



Leadership, Management, and Sustainability (LMS) Project,  
Program to Build Leadership and Accountability in Nigeria's  
Health System (PLAN-Health)

**FINAL REPORT**  
**JUNE 2010 – DECEMBER 2015**

The PEPFAR/USAID-funded Program to Build Leadership and Accountability in Nigeria's Health System (PLAN-Health), managed by Management Sciences for Health (MSH), is a five year project (2010 – 2015) aimed to strengthen the institutional capacity, leadership, and management skills of public sector institutions and civil society organizations for better HIV/AIDS and other health services delivery to vulnerable groups in Nigeria.

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## ACRONYMS

ACM	AIDS Care Managers
AHDC	African Health Development Center
AIDS	Acquired Immune Deficiency Syndrome
AKSACA	Akwa Ibom State Agency for The Control Of AIDS
ACSASCP	Akwa Ibom State AIDS/STD Control Programme
ANC	Antenatal Care
ARRDEC	Antof Rural Resource Development Center
ART	Antiretroviral Therapy
BoT	Board of Trustees
CB	Capacity-Building Project
CBHI	Community-Based Health Insurance
CCM	Country Coordinating Mechanism
CDC	US Centers for Disease Control and Prevention
CHIEASY	Community Health Insurance Enrollment Authentication System
COHPA	Community Oriented Health Providers Association
CPD	Community Partners for Development
CSO	Civil Society Organization
CSS	Client Satisfaction Survey
DHIS	District Health Information System
DPRS	Department Of Planning, Research, And Statistics
FACA	FCT Agency for The Control Of AIDS
FASCP	FCT AIDS and STI Control Program
FCT	Federal Capital Territory
FMoH	Federal Ministry of Health
GF	Global Fund
GomSACA	Gombe State Agency for Control of AIDS
GOMSACP	Gombe State AIDS/STD Control Programme
HAF	Health Alive Foundation
HCT	HIV Counseling and Testing

HELIN	Heal The Land Initiative in Nigeria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
IAI	Integrated AIDS Initiative
IR	Intermediate Result
JCCI	Jomurota Community Care Initiative
LCDF	Lawanti Community Development Foundation
LDP	Leadership Development Program
LGA	Local Government Area
LMG	Leadership, Management, and Governance
LMS	Leadership, Management, and Sustainability Program
M&E	Monitoring and Evaluation
MLSCN	Medical Laboratory Science Council of Nigeria
MNCH	Maternal, Newborn, and Child Health
MoH	Ministry of Health
MOST	Management, Organizational, and Sustainability Tool
MSH	Management Sciences for Health
NASCAP	National AIDS Control and Prevention Programme
NGO	Non-governmental Organization
NHIS	National Health Insurance Scheme
NHOCAT	National Harmonized Organizational Capacity Assessment Tool
NSHDP	National Strategic Health Development Plan
OPG	Overarching Project Goal
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care Center
PLAN-Health	Program To Build Leadership and Accountability in Nigeria's Health System
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PSI	Public Sector Institutions
RAPAC	Redeemed AIDS Programme Action Committee
QIHE	Queenette Initiative for Health Education
SHI	Sustainable Health Care Initiative
SOP	Standard Operating Procedure
SPDC	Shell Petroleum Development Company
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TEMIN	Teenagers Empowerment Initiative
TOR	Terms of Reference
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	US Government
WHO	World Health Organization

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We gratefully acknowledge the contributions of the PLAN-Health partners and stakeholders, including the Federal Government of Nigeria, the Federal Capital Territory State Government, Gombe State Government and Akwa Ibom State Government, the Global Fund Country Coordinating Mechanism (CCM), and the civil society organizations that the project supported.

The success of PLAN-Health is due to the extensive, collegial, and collaborative efforts of its staff, partners, and consultants. We thank past and present PLAN-Health staff, as well as Management Sciences for Health (MSH).

This report was written by Philomena Orji and Joy Kolin and was reviewed and edited by Funmi Esan, Sara Weinstein, Kathleen Alvarez, and Cindy Shiner.

## EXECUTIVE SUMMARY

The Program to Build Leadership and Accountability in Nigeria's Health System (PLAN-Health) is a five-year program funded by the US Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR) and implemented by Management Sciences for Health. The project, awarded in June 2010, is an Associate Award under the global Leadership, Management, and Sustainability program.<sup>1</sup> PLAN-Health is a long-term transformative program designed to strengthen the institutional capacity of public sector institutions and civil society organizations for improved health and HIV & AIDS service delivery across the three tiers of the Nigerian health sector – federal, state, and local.

PLAN-Health operated in three states – the Federal Capital Territory (FCT), Gombe, and Akwa Ibom.<sup>2</sup> PLAN-Health worked in FCT and Akwa Ibom State because of their high HIV prevalence (8.6% and 10.9% respectively<sup>3</sup>), in order to strengthen the government's capacity to achieve control of the AIDS epidemic and move closer to the goal of achieving an HIV-free generation. Through a combination of workshops, internships, embedded consultants, technical assistance (TA), coaching, and mentoring, PLAN-Health has helped to build strong and viable organizations by developing leadership skills, more capable managers, and transparent and accountable institutions. The project aligned with the federal and state health plans specifically pertaining to leadership and governance, human resources for health, health management information systems, health financing through community-based health insurance, and service delivery for effective health systems strengthening at the federal, state, and local government area (LGA) levels.

### Background

In 2010, when the project was initiated, the Nigerian health system was fragmented, with little coordination or dialogue between the federal and state levels. Implementation of national policies at the state level was inadequate and health statistics reporting rates were very low. In response, the Federal Ministry of Health, together with USAID, identified the need to improve governance as one of the foundations to increase the Nigerian government's capacity and financial commitment to health services and, more specifically, HIV & AIDS. USAID's strategy included programs that would work with civil society, the private sector, and other donors to strengthen service delivery systems and increase transparency and accountability. The PLAN-Health project was one avenue employed to improve governance through strengthened leadership and management and increased coordination between the federal and state level as well as between the public and private sector.

### Project Activities

Over the life of the project, PLAN-Health introduced numerous innovations to the Nigeria health landscape that helped develop capable leaders, strengthen management systems, and improve governance structures – contributing to the improvement in health and HIV service delivery.

***Developing Strong Local Leaders.*** The project adapted MSH's successful Leadership Development Program (LDP) and LDP-Plus to the Nigeria context and introduced participants to leading, managing, and governance practices to improve capacity to respond to change for improved health outcomes. The PEPFAR Health Professionals' Fellowship Program, the first of its kind in Nigeria, developed change agents by equipping them with the requisite leadership and management skills to tackle challenges and achieve positive health outcomes.

***Building Sustainable Management Systems.*** PLAN-Health applied key management practices for both its civil society organization (CSO) and public sector institution (PSI) clients to help streamline processes and improve the efficiency and effectiveness of organizations to deliver health services. With CSOs, PLAN-Health focused on financial management, monitoring and evaluation, and human resources management and planning to enable CSOs to plan, organize, and implement their activities; track their budgets and expenditures; monitor and showcase program results; and manage their staff and manpower. For PSIs, the project focused on health policy, planning and management, and coordination. Interventions were aligned with the national and state health plans, specifically components pertaining to health management information systems (HMIS) and human resources for health.

***Improving Governance and Accountability.*** PLAN-Health supported CSOs to develop plans that set the strategic direction of the organization, strengthened governance boards and their oversight capacity to ensure accountability, and enhanced resource mobilization capacity to attract additional resources and utilize them wisely to promote sustainability.

Activities with PSIs helped to develop policies and strategic plans that set the policy direction and create an enabling environment for health development. The project strengthened PSIs' coordination and oversight capacity to engage and synchronize with multiple partners and stakeholders to achieve shared goals. PLAN-Health also established structures and models for implementation of community-based health insurance (CBHI), ensuring effective stewardship of scarce resources, and increasing access to health services. Lastly, the project worked with the Global Fund Country Coordinating Mechanism (CCM) to improve its oversight capacity to monitor principal recipients.

### Key Achievements

Over the past five years, PLAN-Health worked with 52 organizations (both PSIs and CSOs) and built the capacity of 1,570 individuals at the federal and state levels.<sup>4</sup> Key achievements presented below align with the project's six intermediate result (IR) areas.

#### **IR1: Strengthen leadership and management practices of select PSIs and CSOs**

- PLAN-Health introduced, adapted, and implemented MSH's global LDP in Nigeria. A total of 299 managers from 38 organizations strengthened their leadership and management skills through the LDP.

<sup>1</sup> The project was originally scheduled to end on June 10, 2015 but USAID granted PLAN-Health a no-cost extension until December 6, 2015.

<sup>2</sup> Akwa Ibom was added to the project in July 2012.

<sup>3</sup> 2010 National HIV sero-prevalence sentinel survey.

<sup>4</sup> The full list of PLAN-Health clients is included in Annex 1 of this report.

### **IR2: Develop and strengthen organizational systems (e.g., human resources, finance, HMIS, supply chain, service delivery, and planning) of PSIs and CSOs**

- PLAN-Health implemented client satisfaction surveys of HIV & AIDS service delivery (2012 and 2014/5) in Gombe and the FCT. The project noted a 63% increase in Gombe and 46.9% increase in the FCT in health care worker communication as a result of interpersonal communications trainings for facility staff.
- The project recorded an improvement in reporting of health statistics by state agencies and incorporation of health information into the district health information system. Reporting of health statistics by the FCT administration increased from 0% to 60%, in Gombe State from 39% to 77%, and in Akwa Ibom State from 22% to 86%.<sup>5</sup>
- Sixteen local CSOs passed the USAID financial pre-award survey, enabling them to receive direct funding from US government sources.

### **IR3: Strengthen governance practices (e.g., accountability, board development, business development) of PSIs and CSOs**

- Resource mobilization training for CSOs in the FCT, Gombe, and Akwa Ibom led to \$49.8 million in additional resources from the Government of Nigeria and international donors to implement health and HIV projects.

### **IR4: Strengthen the coordination among PSIs at all levels and partnerships with CSOs**

- The project supported the development of strategic and operations plans for national and state agencies. Implementation of activities included in the plans increased from year to year. For example the FCT Agency for the Control of AIDS implemented 37.9% of its 2011–2012 plan, while in 2013 it accomplished 53%. The Akwa Ibom State AIDS/STD Control Programme and Gombe State Agency for Control of AIDS did not have a plan before 2013 and that year implemented 71% and 70% of their plans, respectively.
- PLAN-Health drafted and developed a policy framework for the regulation of traditional birth attendants (TBAs) in Akwa Ibom to improve maternal, newborn, and child health services and prevention of mother-to-child transmission uptake. This is the first policy framework ever developed in the state for engaging TBAs.

### **IR5: Develop a new cadre of individuals and institutions providing technical assistance in management and leadership that meets international standards**

- The PEPFAR Health Professionals' Fellowship is institutionalized at two Nigerian universities. A total of 310 health professionals were trained through the fellowship and 4.4 million people<sup>6</sup> were impacted through fellows' community outreach activities.

### **IR6: Strengthen the institutional capacity of the national health insurance scheme (NHIS), state counterparts, local communities, and select CSOs to provide access to quality health services through sustainable CBHI programs**

- The project designed and developed the first community-based, -funded, -owned, and -governed insurance scheme in Nigeria (in Akwa Ibom State). As of November 2015, 515 people enrolled and have health insurance for the first time in their lives.

- PLAN-Health facilitated the design and deployment of the Community Health Insurance Enrollment Authentication System (CHIEASY) - a web-based application that tracks CBHI enrollment and payment of both premium and capitation. The utilization of CHIEASY increased the enrollee base of the Shell Petroleum Development Company of Nigeria-supported-CBHI program from 556 people in April 2014 to 5,656 people by December 2014.

### **Conclusion**

Over the life of the project, the importance of strong leaders, capable managers, and robust governance structures has become clearer. At the conclusion of the PLAN-Health project in 2015, coordination and partnerships between health regulatory agencies and other actors in the health sector have been strengthened. Reporting of health data increased as a result of better understanding of the national HMIS. Roles and responsibilities of federal, state, and local government actors are clearer. This resulted in better and more efficient planning of resources that strategically target geographic areas and populations where the most impact can be achieved for investments made. CSOs recognize their role as a bridge between the government and the populations they serve, and have enhanced institutional capacity to raise and manage funds, to ensure sustainability of their programs. Health care workers have stronger leadership and management skills and are better equipped to deal with the challenging environments they face.

Improvements in the health system have translated to service delivery enhancements but much still remains to be done to ensure that all Nigerians have access to quality health and HIV services. PSIs' capacity to effectively implement policies and monitor implementation progress and results is still limited. There is also a need for continuous capacity-building to strengthen PSIs' coordination and oversight between the federal, state, and LGA levels, as well as, support the government to engage with and regulate TBAs and other informal health care providers to scale- up and expand high-impact strategies, and improve the health of the population.

CSOs require technical support to make them sustainable and provide more and better services for the people they serve, particularly marginalized populations that are most affected by HIV & AIDS. These services will help to reduce infection rates in women and adolescent girls and ensure that they are supported to become resilient, empowered and AIDS-free.

In a country like Nigeria that has a large informal sector and significant population of poor people, it is important to design and implement innovative financing mechanisms and incentive programs like performance-based financing to mobilize resources to fund health for all. With support from the NHIS and development partners, state governments can increase their direct investment in health, raise awareness of health insurance among its citizens, encourage participation, and enroll more people, which will also deepen the impact of efforts by the Government of Nigeria and the US Government to improve access to quality health care for the poor and vulnerable.

<sup>5</sup> Source: Nigeria HMIS

<sup>6</sup> Source: Fellows monthly progress reports

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# **PART 1:** The PLAN-Health Story



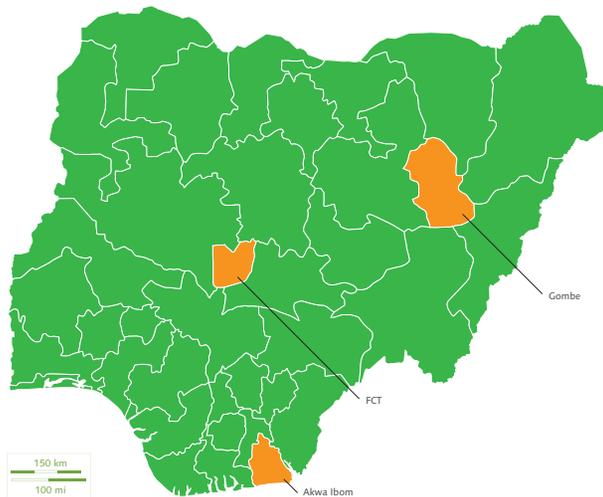
*Photo by MSH*

## PROJECT SUMMARY

The Program to Build Leadership and Accountability in Nigeria's Health system (PLAN-Health) is a five-year program funded by the President's Emergency Plan for AIDS Relief (PEPFAR) and the US Agency for International Development (USAID) and implemented by Management Sciences for Health (MSH). The project, awarded in June 2010, is an Associate Award under the global Leadership, Management, and Sustainability (LMS) program.<sup>7</sup> PLAN-Health is a long-term transformative program designed to strengthen the institutional capacity of public sector institutions (PSIs) and civil society organizations (CSOs) for improved health and HIV & AIDS service delivery across the three tiers of the Nigerian health sector - federal, state, and local.

With an overall ceiling of \$24,995,963, the project operated in three states – the Federal Capital Territory (FCT), Gombe, and Akwa Ibom.<sup>8</sup> Through a combination of workshops, internships, embedded consultants, technical assistance (TA), coaching, and mentoring, PLAN-Health has helped to build strong and viable organizations by developing leadership skills, more capable managers, and transparent and accountable institutions. The project aligned with the federal and state health plans specifically pertaining to leadership and governance, human resources for health (HRH), health management information systems (HMIS), health financing through community-based health insurance (CBHI), and service delivery for effective health systems strengthening at the federal, state, and local levels.

Figure 1: The Federal Capital Territory, Akwa Ibom, and Gombe



<sup>7</sup> The project was originally scheduled to end on June 10, 2015 but USAID granted PLAN-Health a no-cost extension until December 6, 2015.

<sup>8</sup> Akwa Ibom was added to the project in July 2012.

## BACKGROUND

Nigeria has been slow to recognize the gravity of the HIV & AIDS epidemic and to mobilize the commitment and resources required for a sustainable national response. When the PLAN-Health project commenced in 2010, the national HIV prevalence rate was 4.1%.<sup>9</sup> Nigeria's health indicators also ranked poorly when compared to those of other countries with similar per capita income, while inequalities exist within the country between rural, semi-urban, and urban areas, between northern and southern zones, and across income groups. The poor health outcomes were not only a consequence of the high increase in the poverty level but also a result of the weaknesses in the health system, especially in the delivery of primary health care services.<sup>10</sup>

Contributing to the poor state of Nigeria's health status is the structure of the health system. The Nigerian health system is very fragmented, with three tiers of government and poor coordination arrangements: federal; 36 states and the FCT; and 774 local government areas (LGAs). Statutorily, these tiers of government have concurrent responsibilities to provide social services, including health. In the present democratic era, these levels also have substantial autonomy and exercise considerable discretion over the allocation and utilization of their resources. This arrangement constrains the influence that the federal government has over state and local governments, including their investments in health.<sup>11</sup>

Taking into account this environment, the Federal Ministry of Health (FMOH), together with USAID, identified the need to improve governance as one of the foundations to increase the Nigerian government's capacity and financial commitment to health services and, specifically, HIV & AIDS. USAID's strategy included programs that would work with civil society, the private sector, and other donors to strengthen service delivery systems and increase transparency and accountability. The PLAN-Health project was one avenue employed to improve governance through strengthened leadership and management and increased coordination between the federal and state level as well as between the public and private sector.

The PLAN-Health project also tied into the National Strategic Health Development Plan (NSHDP) that was developed and adopted in July 2009 by the Nigerian government. The NSHDP (2010-2015) aims to strengthen the health system and improve the health status of Nigerians. Leadership and governance is one of the eight priority areas outlined in the NSHDP. The goal of the leadership and governance component is to create and sustain an enabling environment for responsive health development in Nigeria.

**PLAN-Health helped promote NSHDP Priority Area 1:**  
*Leadership and governance for health to enhance the performance of the national health system and provide clear policy directions for health*

<sup>9</sup> National Agency for the Control of AIDS, (NACA), Federal Republic of Nigeria, "Global AIDS Response Country Progress Report," Nigeria (GARPR), [http://www.unaids.org/sites/default/files/country/documents/NGA\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/NGA_narrative_report_2014.pdf), 2014, (accessed 1 September 2015).

<sup>10</sup> Federal Ministry of Health, Abuja, Nigeria Federal Ministry of Health [Nigeria] (2009), Nigeria Strengthening National Health Systems, A Country Experience.

