

“THE GROUND IS SOFTENING”
FOR THE
USAID/NIGERIA HEALTH PORTFOLIO
CONSIDERATIONS FOR THE PRESENT AND THE FUTURE

by

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submitted to
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Disclaimer: The authors views expressed in this report do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

ACRONYMS

ACCESS	Access to Clinical and Community Maternal, Newborn and Women's Health Services
ACQUIRE	Access, Quality and Use in Reproductive Health
ANC	Antenatal Care
BCC	Behavior Change Communication
BoH	Banking on Health
CHEW	Community Health Extension Worker
CIDA	Canadian International Development Agency
CLMS	Contraceptive Logistics Management System
COMPASS	Community Action for Participation in the Social Sector
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DfID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
EBF	Exclusive Breastfeeding
FMOH	Federal Ministry of Health
FP	Family Planning
GHAIN	Global HIV/AIDS Initiative in Nigeria
GON	Government of Nigeria
HIV/AIDS	Human Immune Virus/Auto Immune Deficiency Syndrome
HMO	Health Maintenance Organization
HRH	Human Resources for Health
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information, Education and Communication
IMNCH	Integrated Maternal, Newborn and Child Health
IP	Implementing Partner
IPC	Interpersonal Communication
IRHIN	Improved Reproductive Health in Nigeria
LAM	Lactational Amenorrhea Method
LGA	Local Government Administration
MDG	Millenium Development Goals
MNCH	Maternal, Newborn and Child Health
NEEDS	National Empowerment and Development Strategy
NHIS	National Health Insurance Scheme
PAC	Postabortion Care
PEPFAR	President's Emergency Plan for AIDS Response
PHC	Primary Health Center
PLHA	People living with HIV/AIDS
PP	Postpartum
PRH	Office of Population and Reproductive Health (USAID)
PSP-One	Private Sector Program - One
RH/FP	Reproductive Health/Family Planning

SBM	Standards Based Management
SFH	Society for Family Health
SMOH	State Ministry of Health
TFR	Total Fertility Rate
UNDP	United Nations Development Program
UNICEF	United Nations Children’s Fund
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
USG	United States Government
VOA	Voice of America
WHO	World Health Organization

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CONSIDERATIONS FOR THE PRESENT AND THE FUTURE

EXECUTIVE SUMMARY

The United States Agency for International Development in Nigeria (USAID/Nigeria) invited two health experts, Joyce Holfeld and Patricia MacDonald, to review of the Mission health portfolio with a particular focus on reproductive health and family planning (RH/FP). The purpose of this review was to identify ways to strengthen the current program and to offer strategic, operational and management considerations for the development of the Mission 2009-2014 Strategy.

This review and the upcoming strategic planning exercise come at an opportune time. There are many changes in Nigeria indicating that the “ground is softening” and which provide opportunities conducive to positive actions for the health sector, especially those that reduce maternal, infant and child mortality: Recent elections in Nigeria have pushed to the top of the agenda extensive plans for economic and social development. The Government of Nigeria (GON) has enacted a national strategy for poverty alleviation and fundamental reform of the health system and has asked donors including the United States Government (USG) to help in the implementation of the new strategies. Specific new plans have been drawn-up for the strengthening of maternal, newborn and child health (MNCH) services and upgrading the primary health care (PHC) system. Additional and significant financial resources are coming into the country for improvements in the health sector from multilateral and bilateral programs, foundations, private voluntary organizations, and multi-national corporations. A robust private sector is establishing new and unique avenues to provide health services. The National Health Insurance Scheme (NHIS) is offering third party payments for key health care services provided to the working population. The time is right to support these reforms and reinforce systems that can effectively deliver health services to the people, especially to women and children who are particularly vulnerable.

The consultants believe that USAID’s investment in people through better health is critical to the achievement of the Mission’s overall goal to ensure economic and social prosperity and stability. The USAID/Nigeria health program has already initiated substantive activities leading to improvements in the delivery of health services for women and children. The current bilateral and field support programs have successfully worked at the community level in select local government areas (LGAs) in key states in northern Nigeria where the needs are greatest. Excellent work has begun to increase demand for services, expand the access and availability of information and services, improve the quality of services, and create an enabling environment. However, the job is far from done and the sphere of influence is limited to a relatively small number of local government areas in five states in northern Nigeria.

The current USAID Nigeria health portfolio now involves three primary bilateral projects and several key field support activities. For the last several years funds available for USAID's RH/FP program averaged an operating year budget (OYB) of \$10-12 million. In FY 2007, Nigeria was designated as a priority country for the Office of Population and Reproductive Health (PRH) and the budget was increased by \$10 million raising the OYB level to a little over \$20 million. The plus-up was guaranteed only for 2007, and any future increases are dependent on performance and potential for return on investments. Even at this level, the financial resources available through USAID are, at best, meager to address the problems of a neglected system expected to serve a large population. In order to be effective the team recommends that the Mission prioritize its actions and invest in those activities that will have maximum and lasting impact. This report does not provide the answers but rather makes suggestions to be considered by the Mission as it moves to plan for its future investments. Key recommendations for the Mission and its partners include:

- Develop and have all partners adhere to a strategic vision that has clearly defined measures for outcomes and impact.
- Garner greater Nigerian ownership of USAID programs at the community, local government, state and national levels.
- Assist the GON and the private sector in defining a realistic package of essential MNCH and RH/FP health services that are realistic, effective, evidence-based and affordable, and that address the needs of the population in northern Nigeria. In planning, keep the client in mind and at the center of the program actions.
- Avoid stove piping of services and maximize integration where logical and mutually reinforcing for service acceptance, such as the integration of family planning into MNCH and HIV/AIDS services.
- Close the gap between the demand for services and the availability and accessibility of services.
- Continue to support service improvements and quality at both the public and private sectors, but given the potential of the private sector, consider alternatives for expanding quality services in the private sector.
- Further develop the systems and tools that improve the quality, effectiveness and efficiency of services and that underpin optimal service delivery functioning. Ensure that commodities and materials make it to the "last mile."
- Leverage funding of other donors, foundations, the government, and the private sector to permit the replication of the models at least the state, and preferably at the national level.
- Invest time and encourage better coordination between donors, and partners.

A solid foundation has already been laid through the implementation of the current USAID Strategy. The task now is to plan for the future. The following chapters set the context for programming and give strategic, operational and management ideas for the Mission to consider as it moves to *refine* the current program and extend planning that is appropriate to the new innovations and the improving contextual environment.

A. PURPOSE AND METHODOLOGY OF THE REVIEW

USAID/Nigeria invited Joyce Holfeld, Senior Public Health Advisor and Patricia MacDonald, Senior Technical Advisor for Maternal and Reproductive Health in USAID's Global Health Bureau, to assist the Mission in a participatory review of their current health portfolio. The purpose of this review was to identify ways to strengthen the current program in family planning/reproductive health (FP/RH) and to offer strategic, operational and management considerations for the Mission 2009-2014 Strategy.

The Mission asked the team to consider the specific questions regarding the USAID health program:

- Is the Mission using the right strategies and approaches?
- What are the opportunities and challenges?
- What are the gaps in programming?
- What might be done differently to have maximum and lasting impact?
- How might the Mission integrate FP with MCH, malaria and HIV/AIDS?

The two consultants visited Nigeria during the period November 26-December 13, 2007 and worked closely with USAID staff to involve stakeholders in a participatory review process. The team conducted a number of interviews in Abuja and held entry and exit meetings with the implementing partners (IPs) and key stakeholders. The team members, with the USAID FP/RH Manager, travelled over 1000 kilometers to meet with field staff, state and local government officials service providers and traditional, religious and community leaders in Zaria, Zamfara and Kano States. The team visited the field offices and programs of the bilateral and field support partners and held three stakeholder meetings in the field.

Through this process, the team observed health activities at a representative sample of public and private hospitals, clinics, and primary health centers and private pharmacies/patent medicine shops. The team members had an opportunity to interview many service providers, community outreach works, and most importantly, clients. The team reviewed extensive documentation regarding the overall program and specific program elements: USAID and Government strategies, operational/work plans as well as numerous technical analyses, success stories and trip reports.

The review did have some limitations: time was short and did not allow in-depth and first hand view of activities in all domains, especially in the areas of policy and behavior change; the program is complex and most of the data received was qualitative, and not quantitative. Even so, the team did have an excellent overview and frank and to-the-point briefs from literally hundreds of people involved with or touched by the program. The team believes it did have a solid base upon which to arrive at the findings, conclusions and recommendations found in this report. The report is meant to provide some considerations and options to guide USAID in present and future programming for the health program, and particular for FP/RH.

