# A REPORT ON THE FIRST ROUND IMPLEMENTATION OF MATERNAL AND CHILD HEALTH WEEK

## BAYELSA STATE


**BY**

**JESUDEIGHA PRECIOUS TEBEPAH**

**DATA MANAGEMENT LEAD**


## 13TH – 17TH OF JUNE 2025

## Executive Summary

The June 2025 Maternal, Newborn, and Child Health (MNCH) Week in Bayelsa State was a targeted public health campaign conducted across all eight Local Government Areas (LGAs) and 105 wards. Its aim was to deliver essential maternal and child health services to underserved and high-risk populations. The campaign officially began with a state-wide flag-off ceremony on June 13, 2025, at FSP Clinic Ovom, and ran through June 17, with mop-up activities concluding on June 19. The campaign featured a coordinated delivery of key health interventions including Vitamin A supplementation, deworming, routine immunization, MUAC screening for malnutrition, micronutrient supplements for pregnant women, malaria and HPV vaccinations, and birth registration.

Bayelsa State achieved varying degrees of success across the services offered. Vitamin A supplementation reached 438,628 children out of a target of 527,802, marking an 83% coverage rate. Deworming reached 257,646 children out of 469,167, achieving 55% coverage. MUAC screening was conducted for over 280,000 children, identifying 118 with severe malnutrition (red), 4,521 with moderate malnutrition (yellow), and the remainder as healthy (green). The coverage for Micronutrient Supplements (MMS) among pregnant women stood at 19%, with 12,973 women reached, while only 2,197 women received Iron Folate, indicating a high prevalence of anaemia based on the screening criteria required for administration.

One of the standout achievements was the Human Papillomavirus (HPV) vaccination, which reached 330% of the monthly target. This significant increase was attributed to active school-based outreach conducted during the week, highlighting the effectiveness of focused, high-impact interventions. On the other hand, malaria vaccine coverage was modest at 17%, while birth registration was critically low, with only 1,258 children registered out of a target of 96,764 equating to just 1% coverage.

While the campaign made measurable gains, it also faced several operational and logistical challenges. These included delayed commencement in certain wards, data reporting inconsistencies, commodity shortages, particularly of Albendazole, and insufficient logistics support for teams, especially in hard-to-reach areas. Routine immunization services were inconsistently delivered in some LGAs, further highlighting systemic challenges.

Despite these setbacks, the campaign demonstrated the effectiveness of coordinated planning, strong community engagement, and dedicated field supervision. The MNCH Week also provided valuable lessons and recommendations for strengthening future health interventions in Bayelsa State.

## INTRODUCTION AND BACKGROUND

In a bold and coordinated effort to combat the high rates of maternal, newborn, and child mortality in Nigeria, the Federal Ministry of Health, in collaboration with development partners and state governments, continues to champion the bi-annual Maternal, Newborn, and Child Health Week (MNCHW). This nationwide campaign, first endorsed at the 53rd National Council on Health (NCH) in Asaba in 2010, has since become a flagship initiative for delivering high-impact, lifesaving interventions directly to communities. It is organized twice yearly across all 36 states and the Federal Capital Territory, typically in May/June and November/December, as a means of accelerating access to Reproductive, Maternal, Newborn, Child, and Adolescent Health plus Nutrition (RMNCAH+N) services.

The June 2025 round of MNCHW in Bayelsa State was conducted from June 13 to 17, with a two-day mop-up exercise from June 18 to 19 to reach underserved populations. This marked the state's continued commitment to the National Strategic Health Development Plan II (NSHDP II) and the broader Sustainable Development Goals (SDGs), particularly SDG 3.1 and 3.2, which aim to reduce global maternal mortality to less than 70 per 100,000 live births and end preventable deaths of newborns and children under five years of age by 2030.

The context for this intensified intervention is a stark one. According to the 2023 Progress Report on Improving Maternal and Newborn Health and Survival, Nigeria accounts for approximately 82,000 maternal deaths annually. Neonatal deaths reach 277,000 each year, while about 181,000 stillbirths occur. Additional concerns include 14% low birth weight rates, high anemia prevalence among pregnant women (about 4.6 million affected), and low antenatal care coverage, with only 44% of pregnant women receiving at least one ANC visit. Nutritional deficiencies also remain prevalent. Only 34% of pregnant women receive dietary counseling, and just 67% receive Iron and Folic Acid (IFA) supplements. Furthermore, 14% of pregnant women contract malaria during pregnancy, 59% are affected by H. Pylori infection, and 5% suffer from helminthic infestation. At least one in five women has deficiencies in zinc, vitamin A, or iron, underscoring the urgent need for comprehensive maternal nutrition strategies.

Recognizing this, the Federal Government has taken bold steps in maternal nutrition. In 2021, Nigeria officially permitted the use of Multiple Micronutrient Supplements (MMS) during pregnancy, aligning with the WHO's 2020 recommendation on antenatal care for a positive pregnancy experience. By 2023, Nigeria was selected as one of the prioritized countries for MMS scale-up. Efforts are ongoing in pilot states like Bauchi for adherence research, and Nigeria's inclusion in the 2024 Maternal Nutrition Acceleration Plan has made it eligible for significant MMS stock allocations; up to three million bottles expected in 2024 alone. MMS has since been added to the national essential medicines list and is now a Disbursement Linked Indicator (DLI) under the new World Bank-supported HOPE-PHC initiative. To drive implementation, a national taskforce has been inaugurated to provide technical oversight and policy direction for the MMS scale-up.

Bayelsa State's MNCH Week in June 2025 was therefore designed not just as a routine campaign but as a comprehensive, integrated service delivery model. Anchored on primary health care platforms and implemented through both static and outreach teams, the MNCHW targeted the most vulnerable groups: newborns, children under five, pregnant and nursing mothers, women of childbearing age, caregivers, and even men, who received counseling on family planning, HIV Testing Services (HTS), and health promotion. The week offered an expanded service package including immunization, vitamin A supplementation, deworming, nutrition education, nutrition screening using Mid-Upper Arm Circumference (MUAC), dietary counseling, malaria prevention through LLINs and intermittent preventive treatment, MMS/IFA supplementation, and birth registration.

Teams were structured for efficiency. At the facility level, each team typically consisted of a vaccinator and a recorder, while outreach teams had dedicated immunization and nutrition focal persons and recorders. For school-based interventions, where HPV vaccine delivery was intensified, the outreach model allowed for targeted engagement of adolescents, particularly girls, with proven success as seen in the extraordinary HPV vaccine coverage of 330% during the campaign.

An emphasis was placed on nutrition, with the national protocol guiding the integration of MMS into antenatal care services. MMS was administered after necessary assessments as part of the minimum nutrition package for pregnant women, which also included education on hygiene behaviors, dietary diversity, and anemia and diabetes screening. In line with national guidelines, women diagnosed with anemia during ANC were referred for standard iron-folate treatment rather than MMS, which is intended for preventive use.

The 2025 MNCH Week in Bayelsa State thus reflected a deepening of strategic intent and operational scope. It served not only to catch up on essential services often missed during routine care but also to strengthen community health literacy and drive behavior change. Through structured outreach and targeted supervision, the campaign sought to bridge equity gaps in health service delivery, particularly in remote and riverine areas where access to care remains a persistent challenge.

Conclusively, the MNCHW has evolved into a vital strategy for public health outreach in Nigeria. Its successful execution in Bayelsa demonstrates what can be achieved when national policy, technical expertise, and local implementation converge with a shared goal of improving maternal and child health. However, the campaign also highlighted systemic challenges such as delayed ward activation, commodity shortages, and data quality issues, which need to be addressed to ensure that subsequent rounds of MNCHW are not only comprehensive but also equitable and sustainable. The lessons learned from the 2025 round will inform future programmatic adjustments and advocacy for stronger health systems capable of delivering quality care to every mother and child, regardless of geography.

**BAYELSA STATE: DEMOGRAPHIC, GEOGRAPHIC, AND OPERATIONAL CONTEXT FOR MNCH WEEK IMPLEMENTATION**

Bayelsa State, located in the heart of the Niger Delta region of southern Nigeria, presents a unique demographic and geographic landscape that significantly shapes the planning and implementation of public health interventions such as the Maternal, Newborn, and Child Health (MNCH) Week. Comprising eight Local Government Areas (LGAs), 105 political wards, and 227 Primary Health Care (PHC) facilities, the state is characterized by a combination of densely populated urban centers and expansive, hard-to-reach riverine communities interspersed across its wetlands, creeks, and mangrove swamps.

The recently concluded MNCH Week in Bayelsa State conducted from June 13 to June 17, 2025, with mop-up activities extended until June 19, was a high-impact initiative aimed at scaling up access to essential Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH+N) services. The campaign's success was heavily influenced by careful population-based planning and localized strategies that accounted for the demographic makeup and logistic challenges inherent in the state's terrain.

For the purpose of the MNCH Week implementation, Bayelsa State used a projected 2025 population of 2,932,230, based on a 2.9% growth estimate from the 2024 population. This total population figure served as the basis for deriving the target numbers across various intervention packages. Differentiated percentages were applied to identify the specific population groups eligible for each service, ensuring that resources were allocated efficiently and that high-impact interventions reached their intended beneficiaries.

The breakdown of the population targeting across different health interventions is summarized below:

- Vitamin A Supplementation (Children 6–59 months): 18% of the total population
- Deworming (Children 12–59 months): 16%
- HPV Vaccination (Girls aged 9 years only): 1.3%
- Routine Immunization Antigens (excluding malaria and HPV): 3.3% (monthly estimate)
- Malaria Vaccine (children aged 5–17 months): 3.2% (monthly estimate)
- Multiple Micronutrient Supplementation (MMS) for pregnant women: 4.6% (mid-year estimate)
- Birth Registration (Children under 1 year): 3.3%
- Nutritional Screening (MUAC for children): Full-year population based on age bands

It is important to note that while some interventions such as Vitamin A, deworming, MUAC screening, and birth registration used the full-year projected population figures, others like routine immunization and HPV vaccination used monthly projections to reflect routine service delivery volumes. MMS coverage used the mid-year population to better align with antenatal care flows.