<sup>11</sup> Federal Ministry of Health [Nigeria] (2013), NSHDP 2010-2015, Abuja: MOH

## BUILDING ON PAST SUCCESSES

**P**LAN-Health built on the successful work of its predecessor project, the LMS Capacity-Building (CB) project in Nigeria (2006-2010), a USAID/Nigeria-funded buy-in to the leader award (LMS). CB provided assistance to civil society organizations that applied for US Government (USG) funds through the Annual Program Statement. It also provided technical support to the FMOH divisions of HIV & AIDS and tuberculosis (TB) and to the Federal Ministry of Women's Affairs Orphans and Vulnerable Children (OVC) Division, supported the Nigerian Country Coordinating Mechanism (CCM) for the Global Fund to Fight AIDS, TB, and Malaria (GF), and developed and implemented a fellowship program for health professionals.

## PLAN-HEALTH RESULTS FRAMEWORK

**P**LAN-Health has two overarching goals:

1. To strengthen institutional capacity of select public and civil society organizations at federal, state, and local levels for improved delivery of HIV & AIDS and other health services for Nigeria's vulnerable populations.
2. To develop and institutionalize capacity for building management and leadership skills and practices in Nigeria's health sector.

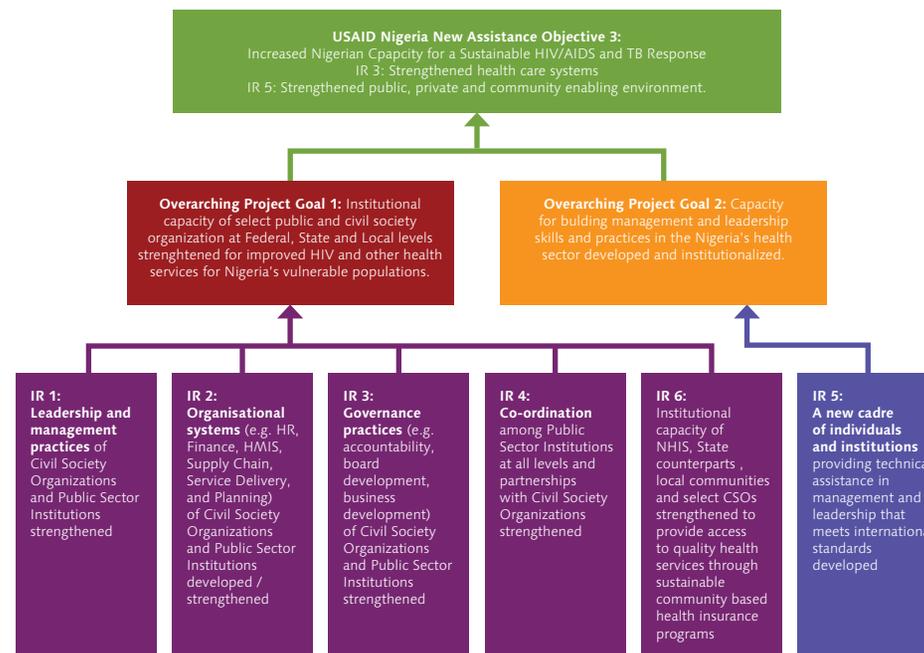
The project's interventions are designed around six Intermediate Results (IRs) outlined below, which align with USAID/Nigeria's Assistance Objective 3 (see chart on next page), the World Health Organization (WHO) recommended health systems building blocks, as well as the NSHDP:

S/N	PLAN-HEALTH INTERMEDIATE RESULTS	WHO HEALTH BUILDING BLOCK <sup>12</sup>
IR1	Strengthen leadership and management practices of select PSIs and CSOs.	Leadership/governance
IR2	Develop and strengthen organizational systems (e.g., HR, finance, HMIS, supply chain, service delivery, and planning) of PSIs and CSOs	Leadership/governance, health workforce, information
IR3	Strengthen governance practices (e.g., accountability, board development, business development) of PSIs and CSOs	Leadership/governance
IR4	Strengthen the coordination among PSIs at all levels and partnerships with CSOs	Leadership/governance
IR5	Develop a new cadre of individuals and institutions providing TA in management and leadership that meets international standards	Health workforce
IR6	Strengthen the institutional capacity of the national health insurance scheme (NHIS), state counterparts, local communities, and select CSOs to provide access to quality health services through sustainable CBHI programs <sup>13</sup>	Financing, leadership/governance

<sup>12</sup> World Health Organization, Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies, Geneva, World Health Organization, 2010.

<sup>13</sup> IR6 was not in the original project description. This IR was added in January 2011 by USAID. Specifically, PLAN-Health was to serve as a mechanism to mobilize community resources to share in the financing of local health services

Figure 2: PLAN-Health results framework



## THE PLAN-HEALTH CONCEPTUAL APPROACH

**T**he PLAN-Health capacity-building approach is a long-term transformational process that includes a combination of TA, trainings, mentoring, and coaching.

The approach used across all IRs and clients is composed of three elements:

1. developing stronger leaders and more capable managers;
2. creating more efficient, coordinated systems and processes; and
3. continuing to increase participating institutions' commitment to positive change and ownership of the processes and the outcomes.

The combination of both strengthening individuals and systems simultaneously enables organizations to function more effectively and efficiently to implement their mission and provide better and more health services (see Figure 3). The approach for each organization, while employing the three basic elements, was tailored to that organization's mission, challenges, needs, and desired outcomes.

and work with community members, health management organizations, CSOs, community-based organizations, health care providers, the public sector, development partners, the state government, and the NHIS as the regulatory body.

Figure 3: PLAN-Health conceptual approach



The project employed a number of strategies to implement this approach and develop capable, effective managers and build strong organizational systems. When working with CSOs, PLAN-Health conducted an organizational assessment to define each CSO's capacity across a variety of organizational areas and then designed a capacity-building plan that included TA and on-the-job training and coaching. The project also organized workshops on the development of proposals and concept papers to enhance the financial sustainability of CSOs.

When engaging with government agencies at the federal, state, and LGA levels, PLAN-Health introduced tools, procedures, and best practices from other country experiences to support systems, policies, and institutional frameworks for health service delivery. At the federal level, the project developed skills and expertise to establish, develop, and review policies and guidelines for the effective functioning of health systems. At the state level, capacity-building via internships, workshops, hands-on mentoring and coaching, and TA were deployed to help translate and implement policies and guidelines into actions as well as adapt these for replication as state policies. At the LGA level, implementation focused on engaging community structures and LGA frameworks for service delivery.

## PLAN-HEALTH GUIDING PRINCIPLES

### 1. Results Focused

- Use PLAN-Health results management framework with clients, USAID, and the project
- Define SMART outcomes and performance indicators for each client
- Develop evidence-based solutions for improving leadership skills, management practices, and governance models
  - Design, implement, and document operational research studies for practical solutions in leadership, management, and governance
- Use of monitoring and evaluation (M&E) data for informed project management decision-making
  - Teams
  - Monthly dashboards, monthly reports
  - M&E with and for each client
- Capacity-building for results
  - Use of workshops as part of a longer term capacity-building effort, not as stand-alone events
  - Develop a capacity-building plan for and with each client/partner
  - Use of ongoing TA, accompaniment, and mentoring with each client
  - Greater use of internships where relevant
  - Strategic use of the fellowship program
  - Strategic use of small infrastructure investments for increased capacity

### 2. Client Ownership/Leadership

- Engage with key stakeholders at project initiation
- Align to client/partner plans
- Respond to demand/client needs/client priorities
- Avoid internal politics
- Maintain fluid communication
- Adapt to partner needs within context of results framework
- Institutionalization of interventions in client organizations

### 3. Scale-up

- Identify opportunities for sharing leadership, management, and governance better practices, learning, and approaches with other partners
- Encourage current partners to apply lessons learned to their networks beyond PLAN-Health states
- Implement with an eye to expansion
- Dedicate some resources for taking advantage of expanding beyond current states
- Find an institutional home for the fellowship and other programs as appropriate

### 4. Partnerships

- Work cooperatively with other partners rather than competitively
- Identify synergies
- Insist that clients lead partner cooperation and coordination

## PLAN-HEALTH KEY ACHIEVEMENTS

Over the past five years, PLAN-Health worked with 52 organizations (both PSIs and CSOs) and built the capacity of 1,570 individuals at the federal and state levels.<sup>14</sup> Key achievements presented below align with the project's six intermediate result (IR) areas.

### IR1: Strengthen leadership and management practices of select PSIs and CSOs

- PLAN-Health introduced, adapted, and implemented MSH's global LDP in Nigeria. A total of 299 managers from 38 organizations strengthened their leadership and management skills through the LDP.

### IR2: Develop and strengthen organizational systems (e.g., human resources, finance, HMIS, supply chain, service delivery, and planning) of PSIs and CSOs

- PLAN-Health implemented client satisfaction surveys of HIV & AIDS service delivery (2012 and 2014/5) in Gombe and the FCT. The project noted a 63% increase in Gombe and 46.9% increase in the FCT in health care worker communication as a result of interpersonal communications trainings for facility staff.
- The project recorded an improvement in reporting of health statistics by state agencies and incorporation of health information into the district health information system. Reporting of health statistics by the FCT administration increased from 0% to 60%, in Gombe State from 39% to 77%, and in Akwa Ibom State from 22% to 86%.<sup>15</sup>
- Sixteen local CSOs passed the USAID financial pre-award survey, enabling them to receive direct funding from US government sources.

### IR3: Strengthen governance practices (e.g., accountability, board development, business development) of PSIs and CSOs

- Resource mobilization training for CSOs in the FCT, Gombe, and Akwa Ibom led to \$49.8 million in additional resources from the Government of Nigeria and international donors to implement health and HIV projects.

### IR4: Strengthen the coordination among PSIs at all levels and partnerships with CSOs

- The project supported the development of strategic and operations plans for national and state agencies. Implementation of activities included in the plans increased from year to year. For example the FCT Agency for the Control of AIDS implemented 37.9% of its 2011-2012 plan, while in 2013 it accomplished 53%. The Akwa Ibom State AIDS/STD Control Programme and Gombe State Agency for Control of AIDS did not have a plan before 2013 and that year implemented 71% and 70% of their plans, respectively.
- PLAN-Health drafted and developed a policy framework for the regulation of traditional birth attendants (TBAs) in Akwa Ibom to improve maternal, newborn, and child health services and prevention of mother-to-child transmission uptake. This is the first policy framework ever developed in the state for engaging TBAs.

### IR5: Develop a new cadre of individuals and institutions providing technical assistance in management and leadership that meets international standards

- The PEPFAR Health Professionals' Fellowship is institutionalized at two Nigerian universities. A total of 310 health professionals were trained through the fellowship and 4.4 million people<sup>16</sup> were impacted through fellows' community outreach activities.

### IR6: Strengthen the institutional capacity of the national health insurance scheme (NHIS), state counterparts, local communities, and select CSOs to provide access to quality health services through sustainable CBHI programs

- The project designed and developed the first community-based, -funded, -owned, and -governed insurance scheme in Nigeria (in Akwa Ibom State). As of November 2015, 515 people enrolled and have health insurance for the first time in their lives.
- PLAN-Health facilitated the design and deployment of the Community Health Insurance Enrollment Authentication System (CHIEASY) - a web-based application that tracks CBHI enrollment and payment of both premium and capitation. The utilization of CHIEASY increased the enrollee base of the Shell Petroleum Development Company of Nigeria-supported-CBHI program from 556 people in April 2014 to 5,656 people by December 2014.

<sup>14</sup> The full list of PLAN-Health clients is included in Annex 1 of this report.  
Nigeria HMIS

<sup>16</sup> Source: Fellows monthly progress reports

# PART 2:

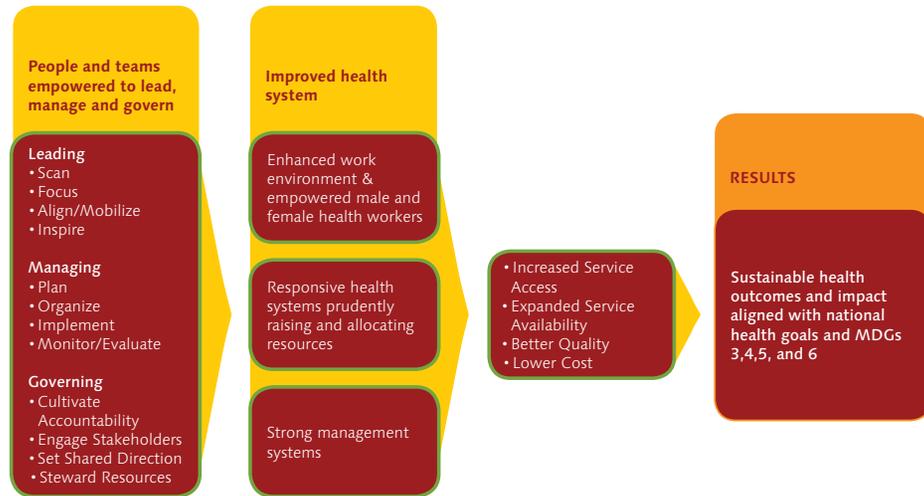
## Leadership, Management, and Governance for Improved Health Outcomes



Photo by MSH

Leadership, management, and governance are interdependent and reinforce each other. All three interact in a balanced way to achieve results. PLAN-Health interventions included these three elements to address some of the health challenges the Nigerian health system faces. The project adopted and adapted the framework developed by the USAID-funded Leadership, Management and Governance (LMG) global project, implemented by MSH, of leading, managing, and governing for results (see Figure 4 below).<sup>17</sup> The figure includes the key practices that people must employ to effectively lead, manage, and govern. These practices lead to improved health system performance, which, in turn, leads to better health outcomes.<sup>18</sup>

Figure 4: Leadership, Management, and Governance conceptual framework



Part 2 of this report reflects these practices and depicts the leadership, management, and governance activities implemented by the project and the results achieved.

<sup>17</sup> The LMG project is the follow-on to the LMS project.  
<sup>18</sup> MSH, How to Govern the Health Sector and Its Institutions Effectively, "The eManager, 2013, No. 1, 2013, p.3 [http://www.lmgforhealth.org/sites/default/files/files/eManager\\_How%20to%20Govern%20the%20Health%20Sector\\_4\\_11\\_13\\_FINAL.pdf](http://www.lmgforhealth.org/sites/default/files/files/eManager_How%20to%20Govern%20the%20Health%20Sector_4_11_13_FINAL.pdf), (accessed 1 September, 2015).

## A. DEVELOPING STRONG LOCAL LEADERS



Photo by MSH

PLAN-Health utilized leading practices to enable health managers to translate policies and policy directions into action, provide clear policy directions for health development, and overcome challenges in their resource-constrained environments to improve service delivery at the federal, state, and local levels. MSH's LDP and LDP-Plus introduced participants to leading, managing, and governance practices – leading to enhanced capacity to respond to change for improved health outcomes. The PEPFAR Health Professionals' Fellowship Program developed change agents by equipping them with the requisite leadership and management skills to tackle challenges and achieve positive health outcomes.

**Leading Practices:**  
 Scan  
 Focus  
 Align/Mobilize  
 Inspire

### The LDP and LDP-Plus

The LDP, developed in 2002 and continuously improved upon by MSH, brings together the best thinking on leadership development, using experiential learning and performance improvement processes that empower teams to set clear goals and achieve measurable results. This approach to leadership development differs from traditional leadership training programs that introduce leadership theories and behaviors in a course setting.

Working in their real work teams, participants learn leadership and management practices that make it possible to face challenges and achieve measurable results. The LDP-Plus, developed in 2012, is the enhanced version of the LDP that builds on the LDP with a quality improvement component. In Nigeria's health sector, the LDP and LDP-Plus were used at all levels – from senior managers to district management and health facility teams, in ministries, and CSOs.

The LDP is a structured participatory process that enables teams to identify and face challenges and achieve results by applying leading and managing practices to specific real challenges and develop the competencies that are needed to achieve desired results. Challenges are real and directly or indirectly linked to service improvements. The LDP is built on the LMG model (see Figure 4) which shows how improved management and leadership practices bring about changes in systems and work climate, which are critical contributors to improved services and health outcomes.

#### The PLAN-Health Nigeria approach to the LDP/LDP-Plus process

The LDP is a performance improvement process that empowers teams to:

- **Create an inspiring shared vision** for accomplishing the mission of their organizations
- **Apply leading and managing practices** to improve teamwork and effectiveness
- **Use a challenge model process** for identifying and achieving measurable results
- **Align stakeholders** around a common challenge

The LDP-Plus includes all of the above LDP activities and adds the following improvements:

- **Strengthen country ownership:** Leaders within the health system direct an LDP-Plus performance improvement process tied to health priorities.
- **Rely on standards of care:** Local technical experts use international and national quality standards to propose indicators and packages of interventions that local teams can adapt and implement to face their local challenges.
- **Impact public health results:** Improvement teams work on common sets of indicators so that the process can show public health impact.
- **Identify and scale up local best practices:** Teams work in shared learning sessions to identify most useful local practices.
- **Use effective governance practices** to scale these up in the larger system.
- **Ensure gender equity** by empowering local teams to evaluate gender access, opportunity, and involvement in decision-making.

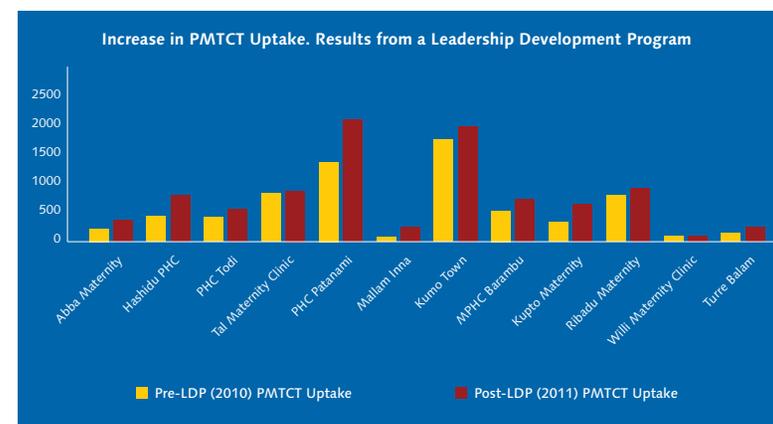
#### Key Achievements

PLAN-Health trained 299 managers from 38 organizations to apply leadership and management practices to achieve measurable results. Some results achieved by organizations include:

- The FCT AIDS and Sexually Transmitted Infection (STI) Control Program (FASCP) activated 10 additional PMTCT sites in 2013 and increased the number of women accessing PMTCT services from 4,918 to 6,001.
- Seven local AIDS control agencies in Gombe State increased uptake of PMTCT services by pregnant women in 12 select facilities by an average of 37%.<sup>19</sup> The results are shown graphically in **Figure 5**.