B. CONTEXT AND OBSERVATION ON CURRENT USAID/NIGERIA HEALTH PROGRAM

1. Health Situation in Nigeria

Nigeria is the largest country in Africa with its population of approximately 132 million people. Nigeria ranked 158 out of 177 countries in the 2005 United Nations Development Program (UNDP) Human Development Index. The health care system has been neglected for the past two decades resulting in devastating statistics as noted in the 2003 Demographic and Health Survey (DHS)¹. For the country as a whole, under-five mortality is estimated at 200 per 1000 live births, with deaths caused primarily by malaria, vaccine preventable diseases, diarrheal disease and acute respiratory infections. Infant mortality is about half of all deaths under five years of age. Immunization rates are extremely low with only 13% of one year olds receiving all recommended vaccinations. Maternal mortality hovers at a shocking 800 per 100,000 live births, with the rate being at least three times that in the northern states. Total fertility is 5.7 children per woman and the prevalence of modern contraceptive methods is 8.9%. Generally, the health conditions and coverage of basic health services in the northern states are much worse than in the southern states.

These outcomes suggest that the entire health care system, public and private sectors, are struggling to meet the challenges. The current public system offers a disjointed and disconnected system:

- The federal level is responsible for setting policies, providing overall guidance, managing and funding tertiary facilities and key programs.
- The state level funds and manages state hospitals and maternities.
- The local governments, with little technical expertise and insufficient funds, are responsible for staffing, managing and financing the primary health care clinics.

The 2003 DHS indicates that consumers are choosing to forego treatment or to pay for treatment with unskilled providers. No treatment is sought for 31% of children with a fever or symptoms of an upper respiratory infection. 20% of children with diarrhea receive no treatment and 66% of deliveries take place in the home with only 35% attended by a skilled provider. The 2006 Private Sector Partnership for Health (PSP-One) Assessment in Nigeria² indicates: “service and consumption indicators make it clear that *neither* the public nor private health systems are functioning effectively. According to a WHO National Health Account analysis from 2003, consumers pay a high share of health expenditures with 67% of health expenditures coming from out-of-pocket vs. 26% from government and 7% from the private insurance and employers.” Even with these devastating statistics there is hope for the future. As noted in the USAID/Nigeria’s 2008 Operational Plan³ and other documents, the Nigerian government, its leadership and people have responded concretely to these development challenges, especially in the health sector. For example:

¹ Nigeria Demographic and Health Survey, 2003: Nigeria National Population Commission and ORC Macro, 2004.

² PSP-One Private Sector Assessment in Nigeria, August 25, 2006

³ USAID/Nigeria, 2008 Operational Plan, submitted November, 2007

- The Government of Nigeria (GON), unveiled in 2003, its poverty reduction strategy—the National Empowerment and Economic Development Strategy (NEEDS). This strategy is being replicated at the state and local government areas (LGAs). The government’s willingness to partner with donors in implementing and monitoring these strategies provides an unparalleled opportunity for dialogue and collaboration.
- To this end, considerable funding is coming into Nigeria for the improvement of the delivery of health services. For example, various bilateral and other donors are providing additional funding: USAID has stepped up funding for malaria and as designated Nigeria a priority country and augmented 2007 funding for the FP/RH programs. The (US) President’s Emergency Plan for AIDS Response (PEPFAR) is allocating nearly \$500 million for AIDS prevention, control and treatment. Britain’s Department for International Development (DfID) has launched a new program for the provision of essential drugs. The Global Fund has recently awarded funding for AIDS, tuberculosis (TB) and malaria. World Bank is investing in health infrastructure building, particularly for the southern delta regions.
- In 2005, Nigeria paid \$6.4 billion in arrears to the Paris Club, meeting the first deadline under the International Monetary Fund program to write off 60% of its \$ 30 billion debt owed to foreign governments. The resources previously used to service this debt have been allocated by the GON to the “Millennium Development Goals (MDG) Account.” A substantive proportion of these funds are to be used to reinforce the health systems at the state, national and LGA levels.
- The Federal Nigerian Ministry of Health (FMOH) has recently developed a national strategy for Integrated Maternal, Newborn and Child Health (IMNCH) and is planning to roll it out to the state-level in the very near future. The GON has also articulated a new national policy to strengthen the delivery of services and upgrade facilities for PHC health care under the sponsorship of the local governments.
- The private sector is robust and is increasingly making health services affordable and commodities available. The Society for Family Health (SFH) provides, through the pharmaceutical system such commodities as contraceptives, safe guard (a water purification solution), insecticide treated bed nets and a variety of other essential medications. Through the Banking on Health (BoH) project, the commercial banking system is looking at making credit available to private providers who offer maternity and preventive care including family planning services.
- There are indications that the climate for child spacing is improving. Child spacing messages are acceptable which advocate for the “mother’s rest” and for the “health of the mother and child.” Religious and traditional leaders have requested greater dialogue and more information regarding FP/RH. And there is an interested in purposeful integration of family planning with MNCH and HIV/AIDS services.
- There are emerging champions for improved maternal, newborn and child health, at the national, state, and local levels. For example, the First Lady of Nigeria has actively

promoted improvement in maternal, newborn, and child health services and has called on all the State Governors' wives to join her in improving services around the country. The Governor of Bauchi recently included a line item for reproductive health and family planning in the state health budget. In the northern states, the traditional leaders and the religious leaders are strong proponents of improved maternity services and encouraged pregnant women to go to the maternities and seek skilled healthcare workers to assist with their delivery.

Given these environmental developments, substantial investments in Nigeria's health care delivery system should yield improved health indicators, particularly in the areas of MNCH and FP/RH. USAID has a unique opportunity in Nigeria. It has a long history of support to health sector in Nigeria, and strong relationships and partnerships have been developed in the health sector in both the public and private sectors. Moreover, USAID has a record of proven track record and comparative advantage in the areas of MNCH and particularly FP/RH.

2. Current Program Strategies and Programs

As noted in USAID/Nigeria's 2008 Operational Plan, the "USG foreign assistance program in Nigeria is crafted to meet strategic goals of energy security and political stability through best practice development programs." Given that the health and educational systems are in crisis in Nigeria, the Mission has chosen to "invest in the Nigerian people" by improving health and educational services. The current strategy supports integrated child health, reproductive health, and education programs in Nigeria.

In the health sector, USAID aims to improve quality of life and social stability by improving the appalling state of maternal, newborn, child and reproductive health; reducing the crushing disease burden of HIV/AIDs, malaria, tuberculosis, and polio; and preventing and treating the devastating and stigmatizing obstetric fistula. The Mission's strategic objective for the health sector looks to increase the "**use of selected health services**," with straight-forward approaches:

- **Creating demand** by mobilizing communities, creating awareness of available services, and providing needed information for clients to seek and properly use services.
- **Increasing access** by developing the number of service sites in both the public and private sector, making commodities and information available, and strengthening the capacity of staff to provide services.
- **Improving quality** by setting standards, introducing service protocols, upgrading facilities, conducting competency-based training, and encouraging proper supervision and on-the-job training.
- **Developing an enabling environment** by advocating for appropriate programs and services, changing policies and regulations to improve quality and services, and encouraging coordination and collaboration.

The Mission implements its health program through a variety of bilateral and field support mechanisms. Since this review is primarily focused on family planning, reproductive health, and maternal health, the team highlights those *key* implementing partners that primarily supported these specific technical areas. The summaries below are extracted from the Mission's 2008 Operational Plan.

- **Community Action for Participation in the Social Sector (COMPASS), Pathfinder International with their collaborating partners**

Awarded in 2004, COMPASS is the Mission's flagship bilateral project for maternal and reproductive health, child survival and education. It currently works in 51 local government areas in 5 states to advocate for and strengthen MCH and FP services in 557 public and 143 private health facilities. In an effort to reduce child mortality in Nigeria COMPASS focuses efforts around vaccine-preventable diseases, diarrhea, acute respiratory infections, nutrition, and quality obstetrics care. Continued resistance to polio eradication remains a challenge in the north and COMPASS is succeeding in reducing cases of non-compliance by working with community and religious leaders to institutionalize understanding of the importance of polio vaccination.

COMPASS is building the capacity of Community Coalitions (CCs) and Quality Improvement Teams (QITs) to advocate for improved healthcare facilities, increased staffing and improved services. In addition, COMPASS trains personnel in integrated MNCH/FP interventions, provides materials and supplies, and is working with DELIVER to improve the contraceptive logistics management system (CLMS).

COMPASS is in an excellent position to encourage closer integration of MNCH and FP/RH, improve public-private partnerships and to obtain community ownership

- **Improved Reproductive Health in Nigeria (IRHIN), Society for Family Health with their collaborating partners**

IRHIN is an ongoing bilateral social marketing project that will contribute to increasing the contraceptive prevalence rate for modern methods in Nigeria. The key expected results from this project are to increase demand for contraceptive commodities nationwide and increase access to quality FP commodities by working with community-based patent medicine vendors and private sector clinics. IRHIN also works to improve the quality of FP/RH services in 21 clinics in three states and the enabling environment for family planning by working with religious leaders, the Pharmacists Council of Nigeria and other national associations. In 2008, IRHIN is expected to provide a total of 2.5 million couple years of protection through social marketing of contraceptives.

- **ENHANSE, Constella-Futures with collaborating partners**

ENHANSE is an ongoing bilateral project designed to strengthen the enabling and policy environment for family planning and reproductive health. With 2007 funds, ENHANSE is assisting in the development of three policies focusing on reproductive health,

adolescent health and gender-based violence; new guidelines on FP/RH and HIV/AIDS integration; a strategic plan for maternal mortality reduction; and a plan for monitoring and evaluation. ENHANSE will also provide capacity building support to members of civil society organizations in policy dialogue and advocacy.