This careful demographic profiling allowed health planners to set realistic and measurable targets, ensuring that the MNCH Week reached the right groups at the right scale.

Bayelsa's geography poses both strategic advantages and operational challenges for health interventions. The state is predominantly riverine, with over 70% of its communities accessible only by water. This makes the deployment of health services logistically complex, particularly during the rainy season (typically from May to October), when waterways can be difficult to navigate and inland roads are prone to flooding and erosion. The MNCH Week fell during this critical weather period, requiring additional planning to ensure timely delivery of services and commodities.

Each of the state's eight LGAs; Brass, Ekeremor, Kolokuma/Opokuma, Nembe, Ogbia, Sagbama, Southern Ijaw, and Yenagoa, has distinct characteristics that influence healthcare delivery. While LGAs like Yenagoa, the state capital, have more urbanized infrastructure and better health facility density, others such as Southern Ijaw and Ekeremor are deeply riverine, with scattered settlements that demand boat travel and mobile outreach strategies.

In total, 105 political wards and 227 Primary Health Care (PHC) facilities participated in the MNCH Week. Health teams were deployed across both fixed posts (facility-based service delivery) and outreach posts (mobile teams to hard-to-reach communities). This dual-mode approach ensured coverage equity between urban and rural/riparian populations.

Bayelsa is predominantly inhabited by Ijaw ethnic groups, with sub-ethnic variations such as Nembe, Ogbia, Epie-Atissa, Izon, and Mein-Ijaw. While cultural homogeneity in many LGAs facilitated coordinated community engagement, localized customs and belief systems still influenced the uptake of services, particularly family planning and immunization. To address this, culturally sensitive health education was integrated into the campaign, and local influencers including traditional leaders, town criers, youth leaders, and religious figures were mobilized to support social mobilization activities across all LGAs.

The state's public health infrastructure, anchored by the Bayelsa State Primary Health Care Board and supported by development partners such as the National Primary Healthcare Development Agency, WHO, UNICEF, CHAI, Corona Management System and other projects, played a central role in coordinating the MNCH Week. Across the 227 participating PHC facilities, services were scaled up using a range of delivery strategies, including:

- Fixed posts at health facilities and mobile fixed posts in the community.
- Mobile outreach teams targeting remote and riverine communities

- HPV Vaccination School Teams

A total of 105 Ward Focal Persons, supported by Local Immunization Officers, Reproductive Health Coordinators, and Nutrition Focal Persons, oversaw field implementation in their respective jurisdictions. Supervisory tools such as GPS-enabled checklists and WhatsApp-based tracking platforms were used to ensure real-time monitoring, efficient redistribution of resources, and prompt resolution of bottlenecks.

To deal with the low coverages, mop-up days on June 18 and 19 were critical in reaching missed settlements, particularly in Southern Ijaw, however, all LGAs were involved in the activity. The mop-up strategy also helped in managing communities where the initial turnout was low.

The socioeconomic patterns in Bayelsa State also play a significant role in health-seeking behavior. Urban and peri-urban dwellers, particularly in Yenagoa, Kolokuma/Opokuma, and parts of Ogbia, have relatively higher access to health information and services. Conversely, many rural households rely on informal healthcare providers or delay seeking care due to distance, cost, or misinformation.

MNCH Week therefore served not only as a service delivery platform but also as a health education campaign. Through radio jingles in Ijaw dialects, town announcements, peer-to-peer communication, and distribution of Information, Education, and Communication (IEC) materials, the campaign promoted demand generation and positive health behaviors. Key messages emphasized the importance of antenatal care, immunization, nutrition, skilled birth attendance, and hygiene practices.

**OBJECTIVES OF THE MATERNAL AND CHILD HEALTH WEEK (MNCH)**

The Maternal, Newborn, and Child Health (MNCH) Week is a strategic national intervention designed to accelerate progress toward reducing preventable maternal, neonatal, and child mortality. The overarching goal of the MNCH Week is to improve the health and survival of mothers, newborns, and children under five by delivering integrated, high-impact health and nutrition interventions across communities. The implementation of MNCH Week in Bayelsa State from June 13–17, 2025 (with mop-up activities ending on June 19), was guided by a set of clear objectives aligned with national health priorities and global development goals. These objectives are outlined as follows:

1. **Improved Health Outcomes for Mothers, Newborns, and Children:** At the heart of the MNCH Week is the commitment to saving lives and enhancing the well-being of women and children. By providing timely and targeted health services, such as antenatal care, skilled birth attendance, essential newborn care, routine immunizations, vitamin A supplementation, and treatment of childhood illnesses, the initiative directly addresses the major causes of maternal and under-five mortality. The goal is to reduce preventable deaths, promote healthy pregnancies and safe deliveries, ensure early childhood development, and prevent disease through preventive and promotive health measures. The cumulative effect of these interventions is the

reduction of the burden of disease, improved child growth and development, and better maternal health outcomes. By reaching thousands of beneficiaries within a short period, MNCH Week serves as a powerful tool for bridging gaps in access and equity in the delivery of life-saving services.

2. **Increased Access to Essential Health Services:** One of the core objectives of the MNCH Week is to increase access to vital health services for populations that are often underserved or hard to reach. This includes children under five, pregnant and lactating women, and women of reproductive age. Many rural and riverine communities in Bayelsa State face challenges related to geography, infrastructure, and socioeconomic barriers that hinder routine access to health care. MNCH Week helps to close this gap by bringing services directly to communities through a combination of facility-based delivery and mobile outreach strategies. Interventions such as deworming, nutritional assessments, micronutrient supplementation, routine immunization, and health promotion messages are delivered free of charge, removing cost barriers and increasing service uptake. This surge in access not only boosts immediate health outcomes but also encourages communities to become more familiar with health facilities and the services they offer, ultimately fostering long-term engagement with the healthcare system.

3. **Enhanced Community Engagement and Participation in Health Initiatives:** A key element of the success of MNCH Week lies in its ability to mobilize and involve communities in health promotion and service delivery. Community engagement is not only a means of increasing demand for services, but it is also essential for fostering ownership and sustainability of health interventions. The campaign leverages existing community structures such as traditional leaders, community-based organizations, women's groups, youth associations, and volunteer health workers to disseminate information, mobilize attendance, and provide basic services. By involving communities in both planning and execution, MNCH Week builds trust and strengthens the relationship between health service providers and the public. This participatory approach enhances the effectiveness of health communication efforts and encourages positive health-seeking behaviors, especially around maternal care, child immunization, and nutrition practices. In particular, health promotion activities such as counseling on exclusive breastfeeding, hygiene, malaria prevention, and the importance of facility-based deliveries help transform cultural attitudes and practices that might otherwise hinder health outcomes.

4. **Strengthened Health Systems and Partnerships:** The MNCH Week also serves as a catalyst for strengthening health systems at the primary care level. During the implementation, health workers receive updated training and supervision to reinforce their skills in delivering maternal and child health services. The campaign often includes refresher sessions on clinical protocols, commodity management, client counseling, and data documentation, which contributes to better quality of care beyond the campaign period. Moreover, MNCH Week fosters collaboration among multiple

stakeholders, including government agencies, donor partners, non-governmental organizations (NGOs), and local communities. This intersectoral partnership model promotes the efficient use of resources, improves logistics coordination, and supports integrated service delivery. It also enables the identification of system gaps, such as staffing, infrastructure, or supply chain challenges, that require policy or operational responses. By doing so, MNCH Week supports broader efforts to build resilient and responsive health systems that can meet the needs of mothers and children year-round.

5. **Enhancing Health-Seeking Behavior:** MNCH Week is strategically designed to not only deliver health services but to also influence individual and collective behavior related to health. Outreach campaigns, community dialogues, radio jingles, posters, and interpersonal communication sessions are used extensively to raise awareness and promote the adoption of positive health practices. These messages target both preventive and curative health behaviors, with a particular emphasis on encouraging timely use of health facilities, especially during pregnancy, childbirth, and childhood illnesses. By placing health education at the center of its strategy, the campaign helps to dispel myths and misconceptions about immunization, family planning, and nutrition. It empowers families to recognize danger signs in pregnancy and childhood illnesses and to seek appropriate care promptly. The cumulative result is a gradual but sustained shift in health-seeking behavior, particularly in marginalized communities that may have previously relied on informal or unskilled sources of care.

6. **Expanding Coverage of RMNCAH+N Interventions:** A major operational objective of MNCH Week is to rapidly scale up the coverage of high-impact Reproductive, Maternal, Newborn, Child, and Adolescent Health plus Nutrition (RMNCAH+N) interventions. The campaign specifically targets an 80% minimum coverage threshold for priority services such as:

    a. Vitamin A supplementation for children aged 6–59 months

    b. Deworming for children aged 12–59 months

    c. Iron-folate or Multiple Micronutrient Supplementation (MMS) for pregnant women

    d. Antenatal care, including malaria prevention and HIV counseling

    e. Family planning services

    f. Nutritional screening and referrals for malnutrition

    g. Routine immunization for children and tetanus toxoid for pregnant women

By deploying these services through both fixed (facility-based) and mobile (outreach-based) channels, the initiative maximizes its reach. This dual approach is particularly effective in Bayelsa State, where terrain and geography, ranging from rivers and creeks to swampy lands, pose significant access barriers. The additional two-day mop-up period conducted from June 18–19, 2025, played a crucial role in ensuring that the campaign met its coverage targets by reaching households that were missed during the initial days.