**The LDP and LDP-Plus contributed to PLAN-Health's IR1. This IR is part of PLAN-Health's overarching project goal (OPG1):**  
*Institutional capacity of select public and civil society organizations at federal, state, and local levels strengthened for improved HIV and other health services for Nigeria's vulnerable populations*

Figure 5: Increase in PMTCT uptake in Gombe state post-LDP



- The Medical Laboratory Science Council of Nigeria (MLSCN) utilized the WHO Regional Office for Africa checklist to improve the quality of services in over 30 laboratories around the country. MLSCN subsequently won a grant of over \$2.5 million from the US Centers for Disease Control and Prevention (CDC) to assess and mentor laboratories in Nigeria towards accreditation. MLSCN also opened a laboratory to assure the quality of all laboratory reagents entering Nigeria.

The first global pilot of the LDP-Plus was conducted by PLAN-Health in 2013 for the FCT Gwagwalada Area Council health team.<sup>20</sup> Some key results include:<sup>21</sup>

- Ibwa Health Facility increased the number of men attending antenatal care (ANC) and HIV testing and counseling with their partners from 20% to 60% (exceeded the target by 40%).
- At the Township Health Facility, the number of pregnant women living with HIV receiving antiretroviral therapy (ART) increased from 89% to 100%.
- Old Kutunku Primary Health Center (PHC) increased the percentage of pregnant women attending ANC by over 300% (from 17 per month to 61 per month).
- PHC Tungan Maje increased from 23% to 100% the percentage of partners of HIV-infected pregnant women attending ANC that are HIV counseled, tested, and receive results.
- PHC Gwako increased the percentage of pregnant women who attended the first ANC and delivered in the facility from 18% to 42%. They also increased from 36% to 100% the percentage of partners of HIV-infected pregnant women that are HIV counseled, tested, and receive results.
- PHC Zuba increased from 25% to 100% the percentage of partners of HIV-infected pregnant women that are HIV counseled, tested, and receive results.

<sup>19</sup> Source: Gombe State health facility records

<sup>20</sup> The LDP-Plus pilot was implemented in collaboration with the USAID-funded global LMG Project.

<sup>21</sup> Source: Gwagwalada Area Council health facility reporting

The teams were able to achieve these improvements by developing strategies for community activities, which included advocacy visits to key stakeholders, community mobilization, male involvement in ANC, sensitization on PMTCT, gatekeepers' sensitization, training of health workers on PMTCT best practices, and support groups for pregnant women and their partners.

### The PEPFAR Health Professionals' Fellowship Program

Building the capacity of health professionals is an essential part of a cost-effective, evidence-based strategy for quality and sustainability in health care service delivery. MSH, under the USAID-funded CB project (2006-2010), was mandated to design and run the PEPFAR Health Professionals' Fellowship Program. The main purpose of the program was to provide in-service training that develops change agents with requisite leadership and management knowledge and skills to tackle challenges in Nigeria's health sector and produce positive health outcomes. The first group was trained in January 2008. PLAN-Health continued to run the fellowship program and was mandated to institutionalize it within training institutions in Nigeria. The fellowship program has uniquely produced a highly skilled cadre of health professionals who have significantly contributed to the increased efficiency and effectiveness of health facilities and interventions across Nigeria.

*The fellowship program is part of PLAN-Health's IR5 which contributes to OPG2: Capacity for building management and leadership skills and practices in the Nigerian's health sector developed and institutionalized*

### Evolution of the PEPFAR Health Professionals' Fellowship Program

The PLAN-Health project refers to each group trained in the program as a cohort. The first five cohorts of the program were trained under the CB project and targeted specific health cadres such as doctors, nurses, and lab scientists. PLAN-Health changed the target audience to a mix of professionals, made up of policymakers, facility-based health workers, and CSO personnel. The premise behind including participants with varied roles was that policymakers would create an enabling environment for quality health services, facility-based health workers would supply the services, while CSO professionals would create demand for the services.

The program began as a nine-week program for nurses. Based on feedback from graduated fellows on modules that they found applicable on their return to their organizations and communities, the program was shortened from nine weeks to six weeks, then five weeks, and finally to two weeks.

The first nine programs were conducted at no cost to the participants. In the last two years of the project PLAN-Health partnered with two tertiary institutions - Benue State University and Obafemi Awolowo University - to institutionalize the program as a fee-paying program. The price paid by participant's ranges from 100,000 naira (\$500) to 175,000 naira (\$875)<sup>22</sup>. The process of transitioning the program to local institutions involved training the facilitators from both institutions on the different fellowship modules. The PLAN-Health team also coached them on experiential adult-learning techniques. To ensure standardization of the program and maintain quality, PLAN-Health, together with Obafemi Awolowo University, developed the program curriculum as a guide for implementation. Lastly, to ensure the sustainability of the program, PLAN-Health helped both institutions identify resource mobilization strategies to continue the program's viability after PLAN-Health.

### Technical approach - blending classroom and hands-on learning

PLAN-Health trained health professionals through classroom learning together with hands on-learning via community outreaches. The classroom learning component included lecture-based instruction on topics critical to the quality of service delivery. Since participants join the program as adult learners with many years of post-qualification experience, facilitators utilized the wealth of participants' experience by using real challenges from local hospitals, clinics, and community organizations.

The fellowship succeeded in creating change agents who applied skills gained from the program to affect far-reaching changes. Unlike many technical training programs, the fellowship program emphasized and reinforced soft skills such as interpersonal communication, listening, emotional intelligence, and empathy in addition to technical skills.

Participants practiced the skills throughout the duration of the program with the guidance and support of their mentors. Participants were assigned to teams with roles and responsibilities defined in a scope of work. For example, a team was responsible for evaluating each day's activities. This task forced them to practice formative evaluation. Teams also provided an update to their colleagues each morning, which gave them opportunity to apply their PowerPoint and creativity skills as well as practice presenting to an audience. Peer performance review helped participants learn to give and receive positive and negative feedback. Working in teams also helped them learn to be better team players, apply negotiation skills, and take on leadership roles.

Participants were required to provide weekly reports to their individual mentors who then provided them with feedback. This process helped them develop report writing skills. Provision of services to the community during weekend activities helped participants understand the importance of giving back. Community assessments were an opportunity for conducting practical community research and provided data for analysis in the Microsoft Excel class. The practicum experience aided them to observe other professional colleagues at work and learn from them. The process of developing and implementing an improvement plan in their organizations and communities gave participants the confidence to tackle bigger challenges and achieve positive results.

<sup>22</sup> The fellowship fee varied by institution.

## Key Achievements

- Thirteen cohorts of health professionals have graduated from the program.
- These cohorts included 310 doctors, nurses, pharmacists, laboratory scientists, other allied health professionals, policymakers and program managers.
- Participants were drawn from health facilities, civil society, and government ministries and parastatals in 32 states across Nigeria, including the FCT.

The fellows accomplished far-reaching changes in their facilities and surrounding communities. Some of the community impact includes:<sup>23</sup>

- Increased TB case detection
- Increased PMTCT uptake
- Increased efficiency within their organizations through improved processes, advocacy, and sensitization programs. For example, fellows reduced client waiting time and turnaround time for laboratory results in some facilities. They provided health education and conducted health outreaches.
- Increased access to HIV counseling and testing by establishing HIV counseling and testing (HCT) sites in facilities where they did not previously exist
- Establishing water and sanitation programs

These programs combined with other health education and promotion activities have reached over 4.4 million Nigerians, which has translated to better health services for Nigerian communities, particularly in low-income settings. The fellows conducted these activities with over \$400,000 that they themselves mobilized using resource mobilization skills gained from the program.

## SUCCESS STORY:

### Increasing PMTCT in Akwa Ibom State through improved leadership skills

*Victoria Ibanga is a nurse and the Director of Primary Health Care (PHC) at Ini LGA, Akwa Ibom State. She attended the PLAN-Health PEPFAR Health Professionals' Fellowship Program in February 2013 to improve her skills. She also wanted the PHC to have better ANC attendance and quality of service, including improved communication between staff and patients. What she gained from the fellowship included leadership styles and tools; knowledge on implementing effective HIV/PMTCT programs; and skills on information technology, proposal writing, and M&E. She also improved her communication and emotional intelligence skills and her ability to multitask. From the knowledge and skills gained in the fellowship, Victoria went back to her community and used those skills in the following ways:*

- *She trained health professionals within the LGA. She also trained the ward development committees and the TBAs to encourage pregnant women to be tested for HIV at health facilities.*
- *She created linkages between Ini LGA and the Queenette Initiative for Health Education, a nongovernmental organization (NGO) in Akwa Ibom State, to create demand for PMTCT and ANC services. She also conducted sensitization outreaches and advocacy visits to traditional rulers and other community leaders.*
- *She held monthly meetings with all the facility heads to listen to their challenges and help them identify solutions. She also held a general meeting of all staff from facilities in her LGA so that everyone has a voice.*



*Photo: Victoria Ibanga during an activity in her community*

*As a result, Victoria's LGA experienced significant improvements in PMTCT:*

Indicator	2012	2013	2014
Uptake of infant HIV testing and postnatal health care service	0	0	2
Use of ART by pregnant women living with HIV	0	0	55
Uptake of ANC services and HIV testing during pregnancy	607	1,073	2,164
Male involvement in facility attendance of pregnant women	1	4	7

***"I want to really appreciate PLAN-Health. They have improved me as an individual. I am no longer the same person. My capacity has been built on PMTCT. I work with so much passion, because if I am not infected, I am affected. It also has helped me to ensure that my staff is also being built to translate the same to the community by changing attitudes to work and our interactions as staff to patients and to the community. Our relationships have improved laterally and vertically."***

*—Victoria Ibanga, PEPFAR fellow, Director PHC, Ini LGA, Akwa Ibom State*

<sup>23</sup> Source: Fellows monthly progress reports

## B. BUILDING SUSTAINABLE MANAGEMENT SYSTEMS



Photo by MSH

**P**LAN-Health interventions were designed around six IRs, the second of which focuses on developing and strengthening organizational management systems. These include systems for human resource management, financial management, planning, M&E, and others. PLAN-Health's activities strengthened the management systems of both CSOs and PSIs.

PLAN-Health applied key management practices through multiple approaches, for both its CSO and PSI clients, to help streamline processes and improve efficiencies and effectiveness of organizations to deliver health services:

- **Workshops:** PLAN-Health delivered training or instructional activities through interactive workshops that were tailored for individual audiences and stakeholders to achieve specific learning objectives. These workshops often resulted in action plans designed to improve organizational performance or service delivery. They were followed by technical support provided to enhance participants' abilities to use the skills, tools, and techniques introduced during the workshops into the real work environment.
- **Mentoring and coaching support:** PLAN-Health designed a set of skill-building processes and activities to assist client CSO or PSI organizations to improve their performance. It was offered in the form of tailored guidance, hands-on and virtual mentoring, and coaching to meet the specific needs of the organization or individual.
- **Short-term consultancies:** In certain instances, when the PLAN-Health team did not have the required expertise, PLAN-Health employed an external professional to provide expert services and advice for a particular management area. Consultancy activities included, but were not limited to, the development/adaptation of tools, development of frameworks and models, and training. For example, consultants helped adapt MSH tools such as the Management Organizational and Sustainability

**Management interventions contributed to PLAN-Health's OPG1: Institutional capacity of select public and civil society organizations at the federal, state, and local levels strengthened for improved HIV and other health services for Nigeria's vulnerable populations**

**Managing Practices:**  
*Plan*  
*Organize*  
*Implement*  
*Monitor/Evaluate*

Tool (MOST) and develop checklists for financial management. PLAN-Health also took advantage of the presence of consultants to build the skills and knowledge of team members to be utilized in a similar capacity at a later date.

- **Embedment:** In several instances, PLAN-Health staff were attached to an organization for a defined period of time to conduct on-site skill-building in financial management and M&E, as well as provide mentoring and coaching. The embedment process was guided by a detailed scope of work with clearly defined deliverables.
- **Internship:** A number of individuals from PLAN-Health client organizations were attached to programs or units within MSH to receive supervised, practical on-the-job training. Internships were guided by a detailed scope of work with clear deliverables. PLAN-Health provided internships in information technology, HR management, M&E, and financial management.
- **Knowledge exchange visits:** Experiential learning and knowledge exchange visits were organized for public sector clients within and outside Nigeria. These visits were mainly to share experiences and learn best practices from programs such as CBHI schemes operating in other locations for replication or modification as appropriate.

### Strengthening CSO Management Systems

During the life of the project, PLAN-Health provided technical support to strengthen the management systems of 33 CSOs that offer HIV & AIDS services. Six of these CSOs were national-level umbrella bodies while the others were state-based CSOs that provide community services. CSOs were at different levels of development in terms of institutional capacity and varied in size as well as in maturity. To qualify for PLAN-Health support, a CSO had to have been providing HIV & AIDS services for a minimum of three years.

PLAN-Health started engaging CSOs by placing a call for expressions of interest in the national daily newspapers targeting CSOs looking to receive organizational systems strengthening support. CSOs that responded were screened based on defined criteria such as proof of registration with the appropriate bodies, physical office address in PLAN-Health focal states, proof of previous work done in the field of HIV & AIDS, and proof of employment of at least two staff members. Once CSOs were identified, PLAN-Health conducted a baseline assessment of the CSOs' organizational capacity. In the first two years of the project, PLAN-Health used MOST for conducting baseline assessments. The MOST assessment instrument defines five critical areas of management: mission, values, strategy, structure, and systems divided into 19 separate, measurable components.

Figure 6: MOST assessment components

Management Components Assessed by the MOST Instrument				
MISSION	VALUES	STRATEGY	STRUCTURE	SYSTEMS
Existence and knowledge	Existence and application	<ul style="list-style-type: none"> <li>• Links to mission and values</li> <li>• Links to clients and community</li> <li>• Links to potential clients</li> </ul>	<ul style="list-style-type: none"> <li>• Lines of authority and accountability</li> <li>• Governance: Board of Directors</li> <li>• Roles and responsibilities</li> <li>• Decision-making</li> </ul>	<ul style="list-style-type: none"> <li>• Planning</li> <li>• Communication</li> <li>• Human Resource Management</li> <li>• Monitoring and evaluation</li> <li>• Information management: Data collection</li> <li>• Information management: Use of information</li> <li>• Quality assurance</li> <li>• Financial management</li> <li>• Revenue generation</li> <li>• Supply management</li> </ul>

Starting in year three of the project, PLAN-Health utilized the Nigerian National Harmonized Organizational Capacity Assessment Tool (NHOCAT) to identify gaps in CSOs' organizational capacity. The NHOCAT was derived from MOST and other tools and adopted as the national tool for assessing organizations working in the field of HIV & AIDS. PLAN-Health was instrumental in helping the government to adapt and adopt this tool, which is now used nationwide.

The NHOCAT assessment process was participatory, with staff members of CSOs answering a series of questions to score their organization's capacity in the different organizational dimensions while providing evidence for each score. The evidence provided was carefully scrutinized by the PLAN-Health team. PLAN-Health then provided TA to tackle the identified gaps. PLAN-Health also utilized other assessment tools such as the USAID pre-award survey tool and the MSH Financial Management Assessment Tool to assess the capacity of the CSO in a specific technical area. At the end of each assessment, PLAN-Health supported the organizations to develop and implement action plans to tackle their capacity gaps (**an example of an action plan is included in Annex 2**).

PLAN-Health's priority management areas were financial management, M&E, and human resources management and planning to enable CSOs to plan, organize, and implement their activities; track their budgets and expenditures; monitor and showcase program results; and manage their staff and manpower.

#### Provision of small grants

PLAN-Health also provided performance-based grants to 20 CSOs, ranging from \$10,000 to \$20,000, to provide PMTCT demand-creation services in Akwa Ibom State and in-school youth (ISY) HIV-prevention services in Gombe State and the FCT. The ISY programs focused on empowering adolescent girls to reduce their risk of gender-based violence and HIV-infection. PLAN-Health strengthened CSOs' organization systems while they implemented the grants. The grants were a tool to test the effectiveness of their systems as CSOs had to provide quarterly program and financial reports highlighting progress toward meeting their targets.

One of the conditions for the release of the final tranche of funds was an improvement in their organizational systems' capacity from the NHOCAT baseline results implemented at the beginning of the grant to the NHOCAT end-line administered at the close of the grant. 19 CSOs showed improvement in their NHOCAT scores (see Annex 3 for NHOCAT scores).

*NHOCAT measures nine different organizational dimensions: governance; experience, knowledge, and skill in service delivery; working with networks and referral systems; resource mobilization; human resource management; provision of health service delivery; procurement and financial management systems; gender management systems; and M&E.*

*PLAN-Health interventions in financial management strengthening also enabled 16 CSOs to pass the USG pre-award survey and obtain direct funding from USAID and other donors to ensure their sustainability.*

#### Key Achievements

- A total of 402 individuals from CSOs were trained on M&E, financial management, and HRH.
- The 20 CSO grantees achieved the following results:
  - **Gombe State and FCT:**
    - 14,806 students received HIV prevention messages
    - 28 health clubs established and strengthened in 28 secondary schools
  - **Akwa Ibom, Gombe, and FCT:**
    - 883 pregnant women HIV counseled, tested, and received their results
    - 1,417 pregnant women completed a minimum of four ANC visits
    - 1,553 pregnant women completed PMTCT referrals TBAs
    - 560 male partners of pregnant women attended at least one ANC visit with their partner
    - 309 meetings conducted for stakeholders to create an enabling environment for pregnant women to access PMTCT services in health facilities

## SUCCESS STORY:

Jomurota Community Care Initiative expands its community reach as PLAN-Health strengthens its systems

*Jomurota Community Care Initiative (JCCI) was established in 2004 and registered in 2006 with the Nigerian Corporate Affairs Commission (CAC/IT/NO 27638). JCCI's goals and objectives are designed to help actualize the dreams of OVCs, widows, and those living with HIV/AIDS. JCCI focuses on the reduction of new HIV infections through creating awareness and demand for comprehensive HIV & AIDS services.*

*Before engaging with PLAN-Health in 2011, JCCI had no systems in place for program management. There was no documentation of activities such as filling out attendance sheets and reports, taking pictures, etc. Activities were ad-hoc and based on perceptions and desires, thus producing few results. There was no financial management system - no budgeting, no tracking of fund flow, or a retirement fund system. There was no organizational system, neither for the board of trustees (no policy or manual), nor for the staff (policies and procedures, time sheets, etc.).*

*PLAN-Health's interventions with JCCI focused on building strong systems for financial management, human resource management, M&E and research. PLAN-Health also developed the leadership capacity of JCCI staff via the LDP. Capacity-building was done through training workshops and hands-on and virtual coaching and mentoring.*

*The organization has shown clear measurable improvements:*

- JCCI now employs 8 full time staff, up from 2 staff in 2011. JCCI has 36 volunteers (versus 9 volunteers in 2011) spread across the 10 wards of Gwagwalada Area Council.
- The number of donor partners increased from 2 to 10 over the course of four years (2011 – 2015)
- Since 2012, JCCI expanded from one program area (OVC) to five areas (OVC, prevention, demand-generation for HIV/TB/malaria, home-based care for PLHIV, voluntary blood donations).
- In 2014 JCCI provided services to 3,001 OVCs, up from 80 in 2011.
- Through the grant provided by PLAN-Health in 2014, JCCI was able to train 176 peer educators in HIV prevention who reached 1,674 students in 4 secondary schools.
- JCCI built a classroom block and a psychosocial center in Gwagwalada Area Council and expanded its services beyond the FCT to neighboring Niger State. JCCI is now even mentoring another CSO, Lion's Pride Initiative, to improve its organizational capacity.