- **Access to Clinical and Community Maternal, Newborn and Women’s Health Services (ACCESS) , JHPIEGO with collaborating partners**

ACCESS is a new field support activity which aims to reduce maternal and newborn mortality in 20 health facilities in two northern states in Nigeria through the provision of integrated community and facility-based essential maternal and newborn care interventions focusing on antenatal care, emergency obstetric care and newborn care (EmONC), postpartum care and family planning for healthy spacing of pregnancies. Overcoming delay in seeking trained medical care during labor remains a significant factor in maternal and newborn survival in northern Nigeria. ACCESS implements a household-to-hospital continuum of care approach by strengthening the facility, connecting the household to the facility, and mobilizing family and community members to make the links necessary to care for mothers and newborns. Moreover, the high fertility rate remains a considerable challenge in the north. ACCESS implements an evidence based behavior change communication approach to increase demand for and acceptance of FP services, especially for postpartum mothers.

- **Access, Quality, and Use in Reproductive Health (ACQUIRE), EngenderHealth with collaborating partners**

The ACQUIRE project is a new field support working in one hospital in each of five states in northern Nigeria. The purpose of the project is to increase access to comprehensive fistula repair, prevention and reintegration services. Employing various strategies including male and community leader participation, ACQUIRE raises awareness in communities to support prevention of fistula and re-integration of women with repaired fistula, including promoting the use of FP and MNCH services, stigma reduction, psychosocial support and microenterprise opportunities. As an integrated reproductive health and maternal health project, ACQUIRE also works to increase the uptake of contraceptive services and use of skilled birth attendants. With 07 funds, ACQUIRE is training surgeons who can perform fistula repair operations on over 1,200 women living with obstetric fistula.

- **Voice of America Hausa Services**

Voice of America (VOA) Hausa Services produces and airs Hausa language radio programming reaching 19 million listeners. VOA offers a unique opportunity to reach outlying rural and underserved populations in northern Nigeria with powerful health education messages. That contributes to increased knowledge and use of MNCH and FP services. VOA airs special reports, first-hand accounts, public service announcements, and panel discussions providing important communication and outreach messages for the USG and GON initiatives. These efforts contributes to increasing the acceptance of polio and routine immunization, greater usage of antenatal, maternal health and family

planning services, and reinforced nutrition and exclusive breastfeeding education messages.

- **DELIVER, John Snow Inc. (JSI)**

DELIVER is a field support activity that assists the GON to develop, strengthen, and operate reliable and sustainable supply systems for contraceptive commodity security in three focal states of Nigeria. Through the introduction and testing of a streamlined CLM system, DELIVER helps decrease the number of service delivery points reporting stock outs of any commodities offered by the service delivery points. To overcome challenges such as lack of supervision and motivation of staff, DELIVER provides technical assistance including capacity building activities for managers, service providers, and chain supply personnel using on-the-job-training, system design, and performance improvement techniques.

- **Demographic and Health Survey, ORC Macro International and sub-contactors**

MEASURE DHS, in an effort to assist the Government of Nigeria to ensure production of adequate, reliable and timely demographic data, produces a Demographic and Health Survey (DHS) every 5 years. DHS contributes to sustainable improvements in health outcomes through improved collection, analysis, and presentation of data for use in planning, policy development, and in monitoring quality maternal and child health, family planning and reproductive health services. One objective of the DHS is to provide reliable data on fertility, fertility preferences, and use and knowledge of family planning methods.

- **Private Sector Partnerships for Health PSP- One**

PSP-One, with central and field support funds, works closely with the Family Health Society to include a MNCH/FP wellness package in the service mix of select health maintenance organizations that are under the aegis of the national health insurance program.

- **Banking on Health**

Banking on Health, using central funds, is establishing a pilot program which stimulates interest of financial institutions to provide loans to private sector health care providers (doctors, nurse-midwives) and develops the capacity of those providers to be good candidates for such loans.

3. Program Accomplishments and Gaps

In general the team was most impressed with progress to date of USAID/Nigeria's health program. Given the slow start of the flagship project, its accomplishments to date have been impressive, and it seems to be on the path to achieving real impact. The other projects are also making headway. Although the data is preliminary and is subject to verification and further

analysis, the 2007 Midline Surveys⁴ compared with the 2005 Baseline Surveys indicated significant achievements particularly in FP in the five states where COMPASS and the other partners have focused most of their efforts (See Table 1):

Table 1: Comparison of Baseline (2005) and Midline (2007) Selected USAID/Nigeria Health Program FP/RH Indicators				
Indicator	Definition and Calculation	Data Source	Baseline Value 2005	Midline Value 2006
Contraceptive Prevalence Rate (CPR)	Percent of all women 15-19 who report current use of a modern method of contraception at time of survey	Household (HH) Survey	9%	25%
Facilities that offer FP/RH services	Percent of health facilities with at least 2 modern contraceptive methods available, a trained provider who has undergone at least basic FP training and have completed FP and ANC records	HH Survey	15%	19%
Pregnant women attending ANC clinic	Percent of mothers who obtained ANC services at least 4 times during their last pregnancy for a trained provider at a hospital or clinic	HH Survey	31%	37%
Skilled assisted delivery	Percent of last deliveries attended by a trained provider: midwife, nurse, CHEW, CHO or doctor	HH Survey	33%	35%
Customers in the community who are satisfied with health services	Percent of women who were somewhat satisfied with or very satisfied with the health facility at the time of the last visit	Health Facility Survey	65%	79%

This data suggests the health program is on the right trajectory. The Mission and its implementing partners have executed a strong tactical approach to creating demand, increasing access, improving quality, and developing an enabling environment. The partners have organized headquarters in Abuja (or Lagos) and have established a strong field presence in their priority states (Lagos, and designated states in northern Nigeria). The partners have recruited qualified management and technical staff, who have established strong project relationships, especially at the community level. The program is poised for fast-track results as the partners are using proven interventions, are building on existing programs and structures, and are working both in the public and private sectors. Although the relationships could be stronger, for the most part the partners are working well together and coordinating for concrete results.

The team was asked to identify needs that result in program gaps, especially in the uptake of FP and MNCH services. These are listed below but are discussed in greater detail in the chapters which follow:

⁴ Nigeria: Reproductive Health, Child Health, and Education Household, School and Health Facility Baseline Surveys, 2005 and 2007, Measure Evaluation, Department of International Health and Development, Tulane University

- **Current strategic framework needs some updating** to define an essential package of integrated services; to utilize HIV/AIDS, malaria and MNCH as entry points to for family planning; to program for maximum and lasting impact by focusing on system strengthening, institutionalization, greater stakeholder ownership, and long-term sustainability.
- **The current program activities are “not totally owned” by the stakeholders but are rather seen as the partners’ program activities or USAID’s activities.** USAID/Nigeria needs to encourage greater alignment with the GON program and greater facilitation of programming between the federal, state and LGA levels. In addition there needs to be activities in the private sectors. Every effort must be made to have the recipients see the program as “their” program, and not the program of the specific partners program or of USAID. Better that the recipients see the partner or USAID and helping or supporting their program. Branding has been a issue of owner, so some items three, four or five logos are on even the simplest of items.
- **There is an imbalance between “demand” and “supply” interventions within programs.** Much effort has been devoted to building demand for services, especially through COMPASS at the community levels. In response, the program must be prepared to deliver quality services to meet this growing demand. Access to and availability of information and services needs to be expanded. For quality services, more staff needs to be recruited, posted and trained, and commodities need to reach the “last mile.” Also the private sector services have the potential to expand and increase supply in all areas – information, services, and commodities.
- **Service quality needs vast improvement.** Systems for training and supervision need to be improved. Interpersonal communication (IPC) skills and behavior change communications (BCC) need to be strengthened. Competency based training needs to be encouraged. Updated standards and service guidelines need to be consistently and broadly implemented. Local data analysis and use needs to be systematized to improve the overall system functioning and service quality.
- **There is a great expectation for services to be scaled up to achieve state level coverage.** Given that there is not likely to be to additional funding, the projects will need to prioritize best practices for replication, focus on geographic area coverage, and seek opportunities to leverage funding.

While the team suggests some refinements in the Mission’s health strategy to address these shortcomings, the program as it now stands is generally on the right track. Given the changing environment, a stronger political will to increased funding from a variety of sources in the health sector, there are good indications that positive results will be made in the future.

C. STRATEGIC CONSIDERATIONS FOR THE PRESENT AND FUTURE

1. Refine USAID Health Strategic Framework

USAID/Nigeria's Health Strategic Framework is focused on strengthening community-based demand for and provision of maternal and child health and family planning services, implemented through the public sector with support from the Mission's bilateral mechanisms, primarily the Compass project. Over time the strategy has evolved and expanded to include private sector care through HMOs, hospital based emergency obstetric and newborn services, postpartum family planning, and fistula repair and prevention, all of which are implemented through field support mechanisms: PSP-One, ACCESS and ACQUIRE.