## PRE-IMPLEMENTATION ACTIVITIES IN BAYELSA STATE FOR THE JUNE 2025 MNCH WEEK

The pre-implementation phase for the June 2025 Maternal, Newborn, and Child Health (MNCH) Week in Bayelsa State marked a period of strategic planning, cross-sectoral coordination, intensive stakeholder engagement, and capacity building. These foundational efforts were instrumental in ensuring the campaign's successful rollout across the state's 8 Local Government Areas (LGAs), 105 wards, and 227 Primary Health Care (PHC) facilities.

Bayelsa State, given its challenging riverine terrain and dispersed population, required a deliberate, context-sensitive approach to the planning and execution of the MNCH Week. The activities conducted during this phase were designed to ensure readiness at every level of implementation, from state-level oversight down to ward-level service delivery.

1. **Technical Working Group (TWG) Meetings and High-Level Coordination**

A series of Technical Working Group (TWG) meetings formed the cornerstone of the campaign's strategic planning process. These meetings brought together key stakeholders, including directors from the Bayelsa State Primary Health Care Board (BSPHCB), program managers, representatives of development partners (UNICEF, WHO, USAID, etc.), social mobilization officers, and LGA team leads. The TWG was chaired by the Executive Secretary of the BSPHCB, whose leadership provided momentum and coherence to the planning phase.

The meetings focused on setting key implementation dates, developing the operational framework, identifying required commodities and logistics, assigning roles and responsibilities, and reviewing lessons from past campaigns. Special emphasis was placed on integrating Advocacy, Communication, and Social Mobilization (ACSM) strategies into the technical workplan to ensure widespread public awareness and participation.

One of the critical outcomes of these meetings was securing the commitment of implementing partners. Partners pledged technical and logistical support for various components of the campaign, including training, vaccine and commodity distribution, supportive supervision, and data management. These collaborative efforts laid the groundwork for an integrated and well-resourced MNCH Week.

2. **Capacity Building: State, LGA, and Ward-Level Trainings**

**State-Level Training**

On June 3, 2025, a comprehensive state-level training session was held at the Bayelsa State Emergency Routine Immunization Coordination Centre (SERICC) Conference Hall. The session brought together LGA immunization officers, State Technical Facilitators (STFs), state supervisors, social mobilization officers, and key focal persons from each LGA.

The training served to reinforce the objectives of the MNCH Week, providing detailed orientation on the key interventions, implementation methodologies, service delivery strategies (fixed and mobile posts), and data reporting protocols. Participants were also equipped with updated guidelines on vaccine administration, multiple micronutrient supplementation (MMS), deworming protocols, MUAC screening, and the newly included Human Papillomavirus (HPV) vaccination.

The state-level session ensured that participants had a unified understanding of the operational targets and quality standards, with an emphasis on real-time data collection and the importance of mop-up strategies to close coverage gaps.

**LGA-Level Training**

Following the state-level sessions, cascading LGA-level trainings were conducted. LGA teams, in collaboration with the State Technical Facilitators, trained health workers, ward focal persons, recorders, and mobile outreach team members. These sessions, held in each LGA's designated training venues, were tailored to local implementation realities and emphasized team roles, daily tallying procedures, vaccine safety, community engagement strategies, and the use of supervisory checklists.

Particular attention was paid to HPV vaccination, given its relatively recent introduction in Bayelsa's immunization schedule. Designated HPV teams were trained on school and community outreach methods to ensure all eligible 9-year-old girls were captured, whether in formal education settings or not.

**Ward-Level Training and Supervision**

To ensure uniform understanding and quality implementation at the grassroots, ward-level trainings were organized. These sessions involved direct interaction with vaccinators, recorders, and community mobilizers. Supervisors emphasized accurate data recording, interpersonal communication techniques, ethical conduct during service delivery, and contingency planning for challenging terrains.

Supervisory mechanisms were reinforced during these sessions, with guidance on daily reviews, intra-day feedback loops, and supportive mentoring from State and LGA supervisors. This structure enabled rapid troubleshooting throughout the campaign's lifespan.

3. **Social Mobilization and Community Engagement**

The ACSM component was activated as early as May, 2025. The State Social Mobilization Officer (SMO) spearheaded a targeted communication campaign to drive awareness and community acceptance of the upcoming MNCH Week.

Advocacy letters were dispatched to religious institutions, first digitally through WhatsApp platforms and subsequently via physical distribution to churches and mosques. These efforts were complemented by outreach to school administrators and traditional leaders, ensuring buy-in from influential community gatekeepers.

Public announcements were conducted in major markets and high-traffic transit points. Through town announcers and local radio spots in native dialects, caregivers were sensitized about the benefits of key MNCH interventions and encouraged to participate actively.

In several wards, town hall meetings were held to further educate the public and demystify any misconceptions around immunization and family planning services. Traditional rulers and women leaders were particularly instrumental in mobilizing community-based volunteers and ensuring peaceful access to all settlements, including remote fishing camps and island communities.

4. **Microplanning and Resource Mapping**

Microplanning was conducted across all 8 LGAs, focusing on the accurate identification of eligible target populations and service delivery points. Each ward compiled an updated list of churches, schools, markets, and other gathering points to facilitate effective reach during the campaign.

Settlement mapping and team microplans were developed to ensure that every community, especially hard-to-reach areas, had a designated team and clear routing schedule. Detailed logistics plans were also created, indicating vaccine quantities, cold chain needs, transportation arrangements, and supervisory coverage.

The microplanning exercise also helped identify human resource gaps, resulting in the recruitment and orientation of additional ad-hoc personnel, including youth volunteers and local health aides.

5. **Team Composition and Deployment Strategy**

For the campaign's operational phase, two main team structures were adopted:

- Mobile Outreach Teams: Comprised a vaccinator and a recorder, often deployed to underserved communities, transit locations, and hard-to-reach settlements.
- Fixed Post Teams: Based at PHC facilities and included vaccinators trained for both routine immunization antigens and MNCH-specific services.

- Specialized HPV vaccination teams were formed with a specific mandate to reach 9-year-old girls through both school-based and community outreach strategies. These teams coordinated closely with education authorities and parents to ensure informed consent and successful administration.

**IMPLEMENTATION PHASE: JUNE 13–17, 2025**

The implementation phase of the June 2025 Maternal, Newborn, and Child Health (MNCH) Week in Bayelsa State officially commenced on June 13, 2025, with a well-organized Flag-Off Ceremony held at the FSP Clinic in Ovom, Yenagoa Local Government Area, anchored by the Executive Secretary of Bayelsa State Primary Healthcare Board and Chaired by the Honourable Commissioner for Health, Dr. Seiyefa Brisibe. This symbolic event served as both a formal inauguration of the campaign and a vital platform for public awareness creation. The ceremony brought together key stakeholders, including senior officials from the Bayelsa State Primary Health Care Board (BSPHCB), representatives from partner organizations, traditional leaders, healthcare providers, and members of the media. Through speeches and community engagement activities, the flag-off event underscored the importance of maternal and child health services and encouraged caregivers to utilize the available interventions during the campaign week.

Immediately following the flag-off, Operations Room activities commenced at Bayelsa Primary Healthcare Data Hub. Here, data managers and technical officers gathered to finalize preparatory logistics. Key activities included reviewing and validating data collection tools, resolving last-minute technical glitches, assigning supervisory responsibilities to specific LGAs, and conducting refresher briefings for data collection in order to resolve any data quality issue in real time. The Operations Room functioned as the nerve center for the campaign, ensuring real-time data monitoring, coordination of mop-up responses, and prompt resolution of implementation challenges.

The initial five-day campaign period (June 13–17) was followed by mop-up activities in most LGAs, ensuring that unreached settlements and missed children were identified and served. The implementation phase demonstrated strong intersectoral collaboration, effective community mobilization, and a commitment to delivering essential MNCH services across all 105 wards and 227 Primary Health Care facilities in the state. While most wards participated in the mop-up, some particularly those already preparing for the upcoming National Immunization Plus Days (NIPDs) had limited capacity for extended mop-up efforts.

The campaign focused on delivering integrated services, including:

- Vitamin A supplementation
- Deworming with Albendazole
- Multiple Micronutrient Supplementation (MMS) for pregnant women

- Routine Immunization (including the new malaria vaccine and HPV)
- MUAC screening for nutrition
- Birth registration

Commodities were pre-positioned at LGA stores and PHC facilities ahead of the campaign. However, by Day 1, certain LGAs reported stockouts of Albendazole due to unexpectedly high turnout. The TWG promptly facilitated the redistribution of additional stock to affected locations to prevent service disruption.

**Monitoring, Supervision, and Daily Review Mechanisms**

Daily online review meetings were held each evening throughout the campaign. These virtual check-ins enabled state coordinators, STFs, and LGA team leads to assess field progress, troubleshoot challenges, and make evidence-informed decisions in real time.

Key issues raised during these meetings included:

- Insufficient quantities of Albendazole in high-demand LGAs
- Limited transportation and logistics support for outreach teams
- Delayed data submission from remote wards due to network challenges
- Low coverage in specific urban wards due to social activities and absentee caregivers

Field supervision reports from STFs and LGA supervisors were reviewed during these sessions, with real-time data captured using mobile devices and dashboards. This allowed the State EOC to visualize coverage trends and identify underperforming teams for immediate follow-up.

**RESULTS OF THE JUNE 2025 MNCH WEEK IN BAYELSA STATE**

The June 2025 Maternal, Newborn, and Child Health (MNCH) Week intervention in Bayelsa State yielded mixed results, with considerable success in some areas and notable shortfalls in others. Overall, the campaign demonstrated the potential for high-impact service delivery when properly coordinated, but also highlighted systemic challenges that require urgent attention.

**Vitamin A Supplementation**

Bayelsa State achieved significant progress in the administration of Vitamin A supplements. By the end of the campaign, 438,628 children aged 6 to 59 months had received Vitamin A, representing an 83% coverage rate against a target population of 527,802. This outcome indicates both effective community mobilization and widespread accessibility of Vitamin A supplements during the campaign period.