*Photo: Talatu Shanwa (AKA Mama HIV), JCCI founder, addressing people with HIV & AIDS on healthy living*

***“PLAN-Health is leaving behind a formidable JCCI that can compete with its counterparts, within the country and outside Nigeria, and a CSO that can withstand the developmental challenges of the contemporary world.”***

—Talatu Shanwa [AKA Mama HIV], JCCI founder

### Strengthening Public Sector Policy, Planning, and Management Systems

PLAN-Health supported a total of 18 PSIs at the federal and state levels and built the capacity of 366 individuals on various organizational system areas throughout the life of the project. Activities focused on health policy, planning and management, reporting and human resources for health. The list of PLAN-Health's PSI clients is included in **Annex 1**.

At the federal level, the project introduced and employed best practices and tools in developing, establishing, and reviewing policies and guidelines for effective planning and management of the health systems. At the state level, the project engaged and provided support via hands-on coaching, mentoring, workshops, and internships to transfer skills and expertise required for implementing policies and guidelines for health service results as required. Interventions were aligned with the national and state health plans, specifically components pertaining to HMIS, HRH, health care financing, leadership, and governance.

### Strengthening health management information systems and reporting

At the state level, reporting on the HMIS platform was historically irregular and inaccurate, and often states ran out of HMIS forms for extended periods of time. Where forms were available, they were either outdated and/or the state M&E officer lacked the know-how to fill in the forms. In response, PLAN-Health supported its PSI clients, particularly the Department of Planning Research and Statistics and state AIDS and STI control programs, to improve health and HIV & AIDS reporting by training personnel on proper reporting using the HMIS forms and the DHIS platform. Health workers were trained on M&E and on the process of collecting data for DHIS indicators using DHIS tools. PLAN-Health also supported the FMOH to revise and update national HMIS tools.

Another challenge the project faced was that government officials did not often recognize the importance of reporting and did not utilize data to make policy decisions. PLAN-Health worked with federal- and state-level PSIs to ensure that the state-level personnel had access to data and were able to input it into the national DHIS platform. The DHIS reporting minimized multiple data reporting by implementing partners and the MoH, ensuring valid and uniform data at the state level.

PLAN-Health also worked with PSIs to improve their capacity to analyze data and utilize it for decision-making and provided TA to state-level PSIs to conduct health data consultative committee (HDCC) meetings.<sup>24</sup> PLAN-Health support helped states analyze data to guide their decisions and to tackle challenges related to data reporting.

The Gombe and Akwa Ibom State AIDS and STD Control Programmes (GomSASCP and AKSASCP), as well as FACA reported significant improvements in reporting rates for specific program areas from 2011 to 2014:

#### Reporting rates of health statistics to the DHIS platform:

*FCT – increase from 0% (2010) to 60% (2014)*

*Gombe State – increase from 39% (2011) to 77% (2015)*

*Akwa Ibom State – increase from 22% (2011) to 86% (2015)*

<sup>24</sup> The HDCC is a statutory body set up to ensure the collation, analysis, and utilization of data at the state level.

Figure 7: Improved HIV/AIDS reporting rates

	GomSASCP		FACA		AKSASCP	
	2011	2014	2011	2014	2011	2014
PMTCT	0.2%	65.6%	0.2%	65.6%	0.1%	86.0%
HCT	0.6%	67.8%	0.6%	67.8%	0.4%	68.3%
ART	0.2%	79.3%	0.2%	79.3%	0.2%	83.8%

### Improving planning and operations

Another area in which PLAN-Health strengthened PSI skills was in translating state strategic health plans into actionable annual operational plans. PLAN-Health supported PSIs to conduct operational planning workshops during which PSIs and their partners developed and costed the plans. Specifically, PLAN-Health facilitated PSIs to:

- structure the planning process and identify relevant stakeholders for the process;
- use national templates and guidelines for the plans; and
- ensure that objectives were aligned to the relevant strategic plans, and that PSIs identified actions that would enable them to achieve the stated objectives.

As a result of PLAN-Health's technical support, AKSASCP implemented 71% of the activities in its 2013-2014 operational plans. Prior to this AKSASCP did not have any operational plans. GomSACA also implemented 70% of the activities in its 2013 operational plan. Like AKSASCP, GomSACA do not have an operational plan prior to 2013. PLAN-Health also supported GomSASCP to develop its first operational plan for 2012 to 2013. GomSASCP implemented 62% of the activities in the plan. FACA showed a progressive increase in the implementation of activities in its operational plan from 37.9% implementation in 2011-2012 to 53% in 2013.

### Improving client satisfaction through interpersonal communication skills development

The growing acknowledgement that clients' satisfaction is as vital to clinical outcome as much as the technical content of care (adherence to treatment protocols and guidelines) has prompted increased enthusiasm for client satisfaction surveys (CSS) for HIV & AIDS as well as other health conditions, particularly chronic diseases of public health importance. If clients are not satisfied with the quality of care they receive, adherence is often negatively affected, and attrition is often considerably high, causing technical quality of care to become less valuable.

To this end, PLAN-Health supported the Government of Gombe State and the FCT to conduct baseline CSSs in 2012. These surveys were followed by interventions geared mainly toward improving the interpersonal communication skills of health workers in order to improve the quality of services they provide. Health workers from the intervention facilities were trained on the following:

- **Effective communication:** Participants were shown how communication plays an important role in behavior change. They acquired skills to help them communicate more and in a clearer manner with patients.
- **Emotional intelligence:** Participants were introduced to the concept of and how it can help them manage their personal and professional relationships.
- **Giving/receiving feedback:** To improve work relationships and drive behavior change through communication, participants were coached on providing feedback in different situations.
- **Attitudinal change:** Participants understood that they provide a service and their clients are expecting a positive attitude from them in exactly the same way that participants expect a positive attitude when they access other services outside their workplace. They learned steps for improving their attitude.

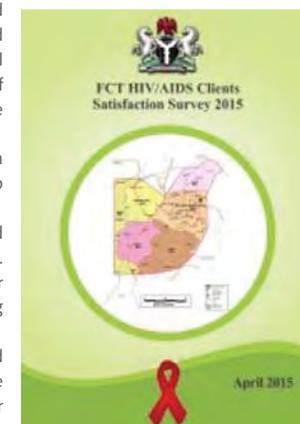


Figure 8: Clients satisfaction survey

Adult learning techniques such as case studies with group exercises, role plays, and plenary discussions were used throughout the workshop to enable participants to practice and utilize the skills. Participants developed action plans for implementing what they had learned on their return to their facilities.

Follow-up surveys were conducted in Gombe in 2014 and in the FCT in 2015. Mixed methods comprising of exit interviews adopted from patients' satisfaction questionnaire (PSQ-18), key informant interviews, and focus group discussions were utilized. In Gombe, 1,291 exit interviews were conducted across 14 facilities (10 intervention facilities and 4 control facilities). In the area of communication, there was a 63% increase in client satisfaction. In the FCT, 1,804 exit interviews were conducted across 18 facilities (9 intervention and 9 control facilities). In the 2015 survey, the majority of the ART clients (89.19%) reported overall satisfaction with ART services while 10.81% were unsure of their level of satisfaction. This result represents a 46.9% improvement compared to the 2012 CSS, where only 60.7% of respondents reported overall satisfaction with the care received.

## SUCCESS STORY:

### PLAN-Health supports FACA to effectively monitor the FCT's HIV & AIDS response

FACA was established to design and implement the FCT Action Plan for the prevention and control of HIV & AIDS, through a multisectoral and collaborative approach (inclusive of line secretariats, NGOs, CBOs, CSOs, and area councils).<sup>25</sup> Because of the expansive and extensive nature of the program, which involves multiple and different stakeholders, there is an enormous need for an effective M&E system.

In 2012, FACA carried out an assessment of its M&E system facilitated by PLAN-Health, leading to the identification of priority actions such as capacity-building for improved M&E and coordination of the HIV & AIDS response. The assessment revealed that staff have inadequate technical capacity for overall HIV programming, particularly for coordination, which is FACA's core function. FACA did not have any guidelines for coordinating its different partners. Furthermore, a needs assessment of people living with HIV/AIDS (PLHIV) showed that FACA's HIV & AIDS programming was being carried out without knowing their specific needs. The FCT's M&E technical working group (TWG) was nonfunctional, even though it had previously been constituted. There was a need for a platform to bring stakeholders together so they could develop and implement plans that promote complementarity and avoid duplication.

In response, PLAN-Health provided TA in the development of FACA's operational plan for HIV & AIDS response (2011-2012), supported the inauguration of the FCT M&E TWG in 2012, helped develop the M&E quarterly FCT Fact Sheet that now is the standard template for reporting, developed an HIV & AIDS service directory, and introduced the mapping of hotspots (an innovation first introduced in the FCT) to assist in the deployment of preventive interventions.

The results of PLAN-Health's interventions are shown in the table below:

ISSUE/THEME	PRE-INTERVENTION	POST-INTERVENTION
M&E	Irregular reporting No terms of reference (TOR) guiding the activities of the M&E TWG	<ul style="list-style-type: none"> <li>Regular monthly reporting</li> <li>Improved reporting rate within the FCT from 0% to over 60% between 2010-2014</li> <li>Overall, the health facility reporting rate is 70% and 100% for the non-health reporting sites (as of the last quarter of 2014)</li> </ul>
Factsheet development	No fact sheets Information loss with suboptimal dissemination	FACA produces a quarterly fact sheet with timely and up-to-date data which is fed into the DHIS.
Coordination	No policies/guidelines or protocols guiding FACA's relationship with stakeholders	Coordination and partnership guidelines have been developed leading to improved coordination and partnership between FACA, the Akwa Ibom Community Action Committee on AIDS, line secretariats and implementing partners.

Figure 9: FACA Fact Sheet

Development of the 2011-2012, 2014-2015 operational plan	Operational plans were not comprehensive, costed, or unified with inputs from all partners.	<ul style="list-style-type: none"> <li>37.9% implementation of the 2011-2012 plan</li> <li>53% implementation of the 2013 plan</li> <li>The operational plan is used as a resource mobilization tool to receive funds estimated at \$1.9 million from World Bank.</li> <li>Improved HIV response and service delivery e.g. 2548 persons started on ARV in 2011. This increased to 4578 persons in 2012.</li> </ul>
HIV & AIDS service and partners directory	The FACA database only included FACA's direct partners.	<ul style="list-style-type: none"> <li>A template was developed in 2012 to capture information from all partners and a comprehensive electronic database of all partners/ prospective partners and services in all the area councils.</li> <li>Improved coordinating role of FACA, evident in selection of CSOs to implement the Health Alive Foundation (HAF) grant.</li> </ul>
Review of operational plans	No systematic review of operational plans was done.	There is an annual systematic review of progress, funding gaps, and challenges leading to evidence-based decision-making.
Prevention	FCT had no HIV & AIDS prevention plan.	A prevention plan has been developed and is being implemented.

**“Before, when we attended national meetings for data validation, there used to be no special note of FACA, but when we went for the last exercise, FCT had the cleanest data in the country.”**

—FACA project manager

**“For FACA, the technical support from PLAN-Health really helped to strengthen the FCT system, in terms of coordinating and program monitoring of health and non-health interventions. The data is now a true reflection of what is happening. The best practices are what are keeping us up to date. Some of these things are what we are carrying over and beyond.”**

—FACA M&E officer

## C. IMPROVING GOVERNANCE AND ACCOUNTABILITY



Photo by MSH

**W**HO defines governance in the health sector as a wide range of steering and rule-making related functions carried out by governments/decision-makers as they seek to achieve national health policy objectives that are conducive to universal health coverage.<sup>26</sup> Building on this definition, MSH identified four governance practices as follows:

1. **Cultivate accountability** to make sure that persons in positions of authority are held accountable for their promises, actions, and tasks
2. **Engage with stakeholders** to build trust, to learn, to serve, to achieve the shared strategic goals and objectives
3. **Set shared direction** to align stakeholders, to promote cooperation, to reduce the probabilities of resistance and sabotage
4. **Steward resources** in order to use resources wisely, fairly, and with integrity

PLAN-Health's governance interventions were geared toward enabling individuals and organizations to develop, strengthen, and imbibe these practices to ensure strong governance systems. Specific interventions include:

1. Governance with CSOs
  - Supporting CSOs to develop strategic plans that set the strategic direction of the organization
  - Strengthening governance boards and their oversight capacity to ensure accountability
  - Building resource mobilization capacity to attract additional resources and utilize them wisely to promote sustainability
2. Governance with PSIs
  - Supporting PSIs to develop policies and strategic plans that set the policy direction and create an enabling environment for health development
  - Strengthening PSIs' coordination and oversight capacity to engage and coordinate with multiple partners and stakeholders to achieve shared goals
3. Governance with multi-sectoral bodies such as Nigeria's CCM for the GF
4. Establishing structures and models for implementing CBHI that ensures effective stewardship of scarce resources and increases access to health services

### CSO Interventions

A well-managed organization has a strong, yet flexible, structure and accountable, transparent governance practices (institutional sustainability). It draws on various sources of revenue, allowing it to support its ongoing efforts and to undertake new initiatives (financial sustainability).<sup>27</sup> PLAN-Health's CSO governance interventions enhanced both institutional and financial sustainability.

**Strategic planning:** During the life of the project, PLAN-Health supported 12 CSOs to develop and implement costed strategic plans. Strategic plans are long-term plans that guide the organization to its desired future. Their formation and implementation helped the organizations to actualize their vision through goals and the objectives that support the goals. PLAN-Health helped CSOs clarify their mission and vision as well as identify their strengths, weaknesses, opportunities and threats. CSOs then developed strategic plans in a workshop setting while their capacity to develop the plans was being built. The strategic plans developed covered a period of five years. The draft plans were completed by the participants on return to their organization with virtual support from PLAN-Health. PLAN-Health also supported the CSOs to translate the strategic plans to actionable annual operational plans.

**Board governance:** Governing boards play an important role in providing fiscal oversight, formulation of policy and objectives, selection of strategies, and evaluation of management performance, thus ensuring accountability. The presence of a strong, functional board helps to ensure organizational sustainability.

PLAN-Health worked with the boards of governance of 24 CSOs to strengthen their oversight and promote sustainability of the CSOs in the absence of the founder, as well as identify and utilize the required criteria to recruit active and effective board members. PLAN-Health also supported the CSOs to develop and apply criteria to recruit effective, gender-sensitive boards. PLAN-Health's interventions, for example, helped the Redeemed AIDS Program Action Committee (RAPAC), a faith-based

*PLAN-Health IR3: Governance practices of CSOs and PSIs strengthened by developing mechanisms for accountability, supporting governing boards, and building sustainability through resource mobilization*

<sup>26</sup> WHO, "Governance", WHO, 2015, Health systems, <http://www.who.int/healthsystems/topics/stewardship/en/>, (accessed 2 September, 2015)

<sup>27</sup> Management Sciences for Health, Management and Organizational Sustainability Tool, Management Sciences for Health, 2010,pg. 1.

organization, expand its funding pool from faith-based sources to a variety of national and international donors. As a result, a donor supported the renovation and upgrading of the organization's medical laboratory.

**Resource mobilization:** Dependence on grants and donations can inhibit the autonomy of CSOs to choose which program activities to undertake and to select the most effective intervention strategies to achieve program and organizational goals. The viability of many CSOs depends on their ability to adapt to changing donor trends and their willingness to pursue diverse alternative sources of funding. Because of this, PLAN-Health provided TA to 26 CSOs in proposal writing and fund-raising to build CSOs' capacity to mobilize and steward resources from multiple sources.

PLAN-Health adopted a hands-on approach to develop CSOs' skills through proposal development workshops during which CSOs responded to actual calls for proposals. During the workshops, the CSOs came to understand the different donor contracting mechanisms. They learned how to analyze and respond to procurements/calls for proposals and practiced how to develop concept notes and proposals. They were also introduced to financial auditing, budgeting, and reporting systems for proposals. As a result of PLAN-Health's efforts, 19 CSOs wrote 88 proposals that were successfully funded by the Government of Nigeria and local and international donors. These CSOs were able to mobilize \$49.8 million in additional funding for HIV/AIDS and other health services.

PLAN-Health also organized short workshops to develop CSOs' capacity to raise funds outside the usual calls for proposals from donor agencies. During the workshops, participants identified potential sources of funding best suited to their organization and practiced writing professional, effective, persuasive requests for funding. They also learned ways to market their fund-raisers. The output of each workshop was a fund-raising plan. Some of the fundraising strategies identified included renting out office space or staff time to smaller CSOs, organizing fund-raising dinners, and engaging in business ventures such as farming. (See Annex 4 for a summary of funding mobilized by PLAN-Health-supported CSOs).

### PSI Interventions

PLAN-Health's interventions with PSIs enabled them to engage with their stakeholders to set a shared policy direction necessary to align and implement state and national policies, thus creating an enabling environment for health development.

**Strategic planning and policy development:** PLAN-Health provided technical support for the review and development of cardinal health sector documents. One of these was the National Health Sector Strategic Plan for HIV/AIDS (2010–2015) which guides the effective implementation of national policies, guidelines, and standard operating procedures (SOPs) for the prevention of new HIV infections as well as treatment, care, and support for those infected and affected by the virus in Nigeria.

The project also supported its focal states (Akwa Ibom, Gombe, and the FCT) to develop operational plans that align with the states' strategic health plans. This included bringing stakeholders together at workshops to develop the plans, providing technical input during the workshops and virtual support to the PSIs to finalize draft plans from the workshops. A list of all policies developed is included in Annex 5 of this report.

The planning and management of HRH in Nigeria remains a challenge for health development in Nigeria for various reasons, such as migration outside the country; poor distribution within the country; poor skill mix; shortage of health workers, especially in remote areas; limited training; etc. PLAN-Health supported its partner PSIs to formulate policies aligned at the state and national levels to develop and retain HRH in Nigeria. PLAN-Health's interventions supported the formulation of policies and plans for HRH for health development. PLAN-Health also helped the FMOH to develop and pilot test the first national HRH training manual, and to conduct a training of trainers on the use of the manual. In addition, PLAN-Health assisted the FCT develop a work force plan. PLAN-Health's activities have resulted in an increase in awareness of the gaps and priorities for HRH development and retention in Nigeria.