The time is right for the Mission to consolidate the objectives of both bilateral and central mechanisms and support them with a package of essential maternal, newborn, child health, and family planning services that also intersect with the HIV/AIDS and malaria programming.

USAID has an opportunity to both provide leadership / influence in this area, and to strategically align with emerging government priorities for an Integrated Maternal, Newborn and Child Health (IMNCH) approach to reducing maternal and child mortality.

A potential strategic framework for the Mission to consolidate the various program objectives to address specific health impacts might include:

FP Impacts: Decreased TFR, Increased birth intervals, Decreased teen pregnancy

- Increase contraceptive prevalence

MH Impacts: Reduced maternal mortality and maternal morbidity (fistula)

- Increased use of focused antenatal care
- Increased use of skilled birth attendant and facility based births
- Improved number of birth and newborn complications managed at facilities
- Increased number of women receiving fistula repair
- Increased use of postpartum family planning

CH Impacts: Reduced newborn mortality and morbidity, Reduced under 5 mortality

- Increased use of essential and emergency newborn care
- Increased coverage of full immunization
- Increased use of key nutrition practices (EBF, Vitamin A, complementary feeding)

HIV Impact: reduced transmission of HIV

- Increased use of FP by PLHA

2. Develop and Implement an Essential Package of Services

Along with these impacts and objectives are the high impact interventions that contribute most directly to achieving improved health outcomes. Within the expansion of USAID/Nigeria's health portfolio, there is a need for a harmonized, client-centered package of services, including the training materials and BCC messages that should be implemented by the implementing partners (IPs).

While the bilateral projects have jointly developed key IEC messages and materials, they could be updated to incorporate the additional messages to support the activities added to USAID's program through its global project partners.

Using the GON's Integrated Maternal, Newborn and Child Health (IMNCH) strategy as a frame of reference, the Mission together with key stakeholders and its IP, should review the current materials and harmonize an essential package of integrated services that all will use, according to the programmatic interventions they implement. Below is an illustrative integrated package of high impact services. It is organized primarily along a continuum of MNCH services, and includes essential FP, Malaria, Nutrition and HIV/AIDS service interventions and counseling information.

Focused Antenatal Care

Key service delivery/clinical interventions:

- pregnancy history and examination,
- tetanus toxoid immunization,
- malaria prevention: intermittent preventive treatment, insecticide treated bednet
- iron supplementation
- screening and referral/treatment for existing fistula, Sexually Transmitted Infections, HIV

Key counseling information:

- maternal nutrition and self care during pregnancy
- birth plan: deliver with SBA at facility
- plan transportation/finances for rapid response if complications arise
- danger signs of complications requiring action, and what to do/where to go
- preparation and expectations for exclusive breastfeeding (EBF) and Lactational Amenorrhea Method (LAM)
- maternal nutrition and hydration needs while breastfeeding
- fertility desires, healthy spacing of pregnancy and FP methods
- specific counseling for HIV+ pregnant women; refer for prevention of mother to child transmission (PMTCT)

Basic and Comprehensive Emergency Obstetric and Newborn Care – Birth to one week

Key service delivery/clinical interventions:

- Prevention and management of prolonged labor: use of partograph, vacuum delivery, C-Section
- Prevention and management of postpartum hemorrhage: active management of third stage of labor, manual removal of placenta, intravenous fluids, blood transfusion
- Detection and management of pre-eclampsia/eclampsia
- Immediate newborn care: drying, warming, cord care, early and exclusive breastfeeding, kangaroo care for low birth weight babies, immunization
- Postabortion care: uterine evacuation, pain management, FP method of choice
- Prevention of mother to child transmission: Nevirapine
- Detection and early treatment for fistula

- Provision of immediate postpartum FP up to 48 hours after birth (IUD, tubal ligation/sterilization)

Key counseling information birth to one week:

- Care of mother and newborn at home: hygiene, nutrition, cord care, insecticide treated bednets
- Danger signs for return to clinic: fever, bleeding, newborn respiratory, diarrhea
- Exclusive breastfeeding for six months, and its link with LAM, maternal nutrition while breastfeeding
- Breastfeeding for HIV+ mothers; special care of mother and baby; follow-up care and treatment referral
- Follow-up visits for postpartum/postnatal care and immunization

Postpartum Maternal and Child Health Care during the first year after birth

Key service delivery/clinical interventions:

- Immunizations: BCG, Polio, DPT 1, 2, 3, Measles
- Vitamin A
- Family Planning, including LAM, short-acting (pill, injectable), long-acting (IUD, Implants), and permanent methods (tubectomy, vasectomy)
- Screening and referral for fistula repair

Key counseling information:

- Fertility desires and healthy spacing of pregnancy
- LAM and transition to other FP method
- Maternal nutrition during breastfeeding
- Weaning, complementary feeding and child nutrition, breastfeed for 2 years
- Link HIV+ mothers/babies with care and treatment for testing, antiretroviral therapy

3. Integrate Family Planning into key MNCH, Malaria and HIV/AIDS Services

The implementation of an essential package of services is, by its nature, integrated client-centered care. Most health programs - MNCH, Nutrition, FP, Malaria, HIV/AIDS programs – have traditionally been implemented vertically. Integrated services need to be purposefully designed; the content in the training curricula for providers should be fully integrated in both preservice and inservice training so that a client-centered approach becomes the norm; and services at the site must be organized in such a way that it enables a smooth flow of integrated services to be provided. This section provides a brief illustration of where FP interventions can be integrated into MNCH, Malaria and HIV/AIDS programs. Several of the Mission projects are already promoting integration in their activities. GHAIN, for example, has begun piloting the inclusion of FP in some of its HIV program interventions, with a strong focus on pre-pregnancy counseling and services for people living with HIV/AIDS (PLHA). ACCESS, ACQUIRE and COMPASS all promote health talks on child spacing and family planning during ANC sessions, as well as encourage use of skilled birth attendant, emergency obstetric services, and postpartum family planning.

FP integrated into key MNCH interventions

- ANC: FP health talks, including fertility desires, healthy pregnancy spacing, exclusive breastfeeding (EBF), lactational amenorrhea method (LAM), selecting a FP method, especially if an IUD or tubectomy is desired immediately postpartum
- Birth=48 hours: Initiate EBF, counsel on LAM, provide immediate postpartum IUD or tubectomy if desired
- EmONC: Initiate EBF, counsel on LAM, provide immediate postpartum IUD or tubectomy if desired
- Postabortion/miscarriage: Counsel on return to fertility, fertility desires and contraceptive options; provide the FP method of choice
- PPC/PNC: Support EBF/LAM and transition to another method, counsel on return to fertility, fertility desires and contraceptive options, provide FP method of choice
- Immunization: Support EBF/LAM (if less than 6 months) and transition to another method, counsel on return to fertility, fertility desires and contraceptive options, provide FP method of choice
- Child Health/Nutrition: Support EBF/LAM (if less than 6 months) and transition to another method, counsel on return to fertility, fertility desires and contraceptive options, provide FP method of choice

FP integrated into key HIV/AIDS interventions

- Counseling and Testing: FP counseling and services; prevent unintended pregnancy
- PMTCT: Support EBF/LAM and transition to another method; counsel on fertility desires and healthy spacing of pregnancy; provide FP method of choice
- Care and Treatment: FP counseling and services; fertility desires and healthy spacing of pregnancy
- Orphans and Vulnerable Children: Youth friendly services, FP, condoms/dual protection, healthy timing (delay age) of pregnancy

FP integrated into Malaria interventions

- Insecticide Treated Nets: Social marketing of FP along with insecticide treated bednets, distribution of FP information (cards, sources of services)
- Intermittent Preventive Therapy: Counsel on healthy spacing of pregnancy and FP when providing Intermittent Preventive Therapy during ANC (see ANC above)
- Indoor Residual Spraying: Hold group health talks about child care and spacing, provide FP information cards

Recommendation: The Mission should determine priorities for integrating FP with essential MNCH and HIV/AIDS interventions and align all implementing partners to focus on aspects of an essential integrated package of services.

D. OPERATIONAL CONSIDERATIONS

1. Expand access and availability

There are several dimensions to expanding access for family planning, including *access* to information, a broader method mix of contraceptives, alternative service delivery points, and to populations most in need. Evidence has shown that increasing access in these areas leads to an increased uptake of family planning. The most important factors for increasing access to maternal health care and newborn care are the *availability* and proximity of skilled providers and facilities, and the affordability of basic and emergency obstetric care services, including transportation.