While some wards struggled with logistics and team mobilization, most areas performed satisfactorily, contributing to the overall high coverage. However, a closer look at the missed opportunities suggests that hard-to-reach settlements and wards with competing public health activities were primarily responsible for the shortfall.

**Deworming**

The deworming component reached a total of 257,646 children out of a target population of 469,167, resulting in a 55% coverage rate. This outcome, though moderate, was impacted by early depletion of Albendazole stock in some LGAs due to higher-than-expected turnout on the first day of the campaign.

Redistribution efforts helped mitigate the shortages, but some wards still reported unmet demand. This emphasizes the need for improved commodity forecasting, pre-positioning, and real-time stock monitoring for future rounds of MNCH Week.

**Mid-Upper Arm Circumference (MUAC) Screening**

MUAC screening was conducted across all LGAs to assess nutritional status among children under five. In total, 284,909 children were screened, representing 54% of the eligible population. Among these:

- **118 children** were categorized as *Red*, indicating severe acute malnutrition (SAM).
- **4,521 children** were classified *Yellow*, denoting moderate acute malnutrition (MAM).
- **280,370 children** were classified as *Green*, indicating satisfactory nutritional status.

While the proportion of children in the "green" category was encouraging, the presence of SAM cases underscores the ongoing need for nutritional interventions, community-based management of acute malnutrition (CMAM), and referral linkages to nutrition stabilization centers.

**Multiple Micronutrient Supplementation (MMS) and Iron Folate**

The state recorded low coverage in maternal supplementation services. Only 12,973 pregnant women received Multiple Micronutrient Supplementation (MMS), representing just 19% coverage. In contrast, Iron Folate Supplementation (IFS) reached only 2,197 pregnant women.

The relatively lower IFS coverage is partly attributed to the national standard operating procedure, which mandates haemoglobin screening before administering iron folate to avoid adverse outcomes in non-anaemic women. The disparity between MMS and IFS uptake may therefore reflect a high underlying prevalence of anaemia among pregnant women in Bayelsa State, suggesting an urgent need for improved antenatal screening and targeted anaemia prevention programs.

**Human Papillomavirus (HPV) Vaccination**

HPV vaccine coverage was a significant outlier, with the state achieving 330% of its monthly target during the MNCH Week. This figure, though anomalously high, can be explained by the intense focus on HPV during the campaign period. Dedicated school-based vaccination teams, in collaboration with community mobilizers and education officials, played a critical role in this success.

This surge in coverage reinforces a long-standing trend in Bayelsa State: HPV vaccination targets are consistently exceeded only during high-impact campaigns or routine immunization intensification weeks. During regular service delivery months, most facilities fall short of their set targets.

This inconsistency points to the need for institutionalizing school-based outreach as a routine strategy, or deploying mobile teams at regular intervals to sustain high coverage of HPV vaccination among eligible girls.

**Malaria Vaccine (Malaria 1)**

The first dose of the malaria vaccine (Malaria 1) recorded 17% coverage during the campaign. This relatively low uptake is not unusual, considering the malaria vaccine is still in its scale-up phase nationally, and many facilities are yet to fully integrate it into routine immunization schedules.

Further training, public awareness, and steady commodity availability will be necessary to boost uptake in future campaigns and routine services.

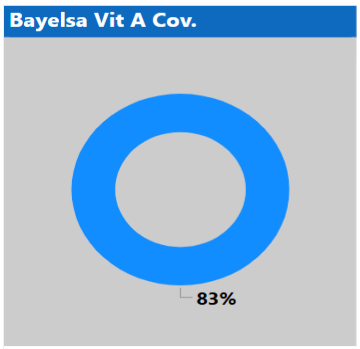
**Birth Registration**

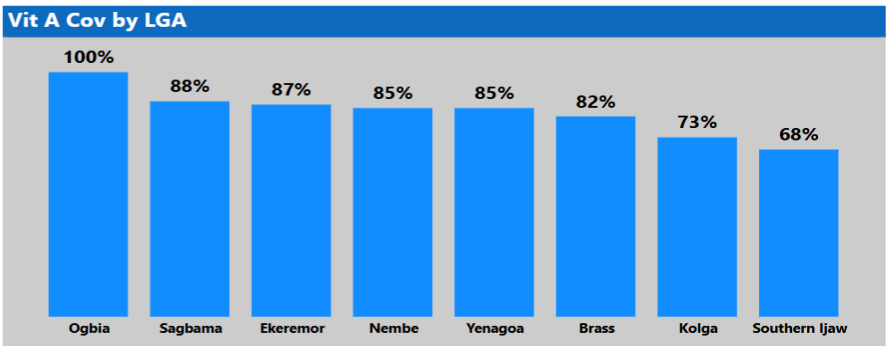
Birth registration remains one of the most underperforming components of MNCH service delivery in Bayelsa State. Out of a target of 96,764, only 1,258 children were registered, translating to a coverage rate of just 1%.

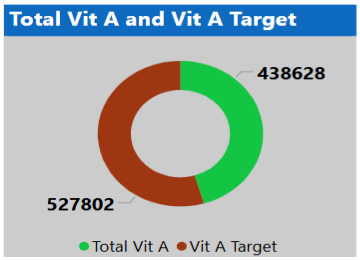
This poor performance is due to multiple factors, including limited collaboration with civil registration authorities, inadequate supply of birth registration materials, and low community demand for registration services. As birth registration plays a critical role in legal identity, education access, and health service planning, it is imperative that it receives focused attention in future interventions.

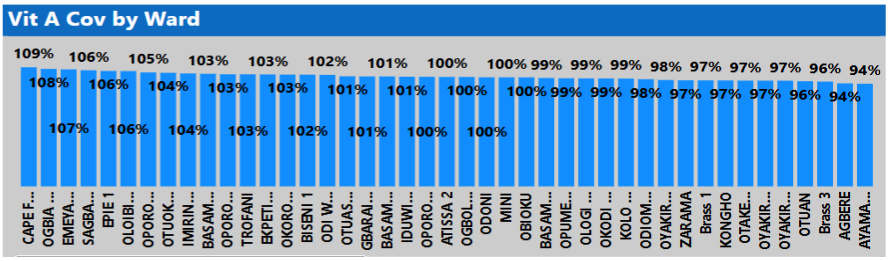
The June 2025 MNCH Week in Bayelsa State demonstrated both progress and persisting gaps in the delivery of essential maternal and child health services. High-performing indicators such as Vitamin A supplementation and HPV vaccination underscore the state's ability to mobilize effectively during campaign periods. However, shortfalls in deworming, MUAC screening, maternal supplementation, and birth registration point to systemic issues in logistics, resource allocation, and service integration.

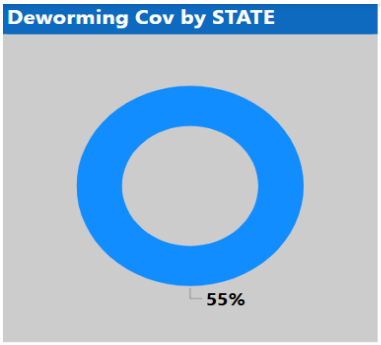
Below are graphical illustrations of the various results from the MNCH week:

