Minutes
2. Full vaccination coverage among children increases.	Difference between the intervention-exposed and the non-exposed groups on the percentage of women age 15-49 who had a live birth in the past one year and whose child immunized in accordance with the RI schedule	Operational Research Report (Base- and End-line Survey)
3. The proportion of pregnant women who utilize ANC and SBA increases	Difference between the intervention-exposed and the non-exposed groups on the percentage of women age 15-49 who had a live birth in the past one year and attended antenatal care more than 4 times during her recent pregnancy	Operational Research Report (Base- and End-line Survey)
	Difference between the intervention-exposed and the non-exposed groups on the percentage of women age 15-49 who had a live birth attended by a skilled birth attendant in the past one year	Operational Research Report (Base- and End-line Survey)

JICA Technical Cooperation Project For
Strengthening Pro-Poor Community Health Services in Lagos State
Web Site: https://www.jica.go.jp/project/nigeria/007/index.html (Japanese)
Facebook: https://www.facebook.com/jicalagospropoorcommunityhealth (English)