The current Mission program is making great strides in expanding access to and availability of FP and MNCH services in the project areas. Through COMPASS, efforts to increase access are generally directed to the population as a whole and toward upgraded government service sites. Through IRHIN and PSP-One, inroads are being made to expand private sector access through patent medicine vendors, the National Health Insurance Scheme and health maintenance organizations. Through the ACCESS and ACQUIRE projects, women have increased access to skilled MNH care, fistula repair, and family planning services. COMPASS, ACCESS and ACQUIRE are encouraging male involvement in their programs, while other donor programs are focusing on reaching youth (Packard) and postabortion (IPAS) clients with reproductive health and family planning services. Some actions for USAID/Nigeria to consider for expanding access to FP include:

- Enhance access to information through BCC strategies that incorporate mass media approaches through radio, TV, hotlines, etc., as well as the community mobilization and interpersonal counseling and communication approaches
- Explore opportunities and expand private sector provision of information and services, such as through community-based distribution, social marketing of products and service delivery outlets, and distribute IEC materials and contraceptives through patent-medicine vendors and private providers
- Expand the method mix of contraceptives to offer more choices. Include the natural family planning methods, LAM and SDM, as these are often gateways to the use of other modern methods. Offer long-acting methods, IUD and implants, and market their appropriateness for a wide range of women (youth wishing to delay pregnancy, women wishing to space their next pregnancy, women who have reached their desired family size, women who are HIV positive and healthy).
- Coordinate with other donors and private pharmaceuticals to provide implants, CuT and Merena IUDs and other contraceptives for public and private distribution
- Work with health insurance programs and HMOs to ensure that the essential package of MNCH and FP services are covered
- Strengthen policy and advocacy at the State and LGA levels for free maternity care, including C-Section, at government hospitals and health centers
- Design programs and expand services to address the special needs of married and unmarried youth for contraceptives, HIV prevention, and essential MNCH services.

- Integrate FP with HIV/AIDS programs to ensure that FP counseling is provided and services are offered to those coming for counseling and testing, those living with HIV/AIDS, those on ARVs, and all HIV+ pregnant and postpartum women.

Recommendation: The Mission should identify and target a variety of approaches for increasing access to and availability of information and services for FP and MNCH.

2. Respond to the need for human resources: balance the supply side with the increasing demand for quality services

USAID/Nigeria's implementing partners are making significant progress in raising awareness, educating communities, and increasing demand for FP and MNCH services. However, most facilities lack the skilled staff and essential commodities – medications, equipment, supplies – necessary to provide the full range of quality MNCH and FP services.

The health care system is faced with a critical shortage of human resources for health (HRH) among all cadres – physicians, midwives and nurses. Community Health Extension Workers (CHEWs) are the principal cadre of providers at PHC centers and many general hospitals. Efforts are underway by USAID partners and other donors to provide inservice training to CHEWs in maternal and newborn Life Saving Skills (LSS), as well as in family planning. ACCESS is beginning to provide support to preservice education at the newly opening nursing and midwifery school in Zamfara.

Of considerable concern is the inability of the health care system to respond to the increased demand being generated through the various IEC and BCC interventions. Health education messages promote antenatal visits, birth at a facility and/or with a skilled provider, while community mobilization activities work with villages to be prepared to respond quickly to emergencies.

The current production of skilled health care workers falls far short of the need. Kano State, with its population of 10 million people, has only one midwifery school that graduates an average of 50 students per year. The graduates are not required to remain in Kano to work. This year the National Youth Service Corps will place approximately 800 midwives and 100 physicians throughout the country for a one-year posting. While this will help to provide some relief, it does not begin to approach the numbers of skilled providers that are needed to significantly impact on maternal and newborn mortality. The adage of 'no product, no program' applies equally to the shortage of healthcare workers 'no provider, no program'. Some activities that The Mission could consider undertaking include:

- Commission an assessment, or a consolidated review of existing assessments, of the human resources for health situation that presents options to the government and to USAID for the way forward.
- Identify tasks that can be shifted to other cadres of providers and build their capacity to perform them.

- Advocate, along with other donors, for greater use of alternate cadres of health workers to perform essential MNCH and FP services such as physician assistants or clinical officers performing C Sections, community based distribution of contraceptives including injectables, anti-malarials, and other home-based therapies
- Support pilot test, if needed, for training and qualification of alternative cadre(s) of providers
- Support and strengthen pre-service education of midwives, and alternate cadres, by strengthening the curricula for competency-based training, building teaching and clinical capacity of faculty and preceptors, and ensuring that staff at clinical practice sites are trained and performing to standard
- Upgrade CHEWs with midwifery and family planning skills
- Strengthen supervision of the service delivery skill of the alternate cadre to ensure that they are performing to competence

Recommendation: The Mission should focus on balancing the supply side needs for skilled healthcare providers with the demand that is generated through the behavior change and community mobilization strategies.

3. Improve the quality of care

It is incumbent upon the health care system to ensure that client expectations for quality of care are being met. It is exciting to see community mobilization activities renovating facilities and breaking down local barriers to access so that more women can deliver in facilities and to bring their children for care and immunization. However, if the quality of services fails to meet the expectations that are being generated, community members may well lose confidence and stop utilizing the services.

Improving quality of care draws upon several systems, the most critical of these being training, supervision, logistics, data monitoring, and quality improvement. Together they contribute to improving the performance of managers, staff, and systems at the facilities. While improved quality begins with defining the standards for care, the heart of quality improvement is through the use of data. This applies equally to monitoring provider performance and quality of care to clients, as well as monitoring the performance and functioning of these essential systems.

Managers, trainers and supervisors should all be guided by standards for their own performance, which may include modeling desired behaviors, providing constructive feedback, and motivating all workers to be high performing and meet the standards for their own positions. This is just as important for non-clinical staff, such as cleaners and guards, as it is for clinical providers, supervisors and managers. The Youth Friendly Services project⁵ has initiated Interpersonal Counseling and Communication (IPC) training for all personnel. Staff who are friendly, make clients feel welcome, keep the facility clean, and provide quality care, build the confidence of clients in the services offered at the facility.

⁵ The Youth Friendly Services program “Listen UP” is implemented by Johns Hopkins University Center for Communication Programs (JHU/CCP) with funding from the Packard Foundation.

Any number of approaches can be used to improve quality of care and the performance of essential systems including: self assessments, staff meetings to review performance data from the facility, quality improvement collaboration among like facilities, peer review, accreditation, internal and external facilitative supervision. In general, while there is little evidence of a systematic approach being applied through the projects to improve provider and system performance and quality of care, each of the projects is addressing performance/quality improvement in some way.

The COMPASS project has initiated Quality Improvement Teams (QIT) for health facilities and schools. These community-based health QITs have identified and addressed several important quality improvements at facilities, primarily related to the physical infrastructure such as building latrines, providing roofs and benches for waiting areas, painting and renovating, and securing water and electricity. The ACCESS and COMPASS projects have introduced basic and emergency obstetric care standards and protocols for hospitals and health centers, and ACCESS is introducing a Standards Based Management (SBM) approach for ensuring that the standards are being implemented in the sites they are supporting. The DELIVER and COMPASS projects have introduced a process for monitoring the contraceptive logistic management system based on the streamlined processes and forms, although each project supports parallel supervision and monitoring independent of the other in their respective LGAs – this system could be further strengthened if the State reviewed performance data with all LGAs, and with DELIVER and COMPASS, until the system takes hold. To strengthen the performance and quality of systems and services, The Mission may want to consider some of the following:

- Define performance standards for key systems, especially training, supervision, logistics, data management, and quality improvement
- Systematize and formalize approaches for on-site collection, analysis and review of data on the performance of system functioning and the quality of care
- Encourage a ‘collaborative’ approach to bring managers and providers of several facilities together to address a common goal, monitor progress toward that goal, and share lessons learned.
- Integrate interpersonal communication and counseling skills into the preservice and inservice training courses for providers, trainers, supervisors and managers

Recommendation: The Mission should ensure that all projects work with their counterpart organizations/institutions to put in place an approach to systematically review standards and monitor their progress toward improving system performance and quality of care

4. Ensure the availability of essential commodities and supplies

A critical aspect for expanding access to FP requires ensuring a reliable supply of contraceptives and essential supplies through both the public sector and the private sector. Currently SFH is capably managing the distribution of contraceptives, mainly pills, condoms and injectables, to private pharmacies and patent medicine vendors. This system of warehousing, ordering and distribution seems to flow smoothly, with little disruption to the supply chain.

In the public sector, the government has five different logistic management systems for essential drugs, contraceptives, TB, HIV/AIDS, and labs. Because these were introduced through vertical programs, they are housed in different parts of the Federal Ministry of Health (FMOH). Although the FMOH would like to integrate them, each logistics chain has inherent weaknesses such that no one system is strong enough for the others to be integrated into.

The Contraceptive Logistic Management System (CLMS) is housed in the Family Health Division of the FMOH. Contraceptives for the public sector are procured by DfID and Candain International Development Agency (CIDA) and go to the central stores at the national level. They are allocated to the states based on their requisition, and transported to all but three states with assistance from UNFPA. The remaining three states are assisted by the DELIVER project, where a pilot project was undertaken to streamline the CLMS that has been implemented by FMOH and UNFPA. Seed stock was provided in the pilot areas ensured that the streamlined system could be appropriately demonstrated. Results of the pilot demonstrated that the new system is both feasible and effective in reducing paperwork and updating requisitioning based on consumption data. A decision was reached to roll out the streamlined CLMS in all states. According to feedback from one of the COMPASS program managers “once the contraceptives started flowing, contraceptive prevalence really went up!”