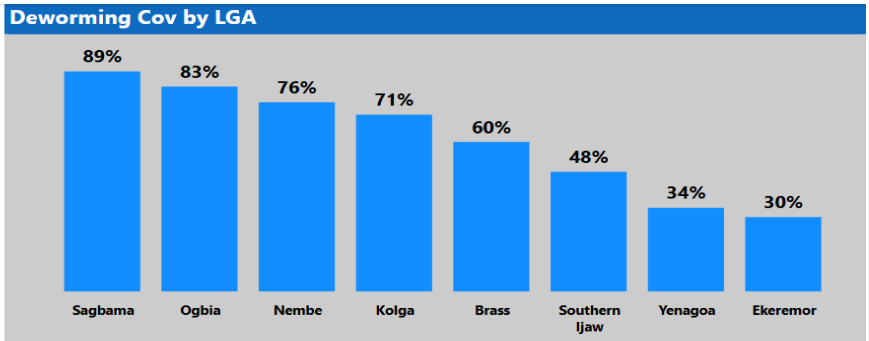


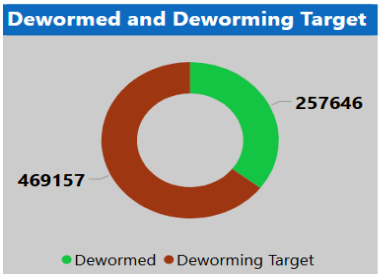



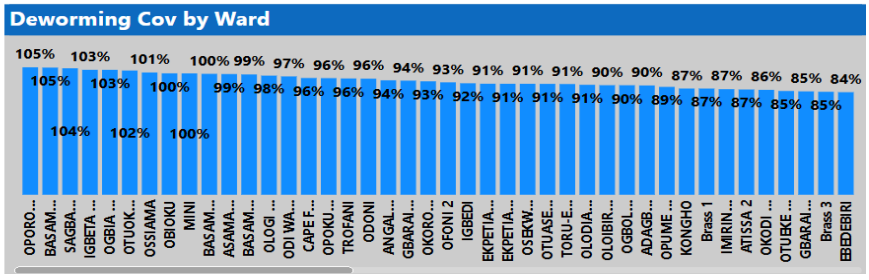



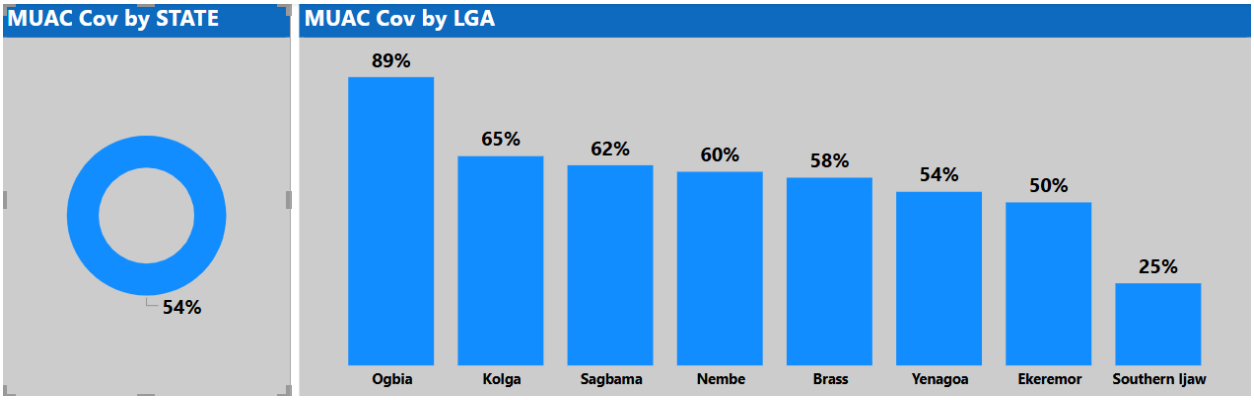



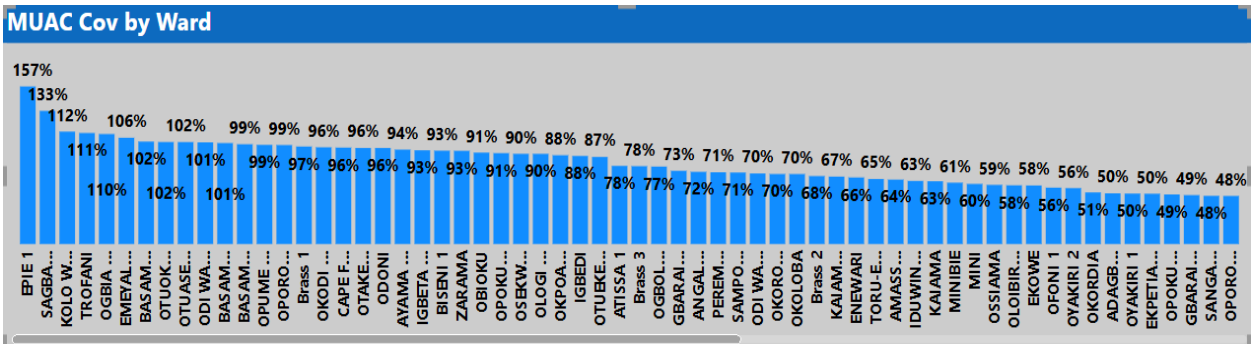



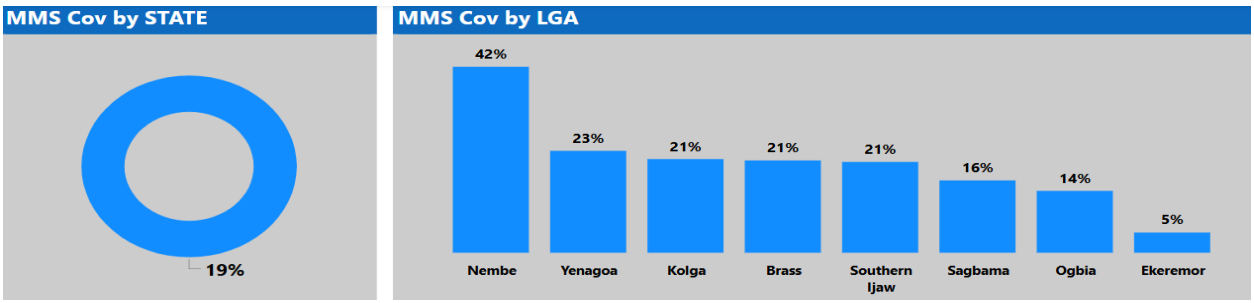



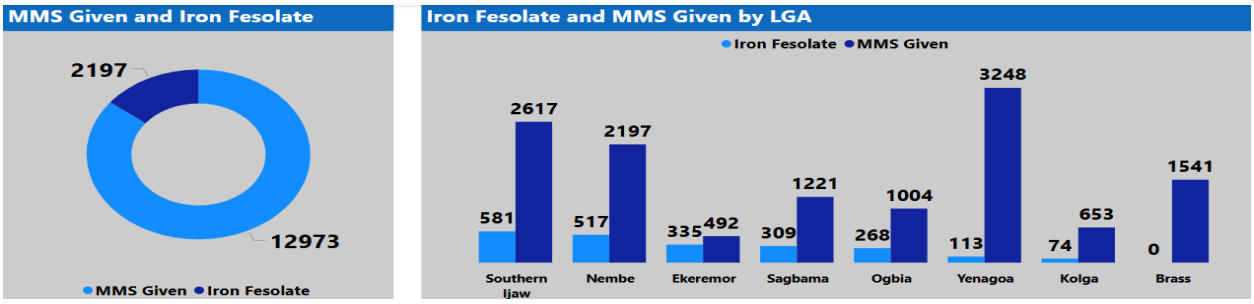



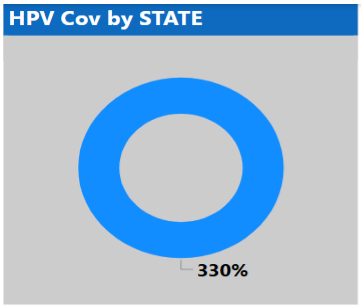



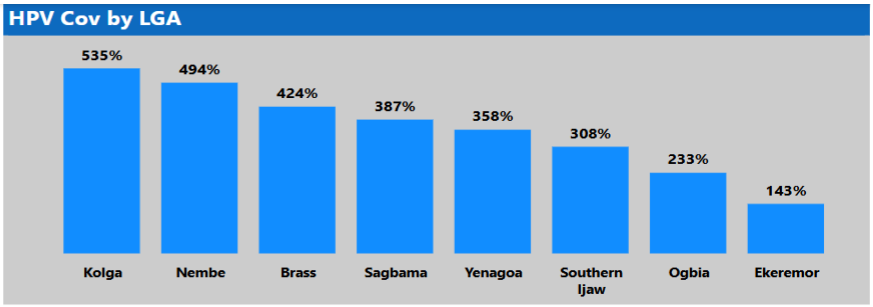

MUAC Cov by STATE
54%
MUAC Cov by LGA
89%
65%
62%
60%
58%
54%
50%
25%
Ogbia
Kolga
Sagbama
Nembe
Brass
Yenagoa
Ekeremor
Southern Ijaw

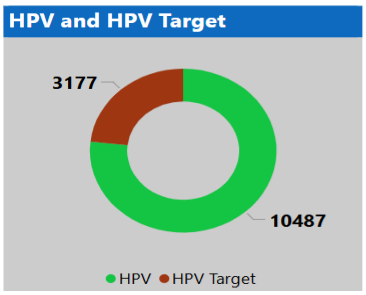

MUAC Cov by Ward
157% 133% 112% 111% 110% 106% 102% 102% 102% 101% 101% 99% 99% 99% 97% 96% 96% 96% 96% 94% 93% 93% 93% 91% 91% 90% 90% 88% 88% 87% 78% 78% 77% 73% 72% 71% 71% 70% 70% 70% 68% 67% 66% 65% 64% 63% 63% 61% 60% 59% 58% 58% 56% 56% 51% 50% 50% 49% 49% 48% 48%
EPIE 1
SAGBA...
KOLO W...
TROFANI
OGBIA ...
EMEYAL...
BASAM...
OTUOK...
OTUASE...
ODI WA...
BASAM...
BASAM...
OPUME ...
OPORO...
Brass 1
OKODI ...
CAPE F...
OTAKE...
ODONI
AYAMA ...
IGBETA ...
BISENI 1
ZARAMA
OBIOKU
OPOKU...
OSEKW...
OLOGI ...
OKPOA...
IGBEDI
OTUEKE...
ATISSA 1
Brass 3
OGBOL...
GBARAI...
ANGAL...
PEREM...
SAMPO...
ODI WA...
OKORO...
OKOLOBA
Brass 2
KAIAM...
ENEWARI
TORU-E...
AMASS...
IDUWIN...
KAIAMA
MINIBIE
MINI
OSSIAMA
OLOIBIR...
EKOWE
OFONI 1
OYAKIRI 2
OKORDIA
ADAGB...
OYAKIRI 1
EKPETIA...
OPOKU...
GBARAI...
SANGA...
OPORO...