**Coordination and partnerships:** States and local governments do not often align to nationally set policy directions, resulting in many uncoordinated services. In many cases, PSIs do not have the tools or capacity for effective coordination. With many stakeholders and partners engaged in providing multiple HIV & AIDS and other services, PLAN-Health's activities included providing technical expertise for the development of coordination and partnership guidelines and other coordination tools. These coordination guidelines clearly defined the roles and responsibilities of all stakeholders at all levels. They also defined the coordination process, how it would be carried out, and tools for coordination. For example, the 2012 National Health Sector HIV Coordination Framework developed in collaboration with the National AIDS Control and Prevention Program (NASCP) articulates and unifies existing structures and practices, as well as defines mechanisms of engagement among HIV & AIDS CSO partners and stakeholders.

PLAN-Health supported five state-level PSIs to develop coordination and partnership guidelines and aided a number of PSIs to conduct partner mapping and produce up-to-date partner directories. Directories contained details of organizations that provide HIV & AIDS and other health services, their profiles, specific services, and their contact details.

PLAN-Health also worked with the National Agency for the Control of AIDS (NACA) in 2012 to harmonize the NHOCAT. The majority of the tool was derived from MSH's MOST. NACA adopted the NHOCAT as the official national tool for assessing HIV & AIDS organizations both public, private, and CSOs providing HIV & AIDS services.

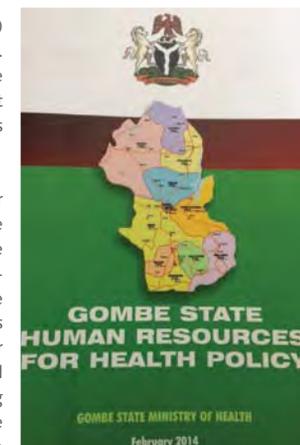


Figure 10: Gombe human resources for health policy

**PLAN-Health IR4:**  
Coordination among PSIs at all levels and partnerships with CSOs strengthened

### Increasing MNCH Uptake and PMTCT Referral through the engagement of Traditional Birth Attendants in Akwa Ibom State

In 2013, PLAN-Health supported AKSACSP, a department within the Akwa Ibom State Ministry of Health, to conduct bimonthly PMTCT alignment meetings to ensure coordination of activities for increased uptake of PMTCT services within the state. Participants at the PMTCT alignment meetings were drawn from state government ministries, agencies, and departments, implementing partners, and CSOs involved in the demand and supply of PMTCT services across the state. The meetings enabled partners to map out the distribution of their services across LGAs and identify gaps to be tackled to ensure effective PMTCT service utilization in the state.

PLAN-Health's support to AKSACSP in Akwa Ibom State to strengthen its oversight and coordination role resulted in a reduction in the duplication of activities and increased complementarity among partners. The mapping exercise enabled the partners and the state to focus efforts and resources more effectively. Thus the state was able to increase PMTCT sites from 34 in 2011 to 393 in 2014. The number of persons accessing PMTCT services rose from 18,000 in 2011 to 117,000 in 2014.

***“I would like to appreciate PLAN-Health as they have impacted positively on management and coordination responsibilities. The way we do things now in AKSACSP is different on the positive side and I can ascribe 65% to 70% of the improvement to Plan-Health between 2013 and now.”***

—State coordinator, AKSACSP

One of the challenges highlighted during the PMTCT alignment meeting was the non-delivery of babies by skilled attendants and late presentation of exposed infants for PMTCT services at health facilities. Available data indicated that 57.2% of pregnant women attend four or more ANC sessions, 49.7% deliver in the health facilities, while only 39.7% of deliveries are attended by skilled birth attendants.<sup>28</sup> Traditional and faith-based attendants were taking deliveries and not referring women to facilities.

In response to these statistics, PLAN-Health conducted a study in 2013 on the “Perception and Beliefs of Women of Reproductive Age on the Use/Non-Use of Health Facilities in Selected Communities in Akwa Ibom State.” The study revealed that nearly 60% of the women interviewed did not deliver in a health facility. The respondents cited the convenience of paying for traditional birth attendants (TBA) services in installments and beliefs that prayers warded off negative spiritual attacks. Some participants said harsh and insolent attitude of nurses, the height of hospital beds, and uncomfortable birth positions were some factors that deterred them from delivering in health facilities.

Following the study, the members of the PMTCT alignment meeting, together with PLAN-Health, developed a directory of TBAs in the state. A total of 2,795 TBAs were captured in the directory. The results of the study along with the large numbers of TBAs in the state persuaded the Akwa Ibom State Ministry of Health (MoH) of the need to engage with and regulate the activities of TBAs in the state. The state MoH turned to PLAN-Health to help develop a policy framework to engage TBAs.

PLAN-Health supported the Akwa Ibom state government to organize a knowledge exchange and experiential learning visit of key government officials to Lagos State to adopt and adapt best practices in engaging TBAs for increased PMTCT uptake and improved MNCH outcomes. After the visit, the Akwa Ibom commissioner for health constituted a technical working group (TWG) to implement action plans and recommendations developed by the team that visited Lagos. The TWG subsequently developed a framework and institutional arrangements for regulating, coordinating, training, monitoring, and supervising TBAs in Akwa Ibom. PLAN-Health supported the development of eight policies to regulate TBAs and improve maternal and child health outcomes in the state. This is the first policy framework ever developed in the state for engaging TBAs.

*The following documents were developed for TBA engagement with PLAN-Health's support:*

- Trainer and participant manuals and guidelines for the training of traditional and faith based birth attendants
- Guidelines on the regulation of activities of traditional and faith based attendants
- Coordination guidelines for traditional and faith based attendants in
- Guidelines for the monitoring and supervision of traditional and faith based birth attendants
- Guidelines on prevention of mother- to-child transmission of HIV and AIDS
- Hospital internship logbook for traditional and faith based birth attendants

### Strengthening the Oversight Capacity of the CCM

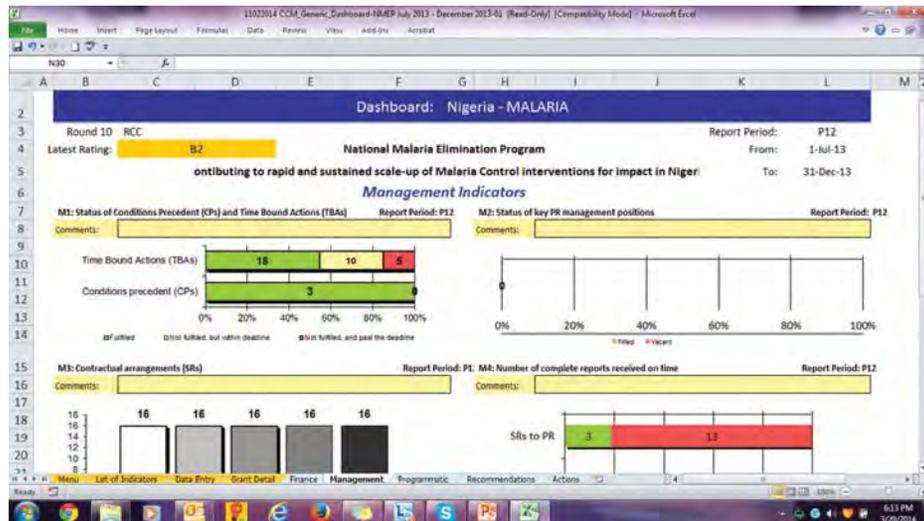
The CCM in Nigeria is a country-level partnership of stakeholders with representatives from government, NGOs, bilateral and multilateral agencies, the public and private sectors, and PLHIV or affected by HIV. It is responsible for submitting proposals to the GF, nominating the grantee(s) or principal recipients, and providing oversight for grant implementation.

PLAN-Health provided technical support to the CCM secretariat to develop and implement financial management policies and manuals to maintain internal controls over its assets and resources and properly account for donor funds. PLAN-Health also built the secretariat's staff capacity to develop, implement, and monitor budgets. This assistance helped the CCM to coordinate with other stakeholders, align its activities with national plans for HIV & AIDS, TB, and malaria, and health systems strengthening. PLAN-Health's assistance ensured that the CCM had the capacity to plan, mobilize, and provide oversight for the effective and efficient use of GF resources to produce results and show accountability to its stakeholders.

<sup>28</sup> National Bureau of Statistics, Nigeria Multiple Indicator Cluster Survey 2011 Main Report, [http://www.unicef.org/nigeria/Multiple\\_Indicators\\_Cluster\\_Survey\\_4\\_Report.pdf](http://www.unicef.org/nigeria/Multiple_Indicators_Cluster_Survey_4_Report.pdf) (accessed 2 September, 2015)

PLAN-Health also supported the CCM to develop and review its oversight reporting tool, the GF Dashboard, to improve its effectiveness and efficiency in tracking grant activities. The dashboard is a tool developed by the GF to be used by principal recipients to report on progress of grant implementation in a timely manner to the CCM for effective coordination and monitoring of sub recipient program management and delivering on agreed targets. This enabled the CCM to respond to the GF monitoring and reporting requirements while enhancing transparency of reporting and increasing the speed in which the performance information was available to the GF and other donors.

Figure 11: Screenshot of the CCM dashboard



PLAN-Health also provided TA to develop the CCM newsletter, which contained relevant information on the interventions carried out in TB, malaria, and HIV activities in the states through GF support. The newsletters enabled the GF to showcase the activities and successes of the principal recipients. PLAN-Health also supported the CCM to update its website, thus increasing CCM visibility and ensuring routine information updates.

As a member of the oversight committee, PLAN-Health participated in oversight visits and also provided TA to the sub recipients to monitor and ensure that deliverables and targets were on track at facility and community levels, using agreed upon monitoring and supervision tools for reporting back to the principal recipients.

## Increasing Access to Health Services through Community-Based Health Insurance

The NHIS was established by Act No. 35 of 1999 with the key mandate to establish and regulate a social health insurance mechanism to supplement the current inadequate and inequitable funding arrangements for financing health care. The NHIS initially launched a formal sector program which only covered federal civil servants. In 2011 the CBHI scheme was launched to cover the informal sector, comprised mainly of rural dwellers – about 75% of the population. Roll-out and full implementation of the program across the country remains a challenge. The service delivery system is weak and distribution of meagre health care resources between urban and rural areas is inequitable.

In 2011, USAID mandated the PLAN-Health project to support the NHIS to implement CBHI and also provide the required TA to the MoHs of its focal states (Akwa-Ibom, the FCT, and Gombe) to establish structures for CBHI implementation. PLAN-Health facilitated several high-level advocacy meetings with the NHIS, FCT Health and Human Services (HSS), Gombe HIS, and other key stakeholders in the health insurance subsectors. Through these meetings, PLAN-Health shared MSH's experience in the implementation of CBHI and performance-based financing (PBF) in Rwanda. This provided valuable lessons to the NHIS team for the implementation of CBHI, such as the need to start with pilot sites for CBHI implementation, and the need for accurate, reliable, and robust databases. These ultimately led to the NHIS roll-out plan for commencement of a CBHI scheme in Nigeria.

Subsequently, PLAN-Health provided technical support to the NHIS to cost the benefits package for the CBHI program using the Cost and Revenue Plus (CORE Plus) analysis tool developed by MSH. Two health centers in Anambra and Kogi states were used for the exercise. The results of the costing exercise were used to develop CBHI premiums, design insurance reimbursement mechanisms and levels, and produce accurate scenarios for health financing options, including insurance reimbursement, input-based financing, and PBF.

In Akwa Ibom and Gombe states, PLAN-Health helped revive moribund village and ward development committees according to National Primary Healthcare Development Agency guidelines. The committees are responsible for community mobilization and for providing feedback to the CBHI Board of Trustees (BoT). PLAN-Health also supported the development of the Akwa Ibom and Gombe State CBHI Handbook and Health Fund document. It also worked with the state MoH and Gombe State Primary Healthcare Development Agency (GSPHCDA) to conduct feasibility studies and facility assessments to guide the choice of a CBHI pilot site and facilitate successful implementation of the CBHI scheme across the state.

**PLAN-Health IR6:** *Institutional capacity of NHIS, state counterparts, local communities, and select CSOs strengthened to provide access to quality health services through sustainable CBHI programs. This contributes to OPG1: Institutional capacity of select public and CSOs at the federal, state, and local levels strengthened for improved HIV and other health services for Nigeria's vulnerable populations.*

In the FCT, the project implemented leadership development sessions to improve work climate, facilitating the design and implementation of the FCT HSS CBHI scheme. PLAN-Health supported the development of a stakeholders and partners' directory for FCT HSS with contact details and profiles of government agencies, health service providers, health management organizations, partners/funders, microfinance banks, and communities they worked in. PLAN-Health also supported FCT HSS to conduct a desk review of previous studies on the CBHI program in order to develop a blueprint/manual for operational modalities and training.

**Akwa Ibom State CBHI – the first community-owned, community-led, and community-funded CBHI scheme in Nigeria**

In Akwa Ibom State, PLAN-Health's support resulted in the successful launch of the Ukana West Ward II CBHI scheme in August 2014. This is the first community-owned, community-led, and community-funded CBHI scheme in Nigeria. The scheme is managed by a BoT from the ward with support from the NHIS, state MoH, and local government and community groups. The BoT is registered with the Corporate Affairs Commission and has NGO status. The project also supported the development of policy guidelines and operational procedures to ensure seamless implementation of the CBHI scheme in the ward and its possible scale-up to other wards. The project worked with the Akwa Ibom MoH to ensure sustainability of the scheme through a community health development fund. The fund is a mechanism for obtaining and pooling subsidies from different funding sources, paying for referrals, and eventually empowering the community members economically.

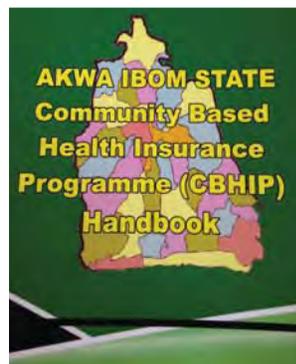
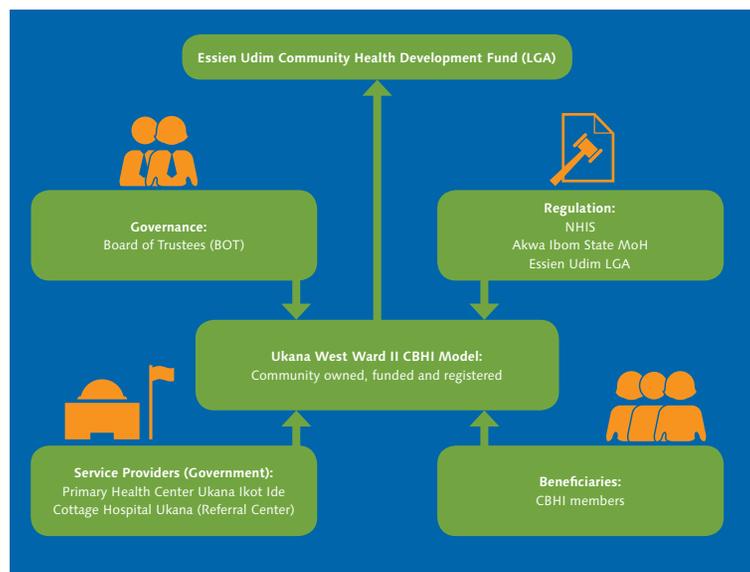


Figure 12: Akwa Ibom State CBHI handbook

Figure 13: The Ukana West Ward II CBHI model



PLAN-Health trained the CBHI BoT to carry out its oversight role in the implementation of the CBHI scheme. Operational manuals, SOPs, and a BoT constitution were developed, and relevant stakeholders were trained on these policy documents. The project supported the development of a drug management system for the CBHI and developed and deployed a web-based application for effective client enrolment into the CBHI scheme.

PLAN-Health conducted community mobilization and sensitization activities to create demand for the CBHI Program in Akwa-Ibom State. PLAN-Health supported participatory meetings facilitated by the BoT of Ukana West Ward II, using local languages and "pidgin" English for ease of understanding. Information on the Ukana West II CBHI scheme was aired on two radio stations in the state. A medical outreach to sensitize community members on the need for health insurance was also conducted and a website ([www.ukanawestcbhi.org](http://www.ukanawestcbhi.org)) was launched to increase transparency of the scheme and information sharing.

*As of November 2015, 515 individuals enrolled into the Ukana West Ward II CBHI scheme. Utilization of the PHC tied to the CBHI scheme increased by 1,100% in one year.*

**Snapshot of the Ukana West Ward II CBHI Scheme**

CATEGORY	DETAILS
Launch date	August 2014
Location	Ukana West Ward II, Essien Udim LGA, Akwa Ibom State
Ownership	Community-owned, led, and managed by a board of trustees elected by the community
Membership	Residents of Ukana West Ward II and its environs
Type of scheme	Voluntary. No person can be excluded from membership.
Premium	Individual: 3,000 Naira /year (\$15) Family of 6: 2,400 Naira /year (per person) (\$12) Additional family member: 1,800 Naira /year (\$9)
Unit of enrollment	Individual, family
Benefit package	National Ward Minimum Package
Health facilities	Primary services are provided by Ukana Ikot Ide PHC and referral services by Cottage Hospital Ukana
Referral package	Customized package
Co-payment	50 Naira (\$0.25) per visit at PHC. None at referral
Payment/contribution period	Annual single payment or payments in two instalments
Provider payment system	Capitation for PHC and fee for service for referral hospital
Waiting period	One month after registration and completion of payment

### Public-private partnership to promote CBHI

In 2014 the project provided technical support to the Shell Petroleum Development Company (SPDC) to strengthen organizational systems of the SPDC-supported CBHI facilities in Rivers State (Obio Cottage Hospital and Rumuokwursi PHC) on financial management, M&E, and data management. PLAN-Health facilitated the design and deployment of the Community Health Insurance Enrollment Authentication System (CHIEASY) web-based application to strengthen the enrolment system of the CBHI program in the two facilities and improve financial transparency of the scheme. The system allows for efficient tracking of CBHI enrolment and payment of both premium and capitation. The utilization of CHIEASY increased the enrollee base of the SPDC-supported CBHI program from 556 people in April 2014 to 5656 people by December 2014. Following this success, in 2015, PLAN-Health expanded the use of CHIEASY to the CBHI scheme in Akwa Ibom State.

PLAN-Health also facilitated the design and roll-out of a unique PBF model for the SPDC CBHI Program in Obio-Akpor LGA, Rivers State. The Obio-Akpor PBF model is distinctive in its implementation and funding. Unlike many PBF models that rely on external funding sources or the MoH, the primary source of funds for Obio-Akpor PBF is the health facilities themselves (Obio Cottage Hospital and Rumuokwursi Model PHC) through the Obio Cottage Foundation. The PBF model led to improved service delivery. For example, during a PBF quantity and quality verification exercise in 2014, the Obio Cottage Hospital received an overall performance score of 46.4%, and the Rumuokwursi /Model PHC scored 57.2% - an increase from baseline scores of 42.3% and 43% respectively in the months before PBF.