However, two aspects of the CLMS still require further attention if the system is to function appropriately, namely the transportation (pick-up/delivery) of contraceptives between national and state, state and LGA, and LGA, and the supervision of the system to review the correct implementation of requisitioning and inventory management. Currently these functions are being supported through the project budgets rather than by the government through its budget allocation. If the streamlined system is to take hold, DELIVER, UNFPA, FMOH, SMOH, and LGAs must address these issues. Moving forward, the Mission might consider some of the following:

- Follow up on the findings and recommendations from Contraceptive Security workshop with FMOH, SMOH, UNFPA, DFID
- Strengthen the CLMS to better inform the FMOH and its donors with data upon which to base the procurement of contraceptives and supplies
- Expand the method mix to make more methods available to clients
- Within the CLMS, package consumable supply “kits” for LAPMs, especially the IUD
- Investigate the feasibility of merging/integrating CLMS with the other systems and strengthening the entire drug/commodity logistic system for the country. This may be an opportune time to approach this discussion with the government as new leadership in the FMOH may be receptive to a new approach
- Investigate the feasibility of establishing a para-statal or private sector entity to take over the distribution and management of the CLMS

Recommendation: The Mission should work with stakeholders to strengthen the current CLMS to ensure the availability of contraceptives, while at the same time investigate the feasibility of alternative approaches for managing the requisitioning, procurement, distribution, and inventory to ensure wide availability of contraceptives.

E. PROGRAMMING FOR MAXIMUM RESULTS AND LASTING IMPACT

1. Develop a master operational plan with a corresponding performance monitoring plan for the entire USAID health program

As noted above, the current USAID health strategy applies mostly to its bilateral programs and over the past year several central and field support mechanisms have been added to the health portfolio. So that all partners are “singing from the same sheet of music,” USAID may want a clearer conceptual framework and plan that aligns all Mission resources around the Mission Operational Plan. This will allow USAID to organize work plans around one overall strategy and *frame* the USAID program in a cohesive and meaningful manner, with each implementing partner knowing its role. Additionally, it will allow USAID to better identify gaps and avoid duplication among the existing partners.

Annually, USAID should require that all implementing partners developed their work plans against the master operational plan. Project level results should be measured against an overall Performance Monitoring Plan (PMP). Even though the operational plan may require standard performance reporting, it can also look at how each IP contributes to the overall achievement of goals. This process will allow USAID to be in the driver’s seat and coordinate the whole program and will provide a framework for stronger oversight of the projects from design to implementation to completion. Using this tool, USAID can and should set the priorities and tone for the health portfolio and establish clear operational expectations not only with the project partners but the host-country stakeholders.

Furthermore, program coordination between the various IPs needs improvement. The master plan could aid in this coordination. There are already some successes with projects linking activities for better results, for example: integrating family planning messages into antenatal care; linking communities with appropriate services; promoting best practices across the various programs; linking basic emergency obstetric care at community level with comprehensive programs at the facility level. But a more concerted coordination action is needed to facilitate and build synergies between the various project elements. Coordination could also produce some program efficiencies if duplication of effort is minimized.

Developing a cohesive PMP to interface with the master operational plan is essential. One of the current concerns is that the program has focused primarily on LGA level results. This is a result of programming at the LGA/community level, rather than programming for state-wide impact. Recent collection of indicators, as required by the Agency Operational Plan, has resulted in additional data being collected, especially for inputs and outputs rather than outcomes. This has confused implementing partners who work collaboratively and are often measuring the same indicators in the same places. A PMP based on the master operational plan could help alleviate some of the issues between the partners by keeping clear who is supposed to do what.

Specific actions leading to actualizing a master plan with a corresponding performance monitoring plan might include:

- Articulate precisely and set the tone and expectations for program actions and implementation in a master operation.
- Hold an annual planning meeting with all implementing partners to coordinate separate work plans against the master plan.
- Identify potential areas of synergy and cross fertilization between partners and maximize, also identify areas of possible duplication and minimize.
- Consider joint programming of specific project activities that are clearly mutually beneficial.
- Develop a comprehensive and cohesive PMP to which both bilateral and field supported IPs contributes.
- Devise practical means to monitor activities on a quarterly or biannual basis.
- Use IP work plans to document successes and identify problems early.

Recommendation: The Mission should develop a clear conceptual framework and develop a master plan for implementation and performance monitoring. Through this process USAID should set the tone, the standards, and expectations for implementation and results.

2. Respond to health needs for program interventions

USAID health program is currently geared to northern Nigeria. This is the right approach as the need for FP, MNCH and HIV/AIDS is greatest in this region, especially in the North East and North West. The key health indicators in northern Nigeria are most alarming and among the worst in the World. Noted below from the 2003 DHS are indicators for the north east and north west respectively.

7.0 - 6.7	Total fertility rate (North East/North West respectively)
260 - 269	Under-five mortality
20 - 12	Percent assisted by doctor, nurse or midwife at delivery
4 - 5	Percent currently using any contraceptive method
18 - 11	Percent of unmet need for family planning
6 - 4	Percent of children 12-23 months fully immunized
33 - 43	Percent children under 5 who are under weight

By directing the significant USAID health interventions to this region most in need it is probable that significant advances can be made. Also, it should be noted that the North represents close to 50% of the population of Nigeria. In choosing between states in Nigeria for USAID health program support, northern Nigeria is the place to spend the development dollars.

- Confirm the priority for continuing USAID/Nigeria's primary geographic focus on northern Nigeria in the next Strategy cycle for the health program.
- In reviewing plans for the 2008 Demographic and Health Survey request additional analysis of northern region to better design programs to meet the needs in the north.

Recommendation: Given the desperate need and high potential for return on investment, USAID should continue focusing its health program in northern Nigeria.

3. Build Nigerian ownership

Currently the USAID health program writ large and specific project activities are not really owned by the Nigerians. Often in discussions the stakeholders often referred to the program as USAID's program or a specific project's program (i.e., COMPASS, ACCESS, ACQUIRE, IRHIN, etc.). All materials are labeled with the USAID logo as well as the IP logo, in addition to the government logo. This often creates confusion among local implementers over whether these are government materials or project materials – again begging the question, ‘Whose program is it anyway?’ Several government officials acknowledged the value of USAID's program but seemed to perceive it as a program in and of itself, in part because USAID funding does not go into the government's “basket.” This being said, the USAID health team and the project IPs do take significant time to negotiate project activities, locations, and inputs with the stakeholders and beneficiaries. An additional aspect to these negotiations might be to provide the States/LGAs with the idea that it is not USAID's or the IPs program but to one USAID and the IPs will contribute.

- Support and strengthen the Federal and State levels to articulate a clear and comprehensive technical policies and strategies
- Assist the decentralization of Federal policies and strategies to the State and LGA levels
- Set the tone when talking about the program, that this is a Nigerian program and that USAID and IPs are here to contribute support to both public and private sectors
- Simplify the branding to reduce confusion so that it won't diminish the Nigerian ownership of the program
- Hold regular meetings with Federal, State and LGA officials to develop joint work plans and review progress and contributions of the projects toward the government's program

Recommendation: The Mission and partners should align with Nigerian health policies and strategies at both the public and private sector, and plan and manage program activities to be seen as supportive to the national effort not as programs in and of themselves.

4. Expand FP and MNCH Activities in the Private Sector

Increasingly evidence is showing that in Nigeria there are limits to focusing exclusively on the public sector as a means of improving health status, and especially for achieving RH/FP goals. With very little funding and the provision of contraceptives, The Mission is supporting private sector activities through IRHIN, PSP-One, and Banking on Health. The SFH has successfully led the social marketing of contraceptives and other health products, including the launch of a pilot training of private providers to insert Jadelle. PSP-One has included “wellness” training and MCH services in the practices of private providers working with HMOs under the National Health Insurance Scheme. Through the Banking on Health project, USAID now sponsors a pilot program to increase access to credit with management training for private providers that are

capable of offering FP/MCHN services in their private practices. Last year, these private sector efforts provided over 70 percent of the Mission's annual measure of couple years of contraception protection.

In the summer of 2006, USAID/Nigeria commissioned PSP-One to conduct an assessment of the potential of private sector to provide FP/MNCH services. The purpose of the assessment was to identify barriers that prevent private sector participation and to identify concrete ways for USAID to engage the private sector in the delivery of FP/MNCH services. Given the importance of the national insurance program, the PSP-One team took a close look at potential impact for the NHIS activities, and the opportunities and risks associated with the NHIS. For ease in reference, the key findings of the assessment are quoted below:

- Although a large portion of the population is going to the private sector and consumers are paying a high out of pocket share of expenditures, much of the expense is going for low-quality products and services. Too little regulation is being enforced to ensure minimum quality standards.
- In spite of the large population, the market for RH/FP services is in a market building stage. Interventions which link supply to demand creation will produce the best results. Work can be done to increase the quality and quantity of private sector providers, but it should be done in targeted areas/with targeted groups where demand is established and growing.
- Although there are trained providers (doctors, nurses/midwives and pharmacists), they are not being used to open their own private practices. The main barriers are: a) poor infrastructure, b) no access to credit and c) unfair competition with unregulated, less skilled providers. The nurse midwife practices are further constrained by the requirement for physician supervision.
- The NHIS is a well-designed plan which could have huge potential for encouraging higher quality practices among private providers, increasing consumers' financial access to services, and in pooling risk across a wider share of the population. That said, there are huge challenges in getting providers and consumers to understand how the scheme works as well as providing the necessary training to providers, HMOs, insurance regulators and enrollees.