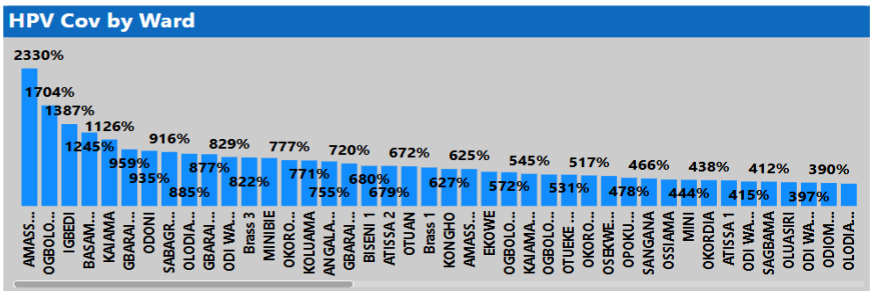

MMS Cov by STATE
19%
MMS Cov by LGA
42%
23%
21%
21%
21%
16%
14%
5%
Nembe
Yenagoa
Kolga
Brass
Southern Ijaw
Sagbama
Ogbia
Ekeremor

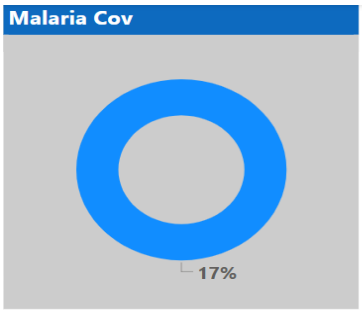

MMS Given and Iron Fesolate
2197
12973
MMS Given
Iron Fesolate
Iron Fesolate and MMS Given by LGA
Iron Fesolate
MMS Given
581
2617
517
2197
335
492
309
1221
268
1004
113
3248
74
653
0
1541
Southern Ijaw
Nembe
Ekeremor
Sagbama
Ogbia
Yenagoa
Kolga
Brass

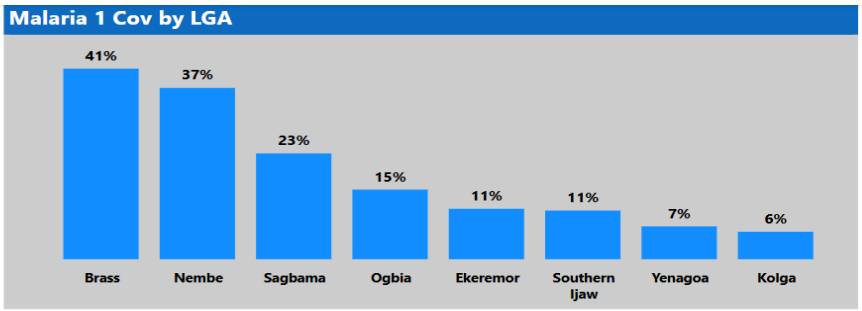


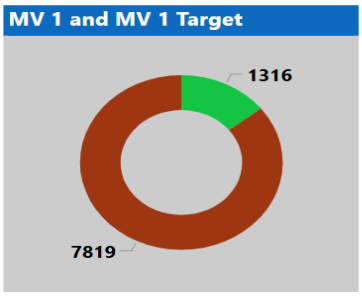



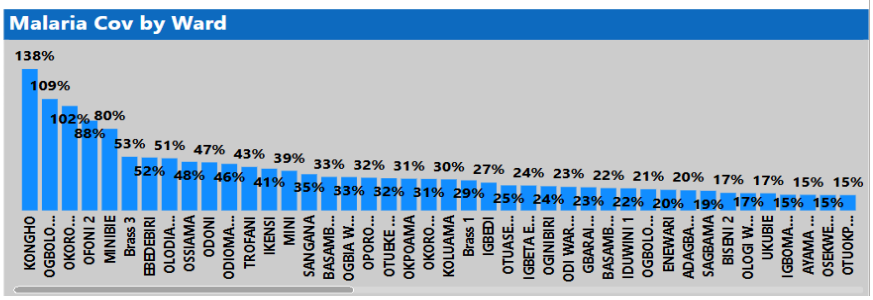



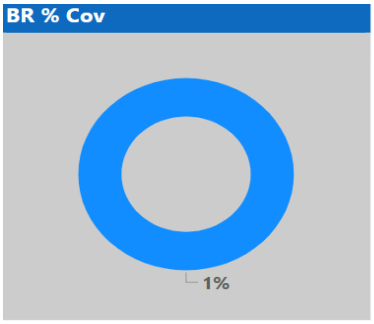



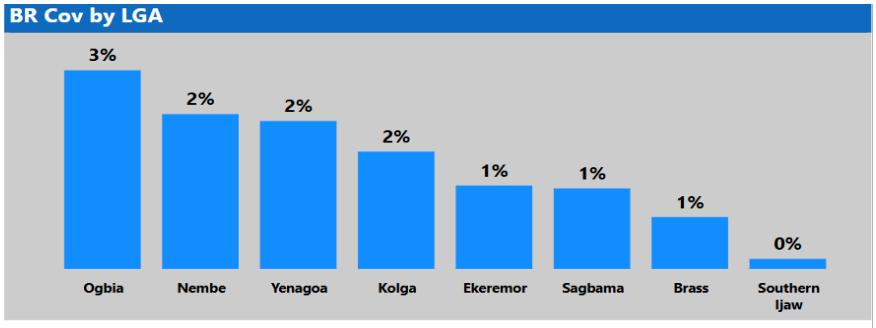



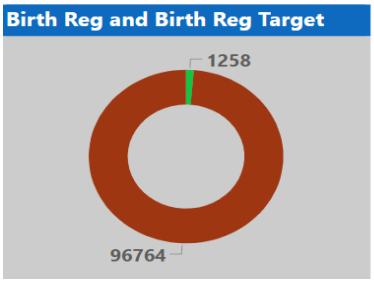



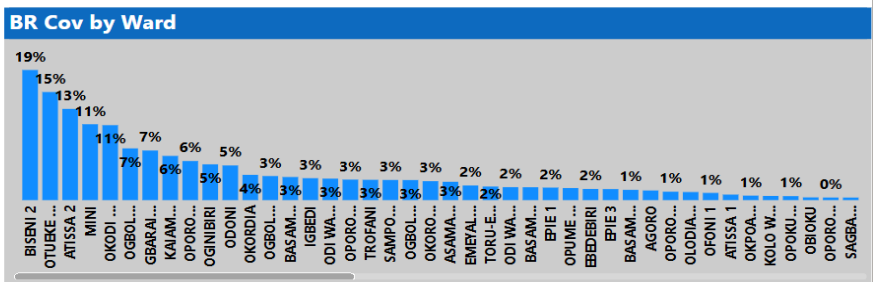

| LGA | HepB | BCG | OPV 0 | OPV1 | Penta1 | PCV1 | IPV1 | ROTA1 | OPV2 | Penta2 | ROTA2 | OPV3 | Penta3 | PCV3 | IPV2 | ROTA3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Brass | 299 | 299 | 299 | 299 | 299 | 299 | 299 | 299 | 283 | 283 | 283 | 263 | 263 | 263 | 263 | 263 |
| Ekeremor | 102 | 103 | 102 | 135 | 135 | 135 | 135 | 135 | 126 | 126 | 126 | 117 | 117 | 117 | 117 | 117 |
| Kolga | 36 | 36 | 36 | 38 | 38 | 38 | 38 | 38 | 23 | 23 | 24 | 23 | 23 | 23 | 23 | 23 |
| Nembe | 42 | 42 | 42 | 103 | 93 | 93 | 93 | 93 | 62 | 62 | 62 | 83 | 83 | 83 | 83 | 84 |
| Ogbia | 58 | 58 | 58 | 123 | 130 | 130 | 130 | 128 | 89 | 89 | 89 | 122 | 122 | 122 | 122 | 122 |
| Sagbama | 131 | 120 | 131 | 151 | 153 | 153 | 153 | 152 | 173 | 173 | 173 | 122 | 123 | 123 | 123 | 123 |
| Southern Ijaw | 97 | 106 | 102 | 164 | 164 | 164 | 160 | 162 | 156 | 147 | 140 | 126 | 126 | 134 | 131 | 125 |
| Yenagoa | 91 | 91 | 91 | 113 | 113 | 113 | 113 | 113 | 109 | 109 | 109 | 92 | 92 | 92 | 92 | 93 |
| Bayelsa | 856 | 855 | 861 | 1126 | 1125 | 1125 | 1121 | 1120 | 1021 | 1012 | 1006 | 948 | 949 | 957 | 954 | 950 |

| LGA | MV 1 | MV 2 | MV 3 | MCV 1 | YF | Men A | MCV 2 | HPV |
|---|---|---|---|---|---|---|---|---|
| Brass | 349 | 298 | 300 | 272 | 272 | 272 | 240 | 1464 |
| Ekeremor | 135 | 131 | 123 | 140 | 140 | 140 | 114 | 722 |
| Kolga | 21 | 23 | 22 | 32 | 32 | 32 | 25 | 771 |
| Nembe | 222 | 190 | 176 | 78 | 69 | 69 | 68 | 1205 |
| Ogbia | 124 | 110 | 104 | 115 | 126 | 132 | 80 | 782 |
| Sagbama | 196 | 207 | 211 | 161 | 161 | 161 | 50 | 1350 |
| Southern Ijaw | 154 | 192 | 199 | 125 | 123 | 117 | 90 | 1837 |
| Yenagoa | 115 | 102 | 103 | 82 | 83 | 84 | 65 | 2356 |
| Bayelsa | 1316 | 1253 | 1238 | 1005 | 1006 | 1007 | 732 | 10487 |




**POST-IMPLEMENTATION PHASE**

Following the conclusion of field activities and mop-up operations, the post-implementation phase of the MNCH Week focused on systematic data management and comprehensive reporting. This phase was critical in transforming raw field data into actionable insights for decision-making and future planning.

Data collation began immediately after the final mop-up day (June 19, 2025), with ward focal persons transmitting completed tally sheets, summary forms, and digital records to their

respective LGA monitoring teams and state technical facilitators. These were then reviewed at the LGA level before submission to the state-level operations room for harmonization. Data managers meticulously cleaned the datasets, checking for inconsistencies, duplicates, and missing entries. Special attention was given to validating high outliers, such as the significant overachievement in HPV vaccination, which was verified through daily review meeting records.

By the end of this phase, the dataset was fully cleaned, harmonized, and disaggregated by service type, LGA, and ward. The cleaned data provided a clear picture of campaign performance across the state's eight LGAs and 105 wards, allowing for robust analysis of service coverage, population reach, and intervention equity.

In addition to quantitative analysis, qualitative feedback was also collected from supervisors, technical facilitators, and frontline workers. Their insights offered valuable lessons on implementation gaps, community response, team performance, and supply chain efficiency. This information has been compiled to inform the end-of-cycle review meeting and refine strategies for future campaigns.