## SUCCESS STORY:

Community-Based Health Insurance (CBHI) impacting the lives of its beneficiaries in Akwa Ibom State

*Nse is a 56 year old man with a family of five. He provides for his family by subsistence farming and occasional menial jobs while his wife is a petty trader. He is also the village town crier and a member of the Village Development Committee (VDC). He and his wife, barely earn up to 700 naira a day (less than \$3.50). As a member of the VDC, he felt compelled to sign up for the community-based health insurance (CBHI) scheme even though he had to borrow the money to do so. Nse paid 9,500 naira (\$38), the annual premium for the scheme that provided coverage for him and his family and they started accessing services at the primary health center in ward.*

*Soon after signing up, Nse had pain in his groin which affected his ability to walk. As a result he could no longer work on his farm or do his job as the town crier. When he visited the PHC, he was referred to the Cottage Hospital where he was diagnosed with a hernia. He had to undergo surgery and was admitted for 8 days. His total bill was 70, 500 naira (\$353) but because he was insured he did not pay anything out-of-pocket. Nse recovered rapidly after his surgery and resumed his normal activities. He is now a fervent advocate for the scheme.*



Nse, CBHI beneficiary

***“At the Cottage Hospital, they gave me a bed for eight days and treated me like a king. Imagine me who has no food to eat, tell me where I would have gotten the money to pay the bills. God brought CBHI people to help me. Last Sunday, I stood before my church and testified how God used CBHI to save me. I show people this umbrella and bags [CBHI promotional items] and tell them to go and register. The other day, I brought my neighbor to register. People have been asking me how I paid my bill because they were waiting to hear that I am dead or that I will sell my land to them to pay the hospital bill, but God saved me through this scheme.”***

—Nse, CBHI beneficiary

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## **PART 3:** Lessons Learned and Future Considerations



*Photo by MSH*

Over the life of the project, the importance of strong leaders, capable managers, and transparent governance structures has increased. In 2010 the system was fragmented, with little coordination and dialogue between the federal and state levels. Implementation of national policies at the state level was inadequate and health reporting rates were very low.

With the project's conclusion in 2015, coordination and partnerships between health regulatory agencies and other actors in the health sector have improved. Reporting of health data increased as a result of better understanding of the national HMIS. Roles and responsibilities of federal, state, and local government actors are clearer and well defined. CSOs recognize their role in the health field and their relationship with the public sector and have enhanced institutional capacity to raise and manage funds. Health care workers have stronger leadership and management skills and are better equipped to deal with the challenging environments they face. In light of these systemic changes, some health statistics have improved. For example, HIV prevalence dropped from 4.1% to 3.4% nationwide, and the maternal mortality rate (per 100,000 live births) decreased from 800 in 2008 to 560 in 2013.<sup>29</sup>

Reflecting on the five years of activities and achievements attained, PLAN-Health encountered numerous challenges in the implementation of the project and in the process devised lessons learned. These lessons offer a different perspective for donors and implementing partners for future health system strengthening projects.

## CHALLENGES

### Leadership development:

- The absence of available data such as a baseline made it extremely difficult to set measurable targets and track progress and results within the LDP and LDP-Plus process. It is important to identify a baseline prior to commencing any capacity-developing leadership program, especially as many of the results obtained may be qualitative.
- Lack of buy-in and commitment from stakeholders slowed and sometimes derailed the LDP and LDP-Plus process. Since the LDP is an improvement and change process, there was resistance from some organizations' leaders, who were not interested in change. In response, PLAN-Health ensured stakeholder buy-in to facilitate the process via a senior alignment meeting (SAM) that was conducted at the beginning of the engagement. The SAM was adapted to other situations, outside the LDP, to facilitate, for example, coordination of PMTCT activities in Akwa Ibom and enhance involvement of government and public officials to ensure positive outcomes.

### Strengthening CSO capacity:

- A number of PLAN-Health-supported CSOs were more focused on program and project implementation than on developing their own internal capacity. Therefore, they could not appreciate and/or dedicate time and resources to the TA provided by the project. In a few cases, the CSO management and their boards were not committed to the process of capacity-building, despite PLAN-Health's repeated efforts. In response, PLAN-Health disengaged with these CSOs. In most cases, the trigger for disengagement was that CSOs did not avail staff for capacity-building or did not implement lessons learned during capacity-building interventions. The process of disengagement involved PLAN-Health agreeing on a timeline with the CSO as to next steps. On completion of activities in the timeline, PLAN-Health conducted a final assessment and then formally disengaged with the organization.
- One major challenge for many of the CSOs was the high turnover of key staff. This was usually due to staff, whose capacity had been built by PLAN-Health, moved on to other better paying organizations, mostly international NGOs. In such situations, PLAN-Health helped CSOs to identify alternative sources to obtain the needed manpower at lower costs, such as the utilization of volunteers (for example, the National Youth Service Corps). PLAN-Health also helped ensure that there were tools, processes, and procedures, such as detailed handover notes and orientation processes in place to guarantee a smooth transition from departing staff members to their replacements.
- Smaller CSOs had very few staff who carried out multiple activities. In some cases this made it impossible to separate functions like financial management, which is necessary to ensure financial accountability. In these cases, the organizations were advised to either hire additional staff, or redefine current staff functions in order to comply with good accounting practices.
- PLAN-Health initially planned to engage with CSO networks at the state level. However, this proved impossible because of their lack of structure (no staff and sometimes no physical location). Thus, PLAN-Health ended up engaging with individual CSOs instead of with CSO networks at the state level. Engagement with CSO networks at the national level was fraught with difficulty. PLAN-Health spent the majority of time managing conflicts arising from in-fighting among members of the networks. Institutional capacity-building was also difficult because the officials of the networks were elected to management positions often without the requisite qualifications to do the job. Thus the amount of effort expended by PLAN-Health did not always translate to the expected results.

### Engaging with PSIs:

- Various health sector reforms have been developed and proposed by the Nigerian health sector in the past. However, one major challenge for PSIs has been translating those reforms into implementation and practice. This can be attributed to: weak accountability structures within the government; the frequent non-release of funds for planned activities; lack of staff to follow-up on organizational systems strengthening activities; and high levels of bureaucracy, resulting in considerable delays in carrying out planned/proposed activities.
- Some of the project outcomes were outside the PLAN-Health sphere of influence, such as providing evidence of implementation of PSI strategic and operational plans. In spite of this, with PLAN-Health TA, PSIs like AKSASCP, GomsASACP, GomsACA, and FACA were able to implement significant portions of their operational plans from year to year.

<sup>29</sup> WHO, World Health Statistics 2015 Global Health Observatory (GHO) Data, [http://www.who.int/gho/publications/world\\_health\\_statistics/2015/en/](http://www.who.int/gho/publications/world_health_statistics/2015/en/), 2015, (accessed 4 September 2015).

**Community-based health insurance:**

- Discrepancies in CBHI enrollee data: There were discrepancies in enrollee data recorded on the CBHI web application and the manual enrolment folders. This was due to several unforeseen factors, such as the system's inability to generate unique identification numbers for each new enrollee, making it difficult to generate data on enrollees. The application also did not recognize duplicate names. Technical sessions were held to reconcile the data discrepancies and an outcome of these sessions was the development of CBHI excel-based M&E database to complement the web application in data management and ensure data accuracy.
- Availability of health workers: Because of the lack of doctors at the PHC, people were reluctant to enroll in the scheme and preferred to go to the Cottage Hospital. The protracted health workers strike in 2014 also proved a major challenge as enrollees and other members of the community were unable to access services during the strike period. In response, PLAN-Health engaged a number of volunteer doctors and worked with the state MoH to draft an agreement with private sector providers that can fill the gaps if future interruptions in public sector services occur.
- Slow enrolment into the scheme: The concept of health insurance is relatively new to Nigeria, and most people, especially in rural areas, did not understand the benefit health insurance can have on their lives. People could not comprehend how it worked and what they received for their money. They preferred to continue to visit patent drug providers and not seek medical care at the primary health facility. This resulted in very slow uptake of the scheme and significant sensitization efforts such as engaging local leaders and pastors, as well as the development of communication materials, medical outreaches, and demand-generation activities were necessary to change the behavior of the ward population.

**Security challenges:**

- The security challenges fueled by religious extremism in the north-eastern part of Nigeria hampered implementation of activities in 2014 and 2015. There were delays in and cancellation of some scheduled activities in Gombe State, where security breaches made implementation difficult and sometimes impossible. For example, PLAN-Health could not roll out CBHI implementation in the state during the life of the project. The project adopted measures to mitigate the effects by changing the location of activities, and increased the use of electronic means of communication to provide TA and capacity-building.

**LESSONS LEARNED**

- TA has to be adapted for each organization to enable individuals within the organization to absorb and apply what they have learned because different organizations are at different levels in terms of capacity. One size does not always fit all. To be effective, capacity-building must be implemented using multiple approaches.
- It is essential for CSOs and PSIs to have ownership of the TA process and the changes involved from day one, since capacity building leads to improvement, and improvement processes are change processes. This ownership increases the chances of achieving the expected capacity-building results and sustaining the results over time.
- Health professionals need to keep abreast on the ever-evolving practices in the health system. The National Health Act of 2014 empowers the FMOH to ensure that adequate resources are available for the education and training of health care personnel to meet the needs of the health system. Unfortunately this has not been implemented, and many health professionals lack the necessary resources for continuous training even when the training programs are available in-country. Keeping health industry professionals informed of important updates to key practices can be done by continually updating their knowledge and skills. Organizations can fill in the gap by prioritizing and funding the training and retraining of their workforce.
- Sustainability of in-service training must be done by institutionalizing training programs in existing training institutions that can continue implementing them even after the originating projects have ended. Many in-service training programs in Nigeria are provided by foreign organizations and are targeted at developing the capacity of health professionals involved in implementing their often short-lived projects. As such, programs are not sustainable as they end at the close of the projects.
- CBHI and other health-financing interventions are better served as stand-alone projects rather than being embedded within a project with IRs such as PLAN-Health, as they are extremely capital intensive and time consuming. Although the project leveraged the health system strengthening and capacity-building expertise of multiple PLAN-Health staff, the impact in technical support to NHIS, Akwa Ibom, and Gombe states could have been greater if there was significantly higher financial and human resources dedicated to CBHI.

## FUTURE CONSIDERATIONS - OPPORTUNITIES AND OBSTACLES

Advancements have been made in the health system over the past five years, and MSH is proud of these accomplishments and looks forward to continuing to be involved in further improvements in Nigeria. However there are still obstacles ahead. Only 6% of the national budget is allocated to health, 95.8% of health expenditure is still paid out-of-pocket, and only 5.2% of the population has health insurance.<sup>30, 31</sup> The system is plagued with frequent strikes by health professionals, and the ratio of doctors, nurses, and midwives to patients has not changed in the past decade - creating a need for future TA and capacity development.<sup>32</sup> To reach the joint United Nations Program on HIV/AIDS' (UNAIDS) ambitious 90-90-90 global goals (90 percent of people with HIV diagnosed, 90 percent on ART and 90 percent virally suppressed by 2020), there is a need to change the status quo and build a strong and resilient health system.

The 2014 Nigeria Public Health Act provides an opportunity to improve access and quality of health services. The act creates a Basic Health Care Provision Fund to provide Nigerians with access to basic health care services through health insurance, the provision of essential vaccines and consumables, and development of human resources for PHCs. The challenge now lies with the act's implementation. Projects like PLAN-Health can help develop PSIs' capacity to effectively implement these policies and monitor implementation progress and results. Enhancing leadership and management skills through the scale-up of the fellowship program, for example, can also facilitate the translation of policy to action.

There is also a need for continuous capacity-building to strengthen PSIs' coordination and oversight capacity between the federal, state, and LGA level to implement the act and other policies and ensure sustainability. Strengthening data collection and reporting can improve the government's capacity to strategically target geographic areas and populations and link expenditure data to inform joint strategic planning to achieve the most impact for investments. The availability of human resources for health programs will also help to ensure the availability of health care infrastructure, workforce and internal resources needed to provide services as Nigeria moves towards epidemic control and an AIDS-free generation.

CSOs can also play an important part in the implementation of the act and the provision of health services by serving as the bridge between the government and the people. Many CSOs still have fragile systems, little knowledge and experience in advocacy, and depend heavily on donor funds. CSOs require technical support to diversify their funding base and mobilize funding to make their programs sustainable and provide more and better services for the populations they serve particularly marginalized populations that are most affected by HIV & AIDS, such as women and adolescent girls. These services will help to reduce infection rates in women and adolescent girls and ensure that they are supported to become resilient, empowered and AIDS-free.

Lastly, in a country like Nigeria that has a large informal sector and significant population of poor people, it is important to design and implement innovative financing mechanisms to mobilize resources to fund health for all. The Government of Nigeria and state partners need to budget adequate resources to improve access to health care for the formal and informal sectors through prepaid, risk pooling mechanisms, and in this way fast track progress toward universal health coverage. With support from the NHIS and development partners, state governments can increase their direct investment in health as well as the awareness of health insurance among its citizens, encourage participation, and enroll more people.

Adequate resources should be devoted to enhance capacity and retain health workers, and also improve quality of health services in public health facilities. Reviving and strengthening community-based structures will also enhance sustainability of CBHI schemes. Investing in health financing through funding for health system strengthening projects on public financial management, resource mobilization, health budget tracking, pro-poor health financing interventions like CBHIs, among others, will deepen the impact of the Government of Nigeria and USG relationships in improving access to good quality health care for the poor and vulnerable.

30 World Health Organization, 'Health System Financing Profile by country', WHO Global Health Expenditure Database [website], 2014, Countries: Nigeria, [http://apps.who.int/nha/database/Country\\_Profile/Index/en](http://apps.who.int/nha/database/Country_Profile/Index/en), (accessed 4 September, 2015)

31 S. Eferara, '17.8 million Nigerians have health insurance', National Mirror, 13 August 2014, <http://nationalmirroronline.net/new/17-8-million-nigerians-have-health-insurance/>, (accessed 4 September 2015).

32 Density of Physicians (per 10,000 population) was 4 between 2000 – 2009 and 4.1 between 2007-2013. Density of nurses and midwives (per 10,000 population) was 16 between 2000 – 2009 and 16 between 2007-2013. Source: World Health Statistics

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## ANNEXES

### Annex 1: List of PLAN-Health Client Organizations

#### Civil Society Organizations

GOMBE	AKWA IBOM	FCT	NETWORKS
Advancement for Women and Youth Initiative (IOWYO)	AIDS Care Managers (ACM)	African Health Project (AHP)	Association of Positive Youth Living with HIV/AIDS in Nigeria (APYIN)
Community Oriented Health Providers Association (COPHA)	African Human Development Center (AHDC)	Centre for Health Education, Economic Rehabilitation and Social Security (CHEERS)	Association of Women living with HIV and AIDS in Nigeria (ASWHAN)
Federation of Muslim Women's Associations In Nigeria (FOMWAN)	Antof Rural Resource Development Center (ARRDEC)	Community Life Advancement Project (CLAP)	Civil Society for HIV/AIDS in Nigeria (CISHAN)
Guidance and Counseling Development Association (GCDA)	Community Partners for Development (CPD)	Centre for the Right to Health (CRH)	Network of People Living with HIV/AIDS in Nigeria (NEPWHAN)
Lawanti Community Development Foundation (LCDF)	Heal the Land Initiative in Nigeria (HELIN)	Gede Foundation	Nigerian Association of Religious Leaders Living and Affected by HIV and AIDS (NINERELA)
Redox Carisa Development Initiative	Integrated Aid Initiative (IAI)	Health Initiative for Safety and Stability in Africa (HIFASS)	Nigerian Youth Network on HIV/AIDS (NYNETHA)
Teenagers' Empowerment Initiative (TEMIN)	Queenette Initiative for Health and Education (QIHE)	Jumorota Community Care Initiative (JCCI)	
	Women Initiative for Self-Actualization (WISA)	Lift Up Care Foundation (LUCAF)	
	Women United for Economic Empowerment (WUEE)	Positive Action for Treatment Access (PATA)	
		Redeemed AIDS Programme Action Committee (RAPAC)	
		Sustainable Health Care Initiative (SHI)	

**Public Sector Institutions (PSIs)**

GOMBE	AKWA IBOM	FCT	NATIONAL
Gombe State Agency for the Control of AIDS (GomSACA)	Akwa Ibom State Agency for the Control of AIDS (AKSACA)	FCT Agency for the Control of AIDS (FACA)	National Agency for the Control of AIDS (NACA)
Gombe State AIDS/STD Control Programme (GomSASCP)	Akwa Ibom State AIDS/STD Control Programme (AKSASCP)	FCT AIDS/STD Control Programme (FASCP)	National AIDS/STD Control Programme (NASCP)
Department of Planning Research and Statistics (DPRS), Gombe State Ministry of Health	Department of Planning, Research, and Statistics (DPRS), Akwa Ibom State Ministry of Health	Department of Planning Research and Statistics (DPRS), FCT Health and Human Services	Department of Planning Research and Statistics (DPRS), Federal Ministry of Health
Gombe State Health Insurance Scheme	Akwa Ibom Health Insurance Scheme	FCT Health Insurance Scheme	National Health Insurance Scheme (NHIS)
			Medical Laboratory Science Council of Nigeria (MLSCN)
			Medical and Dental Council of Nigeria (MDCN)