The PSP-One assessment team identified definite and concrete suggestions for expanding FP and MNCH services through the private sector. All of the recommendations should be carefully reviewed and those considered most feasible and viable should be further developed for possible implementation. Given the relative success of the private sector program to date and the positive findings and recommendations of the private sector assessment, The Mission may want to reassess its current portfolio and consider increasing the proportion of its resource allocation for private sector FP/MNCH activities.

One word of caution would be that the current family planning activities mostly focuses on short term and temporary methods (oral contraceptives, condoms, and injectables). To increase the

impact and sustainability of the FP activities, it is suggested that any expansion of private program incorporate the provision of long-acting and permanent methods (mainly, intra-uterine devices and implants) and quality improvements in the delivery of private FP services. The private sector approach might also provide an excellent opportunity to introduce and/or expand focused antenatal care, basic and comprehensive emergency obstetric and newborn care, postpartum maternal and child care, including FP, during the first year after birth.

Options which might be considered to strengthen and expand USAID's involvement with the private sector include the following:

- Consider expanding current USAID-funding or secure funding from other donors for FP and MNCH activities in the private sector, such as: social marketing programs, HMO and NHIS programs; the banking credit program; and after review and assessment, replicating or scaling up any successes of the Jadelle pilot program.
- Re-review the findings and recommendations of the PSP-One Assessment, including specific recommendations on how to enhance the NHIS programs such as: conducting advocacy for greater coverage of RH/FP and MNCH services under the NHIS; extending family planning promotion and supply efforts to HMO members and enrollees; working with the NHIS and HMOs to improve quality assurance and quality assessments for NHIS accreditation.
- Support existing demand creation strategies and coordinate with supply side interventions through the existing private sector.
- Further explore non-governmental and faith-based organizations as potential RH/FP and MNCH service delivery channels.
- Design and implement a pharmacy network pilot to test and evaluate *new* strategies for increasing quality and access to health pharmaceutical products and contraceptives.

Recommendation: The Mission should reassess its current portfolio and consider increasing the proportion of its resource allocation for the private sector to expand RH/FP and MNCH activities.

5. Go deep, not wide with the FP/MNCH program

The USAID bilateral programs especially, COMPASS, have been extremely effective in mobilizing communities and building demand. COMPASS has made progress in improving health services through training personnel, upgrading and equipping facilities, and developing job aides, counseling tools and other educational materials. ENHANSE has facilitated advocacy at the state and national levels. The private sector program, through IHRIN and PSP-One, has made great in-roads in working through the pharmacies, patent medicine vendors, and HMOs and other private institutions. Several of the field support activities (ACCESS for Emergency Obstetric and Newborn Care and ACQUIRE for fistula repair and prevention) have just begun to make impressive in roads but are still in the nascent stages. While tremendous progress has been made, the program is still fragile and much remains to be done.

The various approaches have generally worked from the aspect of piloting, inventory-building and gaining experience. As discussed in detail in the previous section, the Mission should now

prioritize program content and concentrate focus on selected applications that focused on best practices and proven interventions and integration of program activities that have the greatest potential to be effective, provide return on the investment, and contribute significantly to program impact.

A concerted effort needs to be made to focus and avoid being “spread too thin.” To achieve this, the team recommends taking a system strengthening approach. The operative word here is *system*. Those areas that are particularly conducive to this approach include: using data for planning and decision making; training, supervision and staff development; quality assurance; and logistics management. A clear vision of a process or pathway to programming will be helpful to understanding the precise interventions and conditions that will enable the achievement of maximum results. In fact, it has been demonstrated that the convergence of a system strengthening approach with clearly defined outcomes for technical interventions yields sustained and institutionalized results. To get there, activities might include:

- Focus on a systems approach integrated with the clear identification of technical areas to yield maximum results and achieve institutionalization and sustainability
- Narrow program focus to an essential package of high impact interventions, direct interventions to target populations
- Identify and implement areas that can make the program more effective and efficient.
- Identify those program interventions that have the potential for replication and scale up.
- Ensure that the performance monitoring plan captures the depth of the program to capture outcomes and not just on program inputs and outputs.
- Focus on institutionalization and long term sustainability.
- Identify the “next generation” and build leadership for program planning, implementation and evaluation.

Recommendation: The Mission and its partners should move to prioritize, focus and systematize those interventions that have the greatest potential for impact, replication, scale-up and impact.

6. Look for innovative opportunities for cross-sectoral involvement

The underlying factors that influence health are often multi-sectoral in nature. In order to be most effective, program interventions can be integrated and coordinated within wider development activities. Within the current health portfolio of activities, there are numerous examples of cross-sectoral programming that already exist:

- **Democracy and Governance:** Civil society is being strengthened in the health programs in a number of ways: extensive community mobilization resulting in community decision making regarding the access and availability of health services in the community; involvement of the community leaders in quality improvement teams to demand and support quality health and social services; development of health mutual organizations to provide financial support and at the same time involve the consumer in decision making regarding the financial support package.

- **Economic Growth:** Vocational training at the fistula center in collaboration with the Department of Labor and Employment; use of micro-enterprises to sell of health commodities (contraceptives, bednets, water purification supplies); corporate support for vocational and work programs for women rehabilitating from fistula; development of banking mechanisms to support the financing of health providers and services.
- **Women in Development:** Use of the Ministry of Womens’ Affairs for advocacy and sponsorship of the fistula centers; work with women’s groups to promote FP and MNCH services; integration of health education programs and referral to services for women in employment and literacy programs sponsored by the Ministry of Women.
- **Education:** The teaching of health and nutrition lessons in school programs. Messages in health centers convey the importance of staying in school and educating girls.

These types of cross cutting synergies should be encouraged and promising opportunities further explored. However, it must be noted that for optimal results, work responsibilities should be co-supported by the various sectors involved in regard to purposeful programming, joint funding and shared work responsibilities. Specific actions that might be taken include:

- Take a full inventory of cross-sectoral activities within the current health portfolio.
- Document cross-fertilization of programs and the synergies that have resulted in greater results.
- Meet with USAID staff in other sectors to explore potential for additional cross sectoral programming.
- Explore options for bringing democracy and governance activities from awareness raising and fundraising to also include “voice and choice,” program transparency, accountability, and “watch dogging” for better results
- Consider joint programming of appropriate activities.
- Encourage partners to document cross-sectoral activities and expand where appropriate and feasible.

Recommendation: The Mission and its partners should continue to seek innovative and promising opportunities for cross-sectoral synergy and wider involvement of project activities.

7. Expand alliance building and leveraging of resources for scale-up

USAID/Nigeria, with meager resources for a country of this population size, cannot expect to achieve significant state, regional or national impact by itself. The Mission has steadily built partnerships with the government, other donors and the private sector and successfully leveraged actual funding. Alliance-building and leveraging should be one of The Mission core operating principles to enable country scale-up for maximum impact. USAID can play a leadership role by providing models, testing new innovations and showing the way.

Large scale replication may depend on USAID’s ability to leverage and mobilize resources. Fortunately, USAID does have some potential funding sources to leverage such as Nigerian

Millennium Development Fund, PEPFER, and the Global Fund. USAID can also broker, coordinate and do joint programming with other bilateral programs (e.g. DFID, GTZ), and multilateral programs (e.g., UNFPA, UNICEF, UNAIDS, WHO). Nigeria is also lucky to have a number of major private foundations working in Nigeria, such as the Packard, MacArthur, and Clinton Foundations. Multi-national oil companies who have worked successfully in other countries through the Global Development Alliance are in Nigeria such as Exxon, Mobil and Shell. Finally, there are a number of international and national non-governmental organizations that have contributed to health programs such as Rotary, Lions, as well as international and national business organizations, such as MTN and GLO. To build alliances and leverage resources, the Mission might want to:

- Develop an inventory of potential allies in the health sector, as well institutions that may be sources for funding or joint funding.
- Attend and take a leadership role in donor coordination meetings to advocate for specific program interventions, to introduce specific models that should be replicated, and to share positive results of specific interventions.
- Seek technical assistance from USAID/Washington and other cooperating agencies who have worked in alliance building and resource development.
- Develop a plan of action for systematic alliance building.
- Develop a plan to secure additional resources for the worthy activities of the national program.
- Develop a substantive plan of action to leveraging of funds from such sources as the Global Fund, US President Initiatives, the Nigerian Millennium Development Goals Account, Foundations and Multinational corporations.

Recommendation: The Mission should actively and systematically leverage other sources of funds and build alliances with other stakeholders in the country in order to secure support and monies for the Nigerian Health Programs.

F. USAID MANAGEMENT ISSUES

1. Keep program collaboration and coordination front and center

The USAID Health Program, through its implementing partners—both bilateral and field support funded—conduct a variety of critical functions to provide strategic direction, technical expertise, and monetary support to a wide variety of organizations. The overall health program is complicated and involves an incredible numbers of collaborating organizations. In addition, the program interfaces with the Government of Nigeria at the national, state, and local government levels involving a number of Ministries (Health, Local Governments, Women’s Affairs) The USAID program also works through a variety of non-governmental and private sectors channels, service providers and managers. The program interfaces with multi-lateral (i.e., UNICEF, UNFPA, WHO, UNAIDS,), bilateral donors (i.e., British, German, Canadian) and international professional and voluntary organizations (i.e., medical, midwifery, nursing associations).