Furthermore, the post-implementation phase included documentation of best practices, challenges, and recommendations. A final report was initiated, incorporating key findings, visuals, and narratives to support continuous improvement in Bayelsa State's MNCH programs.

**BEST PRACTICES**

1. **Use of IEC Pictorial Aids:** The inclusion of a user-friendly, pictorial Information, Education, and Communication (IEC) material proved to be highly effective. It visually summarized the package of services provided and reinforced key health messages. These materials were especially helpful in overcoming literacy barriers and enhancing caregiver understanding of the benefits of services such as Vitamin A, deworming, and MUAC screening.

2. **Compulsory Mop-up Activities:** Institutionalizing mop-up activities as a compulsory component of the campaign ensured that children and pregnant women missed during the initial days were not left out. This approach significantly improved coverage, particularly in urban wards with high mobility or rural areas where access was initially delayed.

3. **Evening Review Meetings for Rapid Problem-Solving:** Daily evening review meetings created a feedback loop that enabled rapid identification and resolution of issues. Whether related to commodity shortages, logistics, or team coordination, challenges were addressed within 24 hours, improving overall responsiveness and service quality.

4. **Strong Support from State Supervisors:** The deployment of state supervisors to all LGAs ensured high-level oversight and on-the-ground mentorship. Their support

contributed to better team performance, real-time problem resolution, and enhanced data validation at ward and LGA levels.

5. **Inclusion of HPV and Malaria Vaccination Services:** The integration of newer vaccines such as HPV and the malaria vaccine into the MNCH Week package added significant value. Their inclusion not only expanded the service offering but also created opportunities to build public confidence in these critical immunizations, especially through school-based outreach and direct community mobilization.

**MAJOR CHALLENGES ENCOUNTERED DURING MNCH WEEK IMPLEMENTATION IN BAYELSA STATE**

While the June 2025 Maternal, Newborn, and Child Health (MNCH) Week in Bayelsa State recorded moderate success in terms of reach and service delivery across its eight Local Government Areas (LGAs) and 105 wards, the campaign was not without its operational and logistical challenges. These hurdles, encountered at different stages of the campaign; from pre-implementation to post-implementation impacted the overall effectiveness and equity of service delivery. The following section highlights the most significant challenges, drawing on firsthand reports, field observations, and data review findings.

1. **Delayed Commencement in Some Wards:** One of the critical issues encountered was the delayed start of MNCH activities in certain wards, particularly in Southern Ijaw LGA, which affected the rhythm and consistency of the campaign's implementation. While the official flag-off occurred on June 13, 2025, and most wards began operations on the same day, reports indicate that some teams in Southern Ijaw and parts of Brass did not commence until June 14 or later. These delays were attributed to logistical breakdowns, including late arrival of commodities, lack of transportation for teams, and insufficient mobilization of health workers. As a result, some target beneficiaries were either missed entirely or required extensive mop-up activities to be reached, which placed additional strain on already stretched teams and supervisors.

2. **Data Quality Issues and Reporting Gaps:** A major operational concern during the campaign was the inconsistency in data reporting from field teams. Several data quality gaps were observed such as Incomplete service entries on tally sheets. Inaccurate reporting not only compromised the credibility of the campaign data but also made it difficult to track actual service coverage per intervention and per ward. For instance, although 83% Vitamin A coverage was achieved overall, some discrepancies in ward-level figures cast doubt on the reliability of the aggregated state data. In some cases, reports were sent late or omitted entirely, creating bottlenecks in the post-implementation analysis. The Operations Room, while diligent, had to spend additional time during the post-implementation phase cleaning and validating data.

3. **Routine Immunization (RI) Service Discrepancies:** Despite routine immunization being a central component of MNCH Week, inconsistencies were observed in its

implementation and reporting across the LGAs, with Ekeremor LGA standing out as a major case. While health facilities in the area claimed that RI services were administered at fixed posts, this was not consistently supported by the submitted data. In some wards, no RI data was recorded at all, suggesting either that the services were not delivered or that documentation was inadequately handled. This challenge reflects broader systemic issues including poor documentation practices, low accountability at facility levels, and weak supervisory follow-up, which ultimately hinder the evaluation of true RI performance during high-impact campaigns. It also raises concerns about the continuity and integration of routine services during campaign weeks, when attention may become overly focused on non-routine interventions such as deworming or Vitamin A supplementation.

4. **Commodity Shortages and Uneven Distribution:** One of the most frequently reported field challenges during MNCH Week was stock depletion and uneven distribution of commodities, especially Albendazole tablets. In several LGAs, teams reported that Albendazole supplies were exhausted as early as Day 1, forcing the State Primary Health Care Board (BSPHCB) to make emergency procurement and redistribution arrangements mid-week. This logistical lapse led to service interruptions and reduced deworming coverage in certain wards.

5. **Lack of Transportation and Team Logistics:** Many LGAs reported inadequate transportation arrangements for vaccination teams, which significantly hampered coverage, especially in wards with scattered or riverine settlements. Although vehicle deployment was planned as part of the logistics strategy, the actual execution fell short. Teams had to rely on personal resources, commercial tricycles, or community support, which in turn led to late arrivals, incomplete daily schedules, and in some instances, failure to reach assigned catchment areas. This lack of robust logistical support directly affected productivity and morale among frontline health workers. It also had a domino effect on supervision, as state and LGA supervisors were unable to effectively monitor every team, especially those working in more remote locations.

6. **Limited Mop-Up in Some Wards:** Although mop-up activities were mandated for all wards, not all LGAs complied fully, with some wards opting out due to overlapping preparations for the 2nd Round of National Immunization Plus Days (NIPDs). Consequently, certain settlements remained underserved, particularly those initially missed due to flooding or caregiver unavailability. The absence of comprehensive mop-up efforts created service inequity, leaving pockets of the population unreached.The timing of MNCH Week, closely preceding another major campaign, also placed a significant burden on human and material resources, resulting in burnout among frontline workers and reluctance to continue beyond the scheduled five-day window.

## RECOMMENDATIONS AND WAY FORWARD

**Strengthen Early Planning and Logistics Coordination**

To prevent delayed commencement, especially in remote or riverine LGAs such as Southern Ijaw and Brass:

- Commence logistics planning at least 6–8 weeks ahead of the campaign to allow ample time for commodity distribution, microplanning, team training, and partner coordination.
- Preposition all commodities and tools (e.g., tally sheets, IEC materials, vaccines, deworming tablets) at ward levels at least 3 days before the official start date.
- Conduct simulation exercises or dry runs in high-risk LGAs to test readiness and resolve any last-minute logistical bottlenecks.
- Assign dedicated LGA Logistics Focal Persons and deploy tracking dashboards to monitor distribution timelines in real-time.

**Improve Data Management Systems and Accountability**

To address inconsistencies in reporting and data quality issues:

- Standardize data collection tools and conduct comprehensive pre-campaign training for all health workers, emphasizing proper documentation and reporting procedures.
- Deploy digital data capture tools (such as tablets or mobile-based applications) where possible, with offline capabilities and GPS tracking to reduce manual errors and enhance real-time supervision.
- Establish daily data review checkpoints during implementation at both the ward and LGA levels, ensuring timely correction of errors and re-submission of missing entries.
- Introduce a data quality scoring system that flags incomplete or erroneous submissions and provides feedback to the respective LGA for immediate remediation.
- Ensure that Operations Room personnel include skilled M&E officers to manage real-time review and harmonization of reports.

**Ensure Integration and Consistency of Routine Immunization Services**

To resolve discrepancies in routine immunization service delivery:

- Mandate that routine immunization is fully integrated and consistently implemented alongside all MNCH interventions in every ward.
- Assign dedicated RI focal persons in each LGA and task them with monitoring and verifying the administration and documentation of vaccines during MNCH Week.

- Provide a separate RI performance tracker, to be reviewed daily during campaign implementation meetings.

- Conduct joint supervision by RI officers, STFs, and Ward Focal Persons to ensure standardization and compliance with immunization protocols.

**Strengthen Commodity Forecasting, Procurement, and Distribution**

To avoid stock-outs and inequitable supply:

- Conduct accurate microplanning and forecasting for each ward based on historical data and expected turnout, especially for essential items like Albendazole, Vitamin A, and MMS.

- Use logistics management information systems (LMIS) to track commodity flow from state stores to ward levels in real time.

- Create a buffer stock strategy, ensuring that each LGA holds at least 10–15% excess inventory to respond to unexpected demand surges.

- Build a rapid response mechanism with clearly designated personnel to handle redistribution of commodities mid-campaign in the event of shortages.

**Improve Transportation and Team Deployment Logistics**

To overcome transportation-related setbacks:

- Secure advance commitments from transport vendors, including boats for riverine communities, and ensure transport arrangements are finalized before Day 1 of implementation.

- Allocate transportation budgets directly to LGAs, with accountability structures for fuel and vehicle use to ensure maximum coverage.

- Explore community-based transportation support models, such as partnering with local councils or traditional leaders to mobilize boats, tricycles, and bikes.

- Where feasible, adopt a hub-and-spoke model, where outreach teams operate from a central, well-stocked hub to satellite communities, reducing inefficiencies caused by late deployment.

**Institutionalize Comprehensive Mop-Up Strategies**

To ensure equitable service delivery and coverage:

- Include a fully planned and resourced mop-up phase (minimum 2 days) in the official MNCH Week schedule, with clear guidelines for when and how to conduct follow-up visits.

- Direct LGAs to develop ward-level mop-up plans prior to implementation, identifying settlements likely to require follow-up (e.g., hard-to-reach, flood-prone, or low-coverage areas).

- Incentivize mop-up participation through team-based performance recognition, encouraging full compliance without relying on voluntary effort post-campaign.

- Coordinate campaign calendars at the national and state levels to avoid overlapping health interventions, reducing staff fatigue and service saturation.