**Multisectoral Organizations**

The Global Fund Country Coordinating Mechanism (CCM) for Nigeria

**Annex 2: CSO Action Plan**

Activity No/task No.	Activities/Tasks	NHOCAT Improvement Plan For HELIN												Evidence of Achievement	
		July	Aug.	Sept.	Oct.	Person's Responsible	Resource Needed	Governance							
<b>Objective: To improve HELIN's Governance practices by September 2014</b>															
<b>Activity 1</b>	<b>Provide certified copy of constitution</b>														Minutes of board meeting, copy of certified constitution
Task 1.1	Follow up with lawyer to update reviewed board constitution and get CAC certification		5th											ED	Computer, internet, recharge cards
Task 1.2	Present a copy of CAC certified constitution to board			13th											Copy of reviewed constitution
Task 1.3	Share copies of constitution with staff														Board certified constitution
<b>Activity 2</b>	<b>Document IEC materials distributed</b>													ME	Updated IEC material distribution template
Task 2.1	Create a list of IEC materials		30th												
Task 2.2	Create a template for documenting IEC materials		30th												Computer
Task 2.3	Document IEC materials distributed		30th												
<b>Activity 3</b>	<b>Provide all staff with copies of the personnel policy</b>														Slipped copies of acknowledgment form
Task 3.1	Develop acknowledgment form		24th												Computer
Task 3.2	Share soft/hard copies of the personnel policy with all staff		25th												Copies of personnel policy
Task 3.3	Discuss the policy during staff meeting		25th												Copies of personnel policy
Task 3.4	Distribute acknowledgment form		25th												Printed copies of acknowledgment form
Task 3.5	Document signed copies of acknowledgment form in staff files		25th												
<b>Activity 4</b>	<b>Develop policies that focus on vulnerable groups</b>														Minutes of meeting, attendance sheet, finalized vulnerable groups policy
Task 4.1	Identify vulnerable groups that HELIN is working with		11th											PO	National vulnerable groups Policy/stationeries
Task 4.2	Research from national policy/policies		11th												National vulnerable groups Policy, computer, stationeries
Task 4.3	Adapt the national policy/policies		11th												National vulnerable groups Policy/stationeries, computer
Task 4.4	Present adapted policy/policies for board certification			13th											Adapted vulnerable groups Policy groups policy, acknowledgment forms, stationeries
Task 4.5	Disseminate copies to staff			15th											
<b>Activity 5</b>	<b>Develop an HIV policy</b>														attendance sheet, finalized HIV policy
Task 5.1	Discuss HIV policy review at staff meeting		28th											ED	Policy/stationeries, Copy of adapted HIV policy
Task 5.2	Review the HIV policy		11th												Copy of National HIV Policy/stationeries, Copy of adapted HIV policy, stationeries, computer
Task 5.3	Present a copy for board certification			15th											Copy of adapted HIV policy
Task 5.4	Disseminate copies to staff			29th											Copies of board certified HIV policy, acknowledgment forms





## Comparison of CSO Pre- and Post- NHOCAAT scores

CSO	Pre- NHOCAAT (% score)	Post- NHOCAAT (% score)
ACM	42	57
AHDC	45	61
AHP	0	49
APYIN	60	32
ARRDEC	63	87
CHEERS	38	76
CLAP	22	67
COHPA	36	75
CPD	68	84
HELIN	52	73
IAI	32	55
JCCI	61	86
LAWANTI	47	42
LUCAF	43	77
NINERELA+	56	75
QIHE	38	67
RAPAC	43	76
SHI	48	62
TEMIN	60	85
WISA	45	65
WUEE	57	94

## Annex 4: CSO Resource Mobilization Table

ADDITIONAL FUNDS RAISED BY PLAN-HEALTH CLIENT CSOS						
S/No.	CSO	Funder	Program area	Amount (in Naira)	Amount in USD	Year
1.	WUEE	Action AID - SCEEP	Electoral processes	N40,000,000	\$200,000	2014
		Environfit international	Women's empowerment	N4,500,000	\$22,500	2014
		World Bank/ Akwalbom SACA	HIV & AIDS	N12,000,000	\$60,000	2014
		African Women Development Fund	Sexual and reproductive health	N3,000,000	\$15,000	2014
		British Council	Gender-based violence	N50,000,000	\$250,000	2014
		Virginia Gildersleeve International Fund	Gender-based violence	N1,500,000	\$7,500	2014
		African Women Development Fund	Peace-building	N4,873,500	\$24,368	2014
		Bill and Melinda Gates Foundation	Malaria; MNCH; water, sanitation and hygiene (WASH); agriculture; microfinance; nutrition; and family planning	N7,310,250,000	\$36,551,250	2015
		Enhancing Nigerian Capacity for AIDS Prevention (ENCAP)	HIV prevention	N7,000,000	\$35,000	2015
		Envirofit Int	Entrepreneurship	N3,898,800	\$19,494	2015
		Advocates for Youth	Sexual and reproductive health	N2,274,300	\$11,372	2015
		2.	ARRDEC	TY Danjuma Foundation	PMTCT	N6,000,000
Civil Society on Malaria Immunization and Nutrition (Acomin)	Malaria			N300,000	\$1,500	2014
Society for Family Health (SFH)	HIV prevention for female sex workers			N3,000,000	\$15,000	2014
World Bank / AKSACA	HIV & AIDS			N10,000,000	\$50,000	2014
Elton John Foundation	MSM, sex workers			N6,000,000	\$30,000	2014
3.	IAI	Widows and Orphans Empowerment Organization (WEWE)	OVC	N30,000,000	\$150,000	2014
		Global Environment Fund (GEF)	Agriculture	N7,245,000	\$36,225	2014
		Federal Ministry of Agriculture and Water Resources (FMA&WR)	RUFIN - Rural Finance Institution building program	N500,000	\$2,500	2014

4.	AHDC	Centre for Communication Programs in Nigeria	HC3 - Health communication capacity collaboration. Community-based malaria intervention	N5,000,000	\$25,000	2014
		CSDP-Community and Social Development Program	Gender and vulnerable group profiling and domestication	N2,900,000	\$14,500	2014
		TY Danjuma Foundation	PMTCT	N9,200,000	\$46,000	2014
		Catholic Organisation for Relief and Development Aid (CORDAID)	Community dialogue, government engagement, community rights, and ownership	N5,200,000	\$26,000	2014
		Civil Society on Malaria Immunization and Nutrition (Acomin)	Malaria	N220,000	\$1,100	2014
5.	HELIN	World Bank/AKSACA	MNCH	N12,000,000	\$60,000	2015
		Bill & Melinda Gates Foundation	Youth and women's empowerment	N8,000,000	\$40,000	2014
		Elizabeth Taylor AIDS Foundation	Women's empowerment	N5,000,000	\$25,000	2014
		Civil Society on Malaria Immunization and Nutrition (Acomin)	Malaria	N315,000	\$1,575	2014
6.	QIHE	Elton John Foundation	Commercial sex workers, MSM	N12,000,000	\$60,000	2014
		Bill & Melinda Gates Foundation	Youth and women's empowerment	N8,000,000	\$40,000	2015
		World Bank/AKSACA	HIV & AIDS	N15,000,000	\$75,000	2015
		Virginia Gildersleeve International Fund	Sexual and reproductive health rights	N1,500,000	\$7,500	2014
		Civil Society on Malaria Immunization and Nutrition (Acomin)	Malaria	N400,000	\$2,000	2014
7.	WISA	Elizabeth Taylor AIDS Foundation	Women's empowerment	N5,000,000	\$25,000	2014
		Civil Society on Malaria Immunization and Nutrition (Acomin)	Malaria	N340,000	\$1,700	2014

8.	CPD	Centre for Communication Programs in Nigeria	HC3 - health communication capacity collaboration. Community-based malaria intervention	N5,000,000	\$25,000	2014
		CSDP-Community and Social Development Program	Gender and vulnerable group profiling and domestication	N2,900,000	\$14,500	2014
		TY Danjuma Foundation	PMTCT	N10,800,000	\$54,000	2014
		Catholic Organisation for Relief and Development Aid (CORDAID)	Community dialogue, government engagement, community rights, and ownership	N11,200,000	\$56,000	2014
		Civil Society on Malaria Immunization and Nutrition (Acomin)	Malaria	N233,000	\$1,165	2014
		9.	Ninerela+	International network of religious leaders living with HIV/AIDS	Stigma reduction	N2,000,000
10.	JCCI	Institute of Human Virology of Nigeria (IHVN)	OVC/HCT	N9,944,000	\$49,720	2013
		HAF (Health Alive Foundation)	TB	N8,404,000	\$42,020	2013
		Civil Society for HIV/Aids in Nigeria (CISHAN) and Education as a Vaccine Against AIDS (EVA), Nigeria	ATM (AIDS, TB, and malaria)	N225,000	\$1,125	2014
		Association for Reproductive & Family Health (ARFH)	ATM (AIDS, TB, and malaria)	N460,000	\$2,300	2014
		Safe Blood for African Foundation	Blood drive	N122,000	\$610	2014
		Institute of Human Virology of Nigeria (IHVN)	Psycho-social centre and school	N1,300,000	\$6,500	2014
		GEDE Foundation	Skills acquisition	N1,200,000	\$6,000	2013
11.	RAPAC	PEPFAR Small Grant	OVC	N2,000,000	\$10,000	2014
		Church Engagement	HIV prevention	N1,500,000	\$7,500	2014
		Church Engagement	Income-generating activities/ Empowerment	N750,000	\$3,750	2014
		Church Engagement	HIV prevention	N500,000	\$2,500	2014

12.	CHEERS	National Agency for the Control of AIDS (NACA)	PMTCT	N6,500,000	\$32,500	2014
		National Agency for the Control of AIDS (NACA)	PMTCT	N12,000,000	\$60,000	2014
		UNAIDS	HCT	N5,000,000	\$25,000	2015
		FCT Agency for the Control of AIDS (FACA)	OVC	N6,500,000	\$32,500	2015
		SURE-P Program (Federal Government of Nigeria)	Medical outreach	N5,000,000	\$25,000	2014
		13.	AHP	SFH/Population Council	Prevention/MARPS/IDU	N6,000,000
FCT Agency for the Control of AIDS (FACA)	OVC care and support, PLHIV			N9,000,000	\$45,000	2014
14.	LUCAF	Catholic Relief Services	SMILE: OVC	N15,000,000	\$75,000	2014
		Catholic Relief Services	SMILE: OVC	N38,000,000	\$190,000	2015
		FCT Agency for the Control of AIDS (FACA)	OVC care and support, PLHIV	N9,500,000	\$47,500	2014
		Kogi State Agency for the Control of AIDS (KOSACA)	OVC care and support, PLHIV	N12,800,000	\$64,000	2014
15.	SHI	Global Fund	Malaria	N1,365,000,000	\$6,825,000	2013-2015
		SFH-Global Fund	Social mobilization	N127,312,500	\$636,563	2013
		John Snow International	Assessment survey and data quality assessment	N21,000,000	\$105,000	2013
		PSM-Global fund	Logistics	N136,537,380	\$682,687	2013
		NACA-Global Fund	HIV commodities	N126,000,000	\$630,000	2014
		USAID	Malaria	N88,074,000	\$440,370	2013
16.	COHPA	Civil Society on HIV and AIDS in Nigeria	Prevention of HIV infection among female sex workers	N418,000	\$2,090	2015
		Civil Society on HIV and AIDS in Nigeria	AIDS, TB, and malaria (ATM) project	N342,000	\$1,710	2015
18.	TEMIN	Association for Reproductive and Family Health (ARFH)	OVC care and support	N6,000,000	\$30,000	2013
		USAID Nigeria	Education crisis response	N2,376,000	\$11,880	2015

19.	CLAP	Global fund	OVC	N8,600,000	\$43,000	2013
		CDC Solina Health	OVC prevention	N27,000,000	\$135,000	2013
		Global fund TB HAF	TB	N300,000	\$1,500	2013
		FACA HAF	HIV prevention	N15,100,000	\$75,500	2014
		APIN CDC	HIV prevention	N12,600,000	\$63,000	2012
		Pro Health International	OVC prevention	N17,300,000	\$86,500	2014
		NASACA (World Bank HAF)	HIV prevention, care and support	N16,000,000	\$80,000	2014
		CIHP CDC	HIV prevention, care and support	N84,000,000	\$420,000	2012
		Kogi State Agency for the Control of AIDS (KOSACA)	HIV prevention	N17,000,000	\$85,000	2014
		TACA	HIV prevention, care and support	N18,000,000	\$90,000	2014
		Global fund TB HAF	HIV prevention, care and support	N100,000	\$500	2013
		CRS	OVC prevention	N16,000,000	\$80,000	2014
		CDC Ecwes	HIV prevention, care and support	N19,100,000	\$95,500	2014
		APIN CDC	HIV prevention, care and support	N24,000,000	\$120,000	2012
		<b>Total</b>				<b>N 9,969,476,830</b>

## Annex 5: List of Policies, Guidelines, and Standards

NATIONAL/ FEDERAL LEVEL				
National Agency for the Control of AIDS (NACA)	National Health Insurance Scheme (NHIS)	Department of Planning and Research Statistics (DPRS) Federal Ministry of Health (FMOH)	National AIDS/STD Control Programme (NASCP)	Medical Laboratory Science Council of Nigeria (MLSCN)
Guidelines for Results Based Operational Plans Development- LGA HIV/AIDS Operational Plans Development Process 2010	NHIS Directory of Partners and Collaborators 2012	The Nigeria Federal Ministry of Health Strategic Health Development Plan (2010-2015)	National Coordination Framework for Health Sector Response to HIV/AIDS (2011)	Medical Laboratory Science Council of Nigeria Strategic Plan (2014 – 2018)
The Board Manual for the Multisectoral AIDS Response (2010)	Community Based Social Health Insurance Program (CBSHIP) Blue Print (2009)	Directory of Human Resources for Health Partners 2013	National Health Sector Strategic Plan and Implementation plan for HIV/AIDS (2010 - 2015)	MLSCN Monitoring & Evaluation Framework (2013)
Call Centre Business Plan (2011)		Federal Capital Territory Joint Annual Review of the Strategic Health Development Plan (2011)		MLSCN Monitoring & Evaluation Plan (2013)
Board of Governors Training Curriculum and Board Manual 2011		2015-2016 Biennial Operational Plans for FCT, Akwa-Ibom and Gombe		
HIV/AIDS and Other Related Diseases Toll-Free Call Centre Operations Manual April 2012		Nigerian Health Workforce Forecasting Plan 2011-2015 Nigeria Quality Checklist for Health Centres 2011		

FEDERAL CAPITAL TERRITORY (FCT)			
Department of Planning and Research Statistics (DPRS) FCT	FCT Agency for the Control of AIDS (FACA)	FCT State AIDS/STD Control Programme (FASCP)	FCT Health & Human Services Secretariat (FCT HHS)
Federal Capital Territory Health Statistical Bulletin (2011)	FCT Agency for the Control of AIDS (FACA) Coordination and Partnership Guideline Development (2013)	FCT ART Client Satisfaction Survey Report (2012)	FCT Health & Human Services Secretariat FCT Health Services Scheme Operational Guidelines (2013)
Federal Capital Territory Health Statistical Bulletin (2012)	FCT Agency for the Control of AIDS (FACA), HIV/AIDS Prevention Plan (FPP) 2012	FCT ART Client Satisfaction Survey Report (2015)	FCT Health & Human Services Secretariat Partner's Directory (2012)
	Fact Sheets (2013-2014)	FCT Health Sector HIV/AIDS Strategic Plan (2012 – 2015)	2013 FCT Health & Human Services Secretariat (HSS) Operational Plan
	PLHIV Needs Assessment Survey Report (2014)	FASCP Integrated Supportive Supervision Checklist of Health Sector HIV and AIDS response	2014 FCT Health & Human Services Secretariat (HSS) Operational Plan
	FACA/ AKSACA Partners and Service Directory (2012)		
	FCT Agency for the Control of AIDS (FACA), Communication and Dissemination Plan (2012)		
	FACA Policy Brief :Resourcing Towards a Zero New HIV Infection in the Federal Capital Territory (2013)		
	HIV/AIDS Strategic Framework and Plan 2010 – 2015		
	2011, 2012, 2013 Operational and 2014-2015 Operational Plan Development		
	FCT Agency for Control of AIDS (FACA) Dissemination Guidelines and Plan 2012		
	FCT Agency for Control of AIDS (FACA) , HIV/AIDS Strategic Framework and Plan 2010-2015,		

AKWA IBOM STATE				
Akwa Ibom State Ministry of Health	Akwa Ibom Community Based Health Insurance Scheme (AK CBHI)	Akwa Ibom State AIDS/STD Control Programme (AKSASCP)	Akwa-Ibom State Agency for Control Of AIDS (AKSACA)	Akwa Ibom Department of Planning Research and Statistics (AK DPRS)
Akwa Ibom State Strategic Health Development Plan Operational Plan (2014)	Ukana West Ward II CBHI Scheme Monitoring & Evaluation Guidelines (2015)	2012-2014 Operational Plan for Akwa Ibom State AIDS/STI Control Programme (AKSASCP)	Akwa-Ibom State Agency for Control Of AIDS (AKSACA), Coordination and Partnership Guide (2012)	Akwa Ibom State Human Resources for Health Strategic and Implementation Plan (2015-2019)
Akwa Ibom State Ministry of Health Operational Plan (2013)	Ukana West Ward II Community Based Health Insurance Scheme, Essien Udim Local Government Area Akwa Ibom State Nigeria, Board of Trustees Standard Operating procedures (2014)	HIV/AIDS Coordination and Partnership Guidelines for Akwa Ibom State Action Committee on AIDS (AKSACA) and Akwa Ibom AIDS/STI Control Programme (AKSASCP) 2012	Akwa-Ibom State Agency for Control of AIDS (AKSACA), Website Management Manual (2014)	
Akwa Ibom State Strategic Health Development Plan (2010-2015)	Akwa Ibom Community Based Health Insurance Manual/Handbook 2013		Akwa-Ibom State Agency for Control of AIDS (AKSACA), Communication and Dissemination Plan (2013)	
Akwa Ibom State Health Facility Assessment Tool for Community Based Social Health Insurance Scheme (CBSHIP) (2013)	Akwa-Ibom Health Fund Manual/Handbook 2013			
Community Health Development Fund Essien Udim Local Government Area Akwa Ibom State Standard Operating Procedures (2014)	Ukana West Ward 2, Essien Udim Local Government Area, Akwa-Ibom Community Based Health Insurance Standard Operating Procedures Data Management 2014			
	Akwa-Ibom Drug Management System Standard Operating Procedure 2014			
	Akwa Ibom State CBHI Cal 2.1 Capitation tool 2014-2020			
	Akwa Ibom State CBHI Program Checklist for the Development and Evaluation of CBHI schemes (2015)			