**Enhance Supervision and Field Support Mechanisms**

**Develop a Performance Management and Feedback System**

To promote accountability and continuous improvement:

- Introduce a campaign performance dashboard visible to all LGA teams, displaying daily coverage progress, mop-up needs, and data discrepancies.

- Conduct mid-week implementation reviews to assess progress and reallocate resources based on performance gaps.

- Establish a reward and sanction framework for LGAs based on timeliness, data completeness, coverage, and mop-up compliance.

- Document lessons learned and disseminate a post-implementation review report to all stakeholders within two weeks after campaign closure.

**LESSONS LEARNED FROM THE JUNE 2025 MNCH WEEK IN BAYELSA STATE**

The implementation of the June 2025 Maternal, Newborn, and Child Health (MNCH) Week in Bayelsa State offered numerous valuable lessons that can inform the planning and execution of future high-impact campaigns. These lessons emerged from direct field observations, supervisory feedback, evening review meetings, and post-implementation data analysis. While the campaign recorded moderate success in several areas, it also revealed operational, logistical, and systemic gaps that, if addressed, could significantly improve future outcomes.

Below are the key lessons learned:

1. **Early Planning and Stakeholder Engagement Enhances Coordination:** The pre-implementation phase, particularly the Technical Working Group (TWG) meetings, was instrumental in setting the tone for campaign delivery. The engagement of

stakeholders, including program officers, LGA teams, and community leaders, helped align expectations and facilitated the mobilization of resources. This underscores the importance of starting planning activities well in advance and involving all key actors from the beginning. It also highlights the value of a well-functioning TWG in providing strategic direction and ensuring partner accountability.

2. **Social Mobilization is Most Effective When Context-Specific:** The state's approach to advocacy; leveraging churches, markets, schools, and digital platforms like WhatsApp, demonstrated that decentralized and community-based mobilization efforts generate better awareness and turnout. Engagements with traditional rulers and community heads increased acceptance and local ownership. However, the reach was still uneven across some LGAs, pointing to the need for better micro-targeting and tailored messages to reach underserved and hard-to-reach communities effectively.

3. **Operational Readiness Must Include Transportation and Logistics:** A key operational lesson is that commodity availability alone is insufficient without reliable transportation and logistics for team deployment. In several wards, especially in Southern Ijaw and Brass, activities were delayed due to lack of transport. These logistical shortcomings directly affected coverage, particularly in remote and riverine areas. Future campaigns must prioritize transportation planning alongside commodity distribution.

4. **HPV Vaccine Uptake Can Be Boosted Through School-Based Strategies:** The exceptionally high (330%) HPV coverage achieved during MNCH Week was driven by dedicated outreach to schools, which does not normally occur during routine services. This success illustrates that adolescent health services especially HPV vaccination, are best delivered through structured school outreach. Scaling up school-based or mobile strategies regularly (not just during campaign weeks) could help the state meet its monthly HPV targets sustainably.

5. **Real-Time Data Monitoring Improves Responsiveness**: The establishment of an Operations Room and the conduct of daily evening review meetings allowed rapid response to emerging challenges such as stockouts, poor reporting, and coverage gaps. These forums became critical for resolving problems in real time and ensuring alignment across teams. This demonstrates the effectiveness of adaptive supervision and real-time data analysis during campaigns, and should be institutionalized for future interventions.

6. **Inadequate Mop-Up Leads to Missed Populations:** While mop-up activities were mandated, not all wards implemented them effectively due to competing priorities such as the upcoming National Immunization Plus Days (NIPDs). This created inequities in service delivery, with some communities left out entirely. The lesson here is that mop-up activities should be planned with dedicated resources and timeframes, and should not be optional or dependent on LGA discretion.

7. **Data Quality Remains a Persistent Weakness:** The campaign highlighted ongoing challenges in data entry, completeness, and accuracy, particularly in service tally sheets and routine immunization documentation. This affected the ability to generate reliable performance reports at both LGA and state levels. The lesson here is that field staff require continuous capacity building in data management, as well as supervision to ensure quality assurance. Using digital tools for data capture may also reduce reporting errors in future campaigns.

8. **Routine Immunization Must Not Be Neglected During Campaigns:** One of the unintended consequences of high-impact campaigns like MNCH Week is the deprioritization of routine services. Although routine immunization (RI) was a component of the campaign, several wards failed to provide or report RI services consistently. This suggests a need to reinforce the integration of RI within broader campaigns and ensure that frontline health workers do not shift focus entirely to campaign-specific interventions.

9. **Microplanning Is Essential for Equitable Coverage:** The identification and listing of schools, churches, and settlements during the microplanning phase proved crucial for reaching target groups. However, gaps still existed in certain locations due to outdated or incomplete lists. This lesson underscores the need for robust, community-validated microplans that are updated regularly and inclusive of remote and underserved areas.

10. **Frontline Health Worker Motivation Affects Performance:** Limited transport, commodity shortages, and long hours without incentives negatively impacted the morale of many frontline workers. Some were overburdened by overlapping responsibilities, especially in LGAs where mop-up activities coincided with preparation for another national campaign. This highlights the importance of adequate support, logistics, and motivation (both financial and non-financial) to maintain workforce efficiency and morale.

11. **Multisectoral Collaboration Enhances Reach:** Collaboration between sectors such as education, traditional institutions, and religious bodies enhanced the campaign's reach. Engaging school authorities facilitated access to adolescent girls for HPV vaccination, while community leaders helped mobilize mothers and caregivers for child health interventions. This reflects the value of multisectoral partnerships in achieving broader health goals.

## CONCLUSION

The June 2025 Maternal, Newborn, and Child Health (MNCH) Week in Bayelsa State marked a critical intervention aimed at improving maternal and child health outcomes across the state's eight Local Government Areas (LGAs) and 105 wards. As a strategic initiative under the

broader public health framework, the campaign was designed to deliver a comprehensive package of life-saving services, including Vitamin A supplementation, deworming, routine immunization, malaria vaccination, mid-upper arm circumference (MUAC) screening for malnutrition, Iron/Folate and MMS supplementation for pregnant women, HPV vaccination, and birth registration.

Despite the commendable efforts of the Bayelsa State Primary Health Care Board (BSPHCB), partners, stakeholders, and field teams, the implementation of the MNCH Week was not without challenges. From pre-implementation activities through to data harmonization and post-intervention analysis, several operational, logistical, and systemic bottlenecks were encountered that affected the overall equity, efficiency, and effectiveness of the campaign.

One of the most notable achievements of the week was the overall coverage rate, particularly the impressive 83% for Vitamin A supplementation, and a remarkable 330% coverage for the HPV vaccine; largely driven by school-based outreach strategies. These figures underscore both the potential and the impact of well-coordinated, high-impact campaigns in reaching hard-to-serve populations. Similarly, over 280,000 children were screened for malnutrition, providing crucial data to support future nutrition interventions. These successes speak to the dedication and hard work of frontline health workers and supervisors who overcame significant constraints in the field.

However, the campaign also revealed persistent and structural challenges that need to be addressed moving forward. Delayed starts in some wards, particularly in riverine LGAs like Southern Ijaw and Brass, disrupted uniformity in service delivery. Commodity shortages, especially of Albendazole, highlighted gaps in supply chain planning and distribution logistics. Data quality issues, such as incomplete reporting and inconsistency between expected and reported services (notably for routine immunization), weakened the reliability of the coverage data and the ability to make real-time course corrections. Moreover, logistical gaps in transportation severely hindered team mobility, particularly in remote and difficult-to-reach areas, resulting in missed settlements and increased strain on health workers.

Equally concerning was the low coverage in key services like malaria vaccine (17%) and birth registration (1%), indicating the need for greater integration and prioritization of these interventions. The limited implementation of mop-up activities in some wards due to overlapping campaigns (e.g., the second round of National Immunization Plus Days) further compounded the challenge of equitable service coverage, leaving pockets of vulnerable populations unreached.

Notably, data harmonization at the post-implementation phase proved essential but resource-intensive, highlighting the critical need for real-time data validation mechanisms during campaign rollout. The post-intervention analysis was able to clean and reconcile service figures across LGAs, but this process delayed timely feedback and strategic decision-making.

From a programmatic lens, several best practices emerged from the campaign that should be institutionalized for future rounds. These include the use of pictorial IEC materials that improved caregiver understanding of services, compulsory mop-up strategies to ensure full coverage, evening review meetings that enabled problem-solving, strong supervisory support from state-level actors, and the inclusion of impactful interventions such as HPV and malaria vaccines. These elements contributed significantly to service uptake and community responsiveness and should be embedded into the SOPs for all subsequent campaigns.

Looking ahead, the path to improved MNCH outcomes in Bayelsa lies in addressing the systemic gaps uncovered during this campaign. Strengthening data systems, ensuring timely commodity distribution, improving field logistics (especially transportation and team deployment), enhancing routine immunization integration, and scaling up targeted social mobilization are all critical to achieving more comprehensive, equitable, and efficient campaign delivery. Strategic planning must begin early, be informed by real-time data, and involve all stakeholders; including communities, whose engagement and support are pivotal.

In conclusion, while the MNCH Week in Bayelsa State achieved moderate success in quantitative terms, it exposed critical weaknesses that, if addressed with urgency and commitment, can significantly enhance the quality and reach of future campaigns. It is imperative that all stakeholders; from government to community leaders, technical partners, and frontline workers; commit to continuous improvement. By institutionalizing lessons learned and scaling up best practices, Bayelsa State can strengthen its primary healthcare system and move closer to achieving sustainable maternal and child health outcomes for all its residents.

## PHOTO GALLERY

State Level Training

Market Sensitization with the Executive Secretary


Operations Room

Eligible Child Displaying Vitamin A Card


Eligible Child Displaying Vit. A Card and Marked Finger

Health Workers on Duty with Mother & Child


ACSM Activities

BYSPHCB Executive Secretary Engaged in Health Education