GOMBE STATE				
Gombe State Community Based Health Insurance Scheme(Gombe CBHI)	Gombe State Department of Planning Research and Statistics (DPRS Gombe)	Gombe State Ministry of Health (Gombe SMOH)	Gombe State AIDS/ STD Control Programme (GOMSASCP)	Gombe State Agency for Control of AIDS (GOMSACA)
Gombe CBHI Manual/ Handbook 2013	DPRS Gombe State 2-year costed HIV/AIDS Operational Plan (2011-2013)	Gombe State Ministry of Health Operational Plan 2013	Gombe State AIDS/ STD Control Programme (GOMSASCP), Operational Plan (2012)	Gombe State Agency for Control of AIDS (GOMSACA) Strategic Knowledge Management Systems Manual April 2013
	DPRS Gombe Partners Directory 2013	Gombe State Ministry of Health Operational Plan 2012	Gombe State AIDS/ STD Control Programme (GOMSASCP), Protocol for Data Handling (2011)	Gombe State Agency for Control of AIDS (GOMSACA) Operational Plan (2013)
		Gombe State Human Resources for Strategic Plan (2015-2020)	Gombe State AIDS/ STD Control Programme (GOMSASCP), Integrated Supportive Supervision Checklist (2012)	Gombe State Agency for Control of AIDS (GOMSACA) HIV/AIDS Coordination and Partnership Guidelines (2013)
		Gombe State Human Resources for Health Policy (2014)	Gombe State AIDS/ STD Control Programme (GOMSASCP), Service and Partners Directory (2013)	Gombe State Agency for Control of AIDS (GOMSACA) Factsheet & Annual Bulletin (2012)
		Gombe State HIV Strategic Plan (2011-2015)	Gombe State AIDS/ STD Control Programme (GOMSASCP) Coordination and Partnership Guidelines (2013)	Gombe State Agency for Control of AIDS (GOMSACA), Partners and Service Directory (2013 & 2014)
		Gombe State Strategic Health Development Plan (2010- 2015)	Gombe State AIDS/ STD Control Programme (GOMSASCP) Procurement and Supply Management (PSM) guidelines 2011	Gombe State ART Client Satisfaction Survey Report (2012)
		Department of Planning Research and Statistics (DPRS) Gombe State Partner's Directory		Gombe State ART Client Satisfaction Survey Report (2014)
				Gombe State Agency for Control of AIDS (GOMSACA) 2012-2013 HIV/AIDS Operational Plan (11 LACAs)
				Gombe State Agency for Control of AIDS (GOMSACA) Procurement and Supply Management (PSM) Guidelines 2011



## Annex 6: PLAN-Health Performance Monitoring Plan

INDICATOR	PROJECT TARGETS					PROJECT ACHIEVEMENTS					PROJECT PROGRESS		
	Year 1	Year 2	Year 3	Year 4	Year 5	Cumulative EOP targets	PY 1 June 2010- June 2011	PY 2 July 2011- June 2012	PY 3 July 2012- June 2013	PY 4 July 2013- June 2014	PY 5 July 2014- Dec 2015	Cumulative achievement (Project Start to Date)	Percentage achievement (Project Start to Date)
<b>Overarching Project Goal 1: Institutional capacity of select public and civil society organizations at Federal, State and Local levels strengthened for improved HIV and other health services for Nigeria's vulnerable populations</b>													
OPG #1.1	0	0	2	0	2	4	0	0	2	0	2	4	100.00%
OPG #1.2	NA	NA	66%	66%	66%	66%	0%	0%	31%	60%	88%	88.00%	88.00%
OPG #1.3	10	20	15	0	0	45	0	0	21	13	11	45	100.00%
OPG #1.4	0	4	2	2	2	10	0	2	6	1	0	9	90.00%
OPG#2.1	0	0	0	0	1	1	0	0	0	2	0	2	200.00%
<b>Intermediate Result 1: Leadership and management practices of Civil Society Organizations and Public Sector Institutions strengthened</b>													
Outcome #1.1	5	10	9	6	2	32	3	9	12	8	0	32	100.00%
Output #1.1.1	10	0	2	0	0	12	5	5	3	5	3	21	175.00%
Output #1.1.2	28	0	9	0	0	37	13	20	11	11	4	59	155.46%
Output #1.1.3	180	0	30	0	0	210	154	70	116	10	56	406	193.33%
Outcome #1.2	0	28	0	9	0	37	1	21	10	7	0	39	105.41%
Outcome #1.3	0	14	1	3	2	20	1	4	4	3	11	23	115.00%
<b>Intermediate Result 2: Organizational systems (e.g., HR, Finance, HMIS, Supply Chain, Service Delivery, and Planning) of Civil Society Organizations and Public Sector Institutions developed /strengthened</b>													
Outcome #2.1	0	5	5	2	3	15	0	0	7	1	8	16	106.67%
Output #2.1.1	28	0	9	0	0	37	39	8	7	10	27	91	245.95%
Outcome #2.2	6	6	2	2	0	16	6	6	0	2	0	14	87.50%
Output #2.2.1	40	40	10	10	10	110	211	88	80	47	38	464	421.82%
Output #2.2.2	5	75	75	15	15	185	18	238	156	75	39	526	284.32%
Outcome #2.3	0	20	5	5	0	30	6	0	9	8	8	31	103.33%
Output #2.3.1	0	16	7	7	6	36	37	17	10	2	4	70	194.44%
Output #2.3.2	2	3	4	4	4	17	3	3	1	3	2	12	70.59%
Output #2.3.3	4	4	4	4	4	20	3	3	1	3	2	12	60.00%
Output #2.3.4	4	4	4	4	4	20	3	3	1	3	2	12	60.00%
Output #2.3.5	1	1	1	0	0	3	0	1	1	1	0	3	100.00%
<b>Intermediate Result 3: Governance practices (e.g., accountability, board development, business development) of Civil Society Organizations and Public Sector Institutions strengthened</b>													
Outcome #3.1	0	5	3	5	2	15	0	1	6	1	7	15	100.00%
Outcome #3.2	0	5	3	5	2	15	1	8	1	0	6	16	106.67%
Outcome #3.3	0	4	2	0	1	7	3	4	11	7	2	27	385.71%
Output #3.3.1	0	4	2	0	1	7	3	4	11	7	2	27	385.71%

<b>Output #3.3.2</b>	Output: # of organizations with board development plans developed with PLAN-Health support	0	5	2	0	1	8	3	4	11	7	2	27	337.50%
<b>Output #3.3.3</b>	Output: # of organizations the boards of which receive PLAN-Health technical assistance.	4	4	2	0	0	10	3	4	11	7	2	27	270.00%
<b>Outcome #3.4</b>	Outcome: # of CSOs that successfully source funds and manage programs that help them achieve their mission. (S, L)	0	0	6	5	5	16	0	0	1	5	13	19	118.75%
<b>Output #3.4.1</b>	Output: # of CSOs that wrote proposal that successfully received funding from donors to deliver quality health services, disaggregated by level (S, L)	0	6	5	5	2	18	0	0	1	5	13	19	105.56%
<b>Output #3.4.2</b>	Output: # of proposals funded as a result of skills acquired with PLAN-Health assistance.	0	10	10	10	10	40	0	0	9	21	58	88	220.00%
<b>Output #3.4.3</b>	Output: # of CSOs whose personnel have been trained in proposal writing, disaggregated by level (S, L)	15	0	5	0	0	20	0	22	0	0	4	26	130.00%
<b>Output #3.4.4</b>	Output: # of CSOs trained in business development plan/fundraising, aligned with their organizational mission/disaggregated by level (S, L)	0	15	0	5	0	20	0	3	3	6	9	21	105.00%
<b>Output #3.4.5</b>	Output: # of CCM members participating in capacity strengthening workshops or activities delivered by PLAN-Health	30	0	15	0	0	45	52	0	18	0	0	70	155.56%
<b>Intermediate Result 4:</b>	<b>Coordination among Public Sector Institutions at all levels and partnerships with Civil Society Organizations strengthened</b>													
<b>Outcome #4.1</b>	Outcome: # of PSIs that have a strategic plan that aligns with NHSDP or NSP and have evidence of systematically attempting to implement this plan disaggregated by level)	0	0	8	0	4	12	6	0	0	5	0	11	91.67%
<b>Output #4.1.1</b>	Output: # of PSIs that have operational plans aligned with their strategic plans, disaggregated by level (S/L)	0	10	4	0	0	14	35	12	4	2	0	53	378.57%
<b>Output #4.1.2</b>	Output: # of PSIs that show and sustain an increase in percent implementation of their operational plans.	0	5	5	2	2	14	0	0	2	0	7	9	64.29%
<b>Output #4.1.3</b>	Output: % of coordination meetings that are effective.	20%	30%	40%	50%	60%	60%	100%	100%	100%	100%	100%	100%	100.00%
<b>Output #4.1.4</b>	Output: # of PSIs that have updated information on their partners and their area of focus/ responsibilities	5	8	4	0	0	17	8	0	3	0	3	14	82.35%
<b>Outcome #4.2</b>	Outcome: PSI partners have improved understanding of their roles and responsibilities as identified in their operational plans	5	8	4	0	0	17	35	11	5	0	0	51	300.00%
<b>Output #4.2.1</b>	Output: PSIs have operational plans with defined roles and responsibilities for their partners	5	8	4	0	0	17	35	11	6	1	0	53	311.76%
<b>Intermediate Result 6:</b>	<b>Institutional capacity of NHIS, state counterparts, local communities and select CSOs strengthened to provide access to quality health services through sustainable community based health insurance program.</b>													
<b>Outcome #6.1</b>	Outcome: # of health finance managers with improved understanding of health insurance management for CBSHIP	0	15	15	15	15	60	16	0	9	39	0	64	106.67%
<b>Output #6.1.1</b>	Output: # of senior level managers trained in CBSHIP	0	15	15	15	15	60	16	0	9	39	0	64	106.67%
<b>Output #6.1.2</b>	Output: # of organizations trained in implementation of CBHIS	0	1	1	1	0	3	0	2	2	1	0	5	166.67%

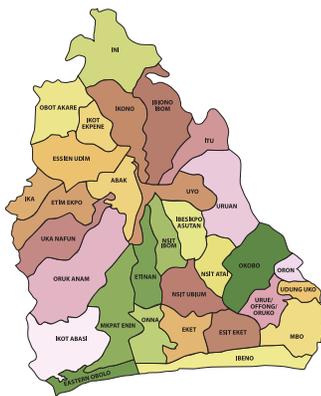
<b>Output #6.1.3</b>	Output: # of study tours facilitated by PLAN-Health	0	1	0	0	0	1	1	0	2	0	0	3	300.00%
<b>Output #6.1.4</b>	Output: # of enrollees in CBHI across all clients	0	0	800	1500	700	3000	0	0	556	4042	2284	6882	231.03%
<b>Outcome #6.2</b>	Outcome: # of PLAN-Health supported organizations implementing CBSHIP according to NHIS guidelines	0	1	1	1	0	3	0	1	1	1	0	3	100.00%
<b>Overarching Project Goal 2:</b>	<b>Capacity for building management and leadership skills and practices in the Nigerian's health sector developed and institutionalized</b>													
<b>OPG #2.1</b>	A structure is identified or created that will coordinate the cadre of health professionals that demonstrate expertise in health systems strengthening.	0	0	0	0	1	1	0	0	0	2	0	2	200.00%
<b>Intermediate Result 5:</b>	<b>A new cadre of individuals and institutions providing technical assistance in management and leadership that meets international standards developed</b>													
<b>Outcome #5.1</b>	Outcome: # of individuals satisfactorily providing TA to Nigerian's health institutions	30	30	30	30	30	150	31	4	4	187	0	226	150.67%
<b>Output #5.1.1</b>	Output: % of individuals identified by PLAN-Health that demonstrate expertise in health systems strengthening disaggregated by the NSHDP priority areas	0	20%	30%	40%	50%	50%	0	0	56%	0	0	80%	80.00%
<b>Output #5.1.2</b>	Output: # of individuals who successfully complete a PEPFAR Fellowship program	25	25	30	25	20	125	24	24	25	22	90	185	148.00%
<b>Output #5.1.3</b>	Output: An MOU is developed and operationalized between MSH and an institution in alignment with MSH's organizational objectives	0	0	0	1	0	1	0	0	0	1	1	2	200.00%

### Annex 7: PLAN-Health State Profiles

**Akwa Ibom State:** Located in the South-South geopolitical zone of Nigeria and has a population of about 4.6 million (based on projections made in 2011 by the National Population Commission). The state is made up of 31 local government areas, and Uyo is the capital city. Citizens are predominantly Christian and the major languages spoken are Ibibio, Anang, and Oron. Economic activities are largely commerce and farming with 85% of the population living in the rural areas.

The health indices of Akwa Ibom State are shown below:

Total fertility rate	3.9
Life expectancy	49 years
Infant mortality rate	58/1000 live births
Under 5 mortality rate	91/1000 live births
Maternal mortality rate	576/100,000 live births
HIV seroprevalence rate	6.5 %



Doctors	193
Nurses/midwives	2,427
Medical lab scientists	41
Medical lab technicians	64
Pharmacists	34
Pharmacy technicians	63
Community health workers	129
Medical records technicians	108

The health sector comprises of public, private for-profit, NGOs, CBOs, faith-based organizations (FBOs), and traditional health care providers and patent medicine vendors. There are about 615 health facilities out of which 38% are privately owned (232). The table (right) includes the distribution of the main cadres of health professionals in public health facilities in the state.

**The Federal Capital Territory (FCT):** The FCT is made up of six area councils, namely the Abuja Municipal Area Council (AMAC), Bwari, Gwagwalada, Kuje, Kwali, and Abaji. The inhabitants are multi-ethnic with diverse vocations. The majority are civil servants and political office holders.

The FCT has a population of about 2.2 million, according to the 2011 population projections of the National Population Commission.

The FCT health indices are shown below:

Total fertility rate	4.5
Infant mortality rate	66/1000 live births
Under 5 mortality rate	100 /1000 live births
Maternal mortality rate	576/100,000 live births
HIV seroprevalence rate	7.5 %



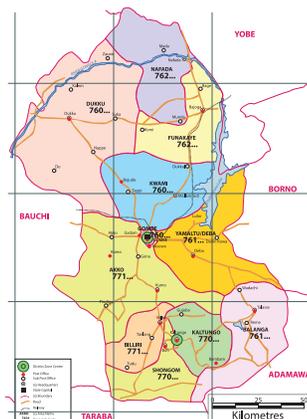
Below is the distribution of the main cadres of public sector health workers in the FCT.

Doctors	350
Nurses/midwives	1,176
Medical lab technicians	121
Pharmacists	138
Community health workers	135
Medical records technicians	121

**Gombe State:** Located in North – Eastern Nigeria and has a population of 2,775,400 million (2011). Gombe is multi-ethnic with 11 local government areas. Some of the ethnic groups are Fulani, Tangale, Waja, Tera, Jukun, Bolewa, Tula, Cham, Lunguda, Awak, Kamo, and Dadiya. Hausa is the inter-ethnic language of communication. Citizens are mostly farmers, cattle-herdsmen, and traders. Other sources of internally generated revenue include large-scale manufacturing companies such as the Ashaka Cement Factory, and numerous medium- and small-scale industries.

The Gombe State health indices are shown below:

Total fertility rate	7.1
Infant mortality rate	77/1,000 live births
Under-5 mortality rate	160/1,000 live births
Maternal mortality rate	576/100,000 live births
HIV seroprevalence rate	3.4 %



The principal causes of morbidity and mortality in the state are malaria, pneumonia, vaccine preventable diseases, snake envenomation, road traffic accidents, and HIV & AIDS.

There are 563 health facilities of which 58 (10.3%) are private health facilities.

Below is the distribution of the main cadres of health professionals in Gombe State public health facilities.

Doctors	159
Nurses/ midwives	688
Medical lab scientists	74
Medical lab technicians	37
Pharmacists	47
Community health workers	338
Medical records technicians	32
Community health officers	114

## Annex 8: PLAN-Health Abstracts and Posters

S/N	CONFERENCE	ABSTRACT TITLE	AUTHOR(S)
1.	3 <sup>rd</sup> Global Symposium on Health Systems Research Cape Town, South Africa, 2014	Strengthening Community Structures for Participation in the Health and Well-being of Citizens: Lessons from CUBS and other MSH Projects in Akwa Ibom State, Nigeria	N. Iboru
2.	141 <sup>st</sup> Public Health Association (APHA) Annual Meeting Boston, 2013	Increasing the Uptake of Prevention of Mother to Child Transmission (PMTCT) Services through Application of Leading and Managing Practices among Health Workers in Gombe State, Nigeria	L. Samaila, P. Orji
3.	Twelfth International Conference on Knowledge, Culture and Change in Organizations Chicago, 2012	Little Investment, Big results: An experience from a Nigerian Public Sector Institution	P. Orji, F. Enase
4.	USAID Local Capacity Development Summit Washington DC, June 2012	Approaches to building the institutional capacity of Nigerian civil society organizations	P.Orji, C.Ogbozor, B.Smith
5.	7th IAS Conference on HIV Pathogenesis, Treatment, and Prevention Washington DC, 2012	Sustainable HIV/AIDS Funding: Considering the Financial Management Capacity of Local NGOs	U. Ezeh, D. Nsima, T. Fadiya, A. Liman, S. Bitrus, P. Nwachukwu
6.	4th Annual International Conference on Education and New Learning Technologies Barcelona, 2012	Mentoring to Facilitate Learning For Health Professionals: Lessons Learned From a Nigerian Health Professional Fellowship Program	P. Orji, V. Ukpere, T. Fadiya
7.	International Conference on Corporate Governance and Business Management Boston, 2012	Board Governance Development : A Strategy for Systems Strengthening and Sustainability	A. Amunega, A. Kurfi, S. Osammor, O.Iyaji-Paul
8.	International Council on Women's Health Issues Baltimore, 2012	Promoting Women's Health through Capacity-Building Approaches to Women Civil Society Organizations	V. Ukpere
9.	6th IAS Conference on HIV Pathogenesis, Treatment ,and Prevention Rome, 2011	Assessing Human Resources for Health (HRH) Practices with an HR Score Card – the MSH Approach	U. Ezeh, V. Ukpere, D. Onyeje, F. Enase, M. Ikenyei

10.	6th IAS Conference on HIV Pathogenesis, Treatment, and Prevention Rome, 2011	Assessing the Financial Management Mechanisms of Health-Focused NGOs in Nigeria	U. Ezeh, V. Ukpere, M. Ikenyei, A. Omoluabi, T. Fadiya, D. Nsima
11.	6th IAS Conference on HIV Pathogenesis, Treatment, and Prevention Rome, 2011	Strengthening Human Resources for Health (HRH): The Nigeria Experience Based on the HRH Action Framework	V. Ukpere
12.	6th IAS Conference on HIV Pathogenesis, Treatment, and Prevention Rome, 2011	Improving service delivery in the health sector through improved work climate: Early indicators of success	F. Enase, P. Orji, K. Onasanya, C. Nwachukwu, O. Ogbuoji, V. Ukpere
13.	6th IAS Conference on HIV Pathogenesis, Treatment, and Prevention Rome, 2011	The effect of coordination in enhancing the national OVC response: the Nigerian experience	M.. Ikenyei, D. Nsima, V. Ukpere, U. Ezeh
14.	6th IAS Conference on HIV Pathogenesis, Treatment, and Prevention Rome, 2011	Missed Opportunities to Increase Awareness of HIV/AIDS and TB among Nigerian Women - A Case for Data-Driven Service Integration	O. Ogbuoji
15.	First Global Symposium on Health Systems Research, Montreux, 2010	Using participatory research as a tool to strengthen clinical and management systems for improved quality of health care services	P. Orji, F. Enase, K. Onasanya
16.	XVIII International AIDS Conference Vienna, 2010	Providing HIV/AIDS Services in Challenging Communities: Lessons from Health Professionals Fellowship Program in Nigeria	C. Ogbozor, P. Orji



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