Needless to say, the success of the health program depends on the ability of USAID and its implementing partners to manage this complex array of relationships. If planned and coordinated, efforts among partners and stakeholders can be much more powerful than ad-hoc collaboration. The Mission and partners needs to utilize every possible avenue to keep communication and coordination lines fully open with its implementing partners through their collaborative networks. Some practical actions to this end could include:

Project Level:

- Develop and formalize a communication plan that systematically keeps partners and stakeholders fully informed.
- Formalize and exchange annual plans, work plans, trips reports, technical reports, special reports, and materials developed by each partner.
- Hold regular meetings of the implementing partners and stakeholders to: provide a definite channel of communications; keep everyone informed of changing policies and programs; exchange ideas and thoughts on program implementations and evolution; and harmonize approaches and coordinate actions. To reduce the burden on the Mission, responsibility for organizing and hosting the meetings could be rotated among implementing partners.
- Hold special technical meetings among relevant partners to do strategic planning, share information, and harmonize specific technical interventions and implementation among partners. This would offer a chance for innovation, information sharing, and coordination

Donor and Country Level:

- Use the offices of the Mission to motivate, facilitate, and develop bilateral, embassy and USG support for program activities and interventions with other donors and the government.
- Continue to participate actively in government coordination efforts, take a leadership seat at the table.
- Continue to participate in donor forum meetings and host meetings, as appropriate.

- Conduct activity-specific meetings with other donors to coordinate, share information, and do joint programming.
- Encourage joint programming and funding by partners and donors in order to: maximize current technical thinking; integrate various points of view and approaches; identify possible points of collaboration; develop and activate relationships among the actors and networks of the various program implementers.

Recommendation: Mission and partners should increase its use of all available coordination mechanisms to develop, facilitate and sustain productive relationships which encourage collaboration and harmonization.

2. Balance staff with the demands of the tasks ahead

Currently the health office is understaffed for the work it does and is certainly not staffed for the tremendous tasks ahead. Within 7-9 months the current Health Team leader will be departing. In addition, there are two vacant positions that must be filled. The next 12-18 months will bring a wave of additional activities, for example: project management and problem solving; analysis and planning for health sector activities as part of the new procurements; development of necessary procurement documents; close-out of project and field support agreements requiring attention; sector planning for the new USAID/Nigeria strategy.

This report, while suggesting that the Mission focus and concentrate, also recommends some expansion of duties (i.e., developing a conceptual framework and performance monitoring program for the plan and stepping up coordination with all bilateral and field support, expanding its role in leveraging funding, increasing coordination and collaboration, documenting more, keeping a visible presence in Washington, etc.). In order to ensure that there are sufficient numbers of staffers with the right qualifications to conduct business and to carry out the functions of the office, there should be an in-house task analysis and management assessment to:

- Assess if the staffing numbers are adequate for the tasks at hand.
- Proceed with haste to find replacement for departing Team Leader. The position should be sparred at a FS-1 to attract the level and experience that is needed to provide technical and management leadership required of the position.
- Proceed immediately with hiring of currently vacant positions
- Continue with team building, and given staff changes, determine if roles and responsibilities of staff remain appropriate and division of labor equitable.
- Determine if some roles can be delegated to the implementing partners.
- Examine the empowerment of the staff, and whether they have the support, latitude, tools and skills to do the expected work to plan, manage and evaluate the program.
- Assess whether there are career development plans to ensure professional and personal growth of employees that can lead to job retention and satisfaction.

Recommendation: The Mission should assess personnel requirements for its Health Office and decide if the structure is configured appropriately to assure that staff has authority, support and means to carry out their duties to maximally achieve results and if any duties can be delegated to the IPs.

3. Stay visible and make the health program successes known to Washington

Washington has been extremely conservative in resource allocation to Nigeria for health programming. Nigeria has 145 million inhabitants and it represents 10% of the world's maternal mortality deaths, yet it gets the same allocation as some other less significant countries which are the size of just one state of Nigeria. There also appears to be phobia regarding Nigeria-- with false impressions that Nigeria is oil-rich (per capita it is not), that it is fraught with graft and corruption, and that it is a "rat hole" for development funds. These are myths that need to be corrected. These false perceptions can impact on standing, prestige, money and access to headquarters resources. While there is an acknowledgement by headquarters that Nigeria plays an important role, the significance and the achievements of the health programs are not always fully appreciated.

It is therefore incumbent on the Mission and partners to tell their stories and make sure that the program is fully understood and its successes are well-recognized. Specifically the Mission should document, with evidence-based precision, the success and impact of the health program. Go beyond in performance reporting, to not just give numbers, but to explain the significance of activities; pro-actively disseminate unique results; and develop and target messages to appropriate audiences on specific issues. In order to do this, some concrete actions could be:

- Educate the members of the Global Health and Africa Bureau country teams so they are knowledgeable advocates in Washington. Invite members to participate in Nigeria planning and programmatic events so that they can see first hand the work of the Nigeria program. Continue routine conference calls with the country team members so those who are most interested stay engaged with the program on a regular basis.
- Write special news articles for Frontlines on noteworthy activities, particularly those of high priority interest (Obstetric Fistula, FP integration with MNCH and HIV/AIDs, dynamic community mobilization, etc.).
- Send in reporting cables (or emails) that can be used in the weekly reports to the Administrator of the Front Offices of the Africa Bureau and Global Health and highlight those successes in the program.
- Provide material and success stories for any Congressional Report (i.e., the OGAC's Annual AIDS Report, the Child Survival and Health Report, the Agency Annual Performance Report, Fistula Briefing Updates).
- Target implementing partner newsletters, lessons learned, and other dissemination material *to groups that care or are technically involved* with the subject matter (i.e., country teams, desk officers, Africa Bureau special committees, country teams, Global Health working groups, and specific technical offices such as the Office of the AIDS Coordinator, the Global Health Offices HIV/AIDs, Population and Reproductive Health, and Health).
- For country-related activities, get to know the people who carry out Public Affairs for the Embassy and assist them by writing new releases for submission through State Channels. Get to know, up close and personal, the Legislative and Public Affairs "communication reporters" for the Africa Bureau, Global Health and the Office of the AIDS Coordinator whose job is to supply good stories for public consumption.

- When passing through Washington, field staff should make rounds and give brown bag presentations to inform the regional program constituency of recent activities. Ask for their help in communicating the good work of the Mission.

Recommendation: The Mission and partners should be proactive in reporting to Washington the value, significance and successes of the program and to develop strong advocates in Washington for the Nigerian program.

G. DESIGN ISSUES FOR NEW FOLLOW-ON HEALTH ACTIVITIES

The current bilateral projects (COMPASS, EHANSE AND IRHIN) will expire in 2009. For any follow-on activity, especially procurements, the Mission will need to define issues and make decisions regarding the scope, technical approach, mechanisms, project life cycle, and budget levels. In addition, the Mission must develop a strategy to involve stakeholders and beneficiaries in a transparent and participatory fashion in order to gain critical information and perspectives and to obtain stakeholder ownership of the process. Some of the stakeholders that should be included in the dialogue include:

- Government: national, state, and LGA officials
- Public and private service providers, managers, and clients
- Traditional, community and religious leaders
- Multilaterals donors – Global Fund, WHO, UNICEF, UNFPA, and UNAIDS representatives
- Bilaterals - DfID, GTZ, CIDA, JICA representatives
- Foundations – Representatives from KfW, Packard, Gates, Clinton, MacArthur, MTN, GLO representative
- Corporations – Officials from pharmaceutical, oil, communications and construction companies
- Professional organizations and affiliates – professionals from medical association, nursing / midwifery associations, pharmacists, credentialing/continuing medical education board leaders
- Nongovernmental, faith based and community based organizations.
- Universities, researchers
- USAID resources: Bureau for Global Health, Africa Bureau, Global Development Alliance resources.

Several of the specific design questions/issues that will need to be answered include:

- **Will the primary obligation instrument be via a contract, a cooperative agreement or a grant?** The health team with the contracting and program officers should explore the advantages and disadvantages of each instrument.
- **What will be the easiest and most feasible procurement mechanisms?** Some options include:
 - Extend the current bilateral programs (COMPASS, IRHIN) for another two years
 - A single, large bilateral that includes all program components. This might be an award to one prime with subcontractors or a consortium
 - Multiple bilateral awards. This might be states –or- topics –or- by levels –or- by combination
 - Field support through central or regional mechanisms
 - A mix of bilateral supplemented by central or regional mechanisms (bilateral for major activities with regional and central for specialty activities)
 - Combine FP/MNCH with HIV/AIDS or other health procurements

Worldwide experience indicates that for a large country program like Nigeria, that it is useful to have management centralized with a bilateral mechanism at the Mission level, but then have the flexibility to access specialized technical services provided through central or regional field support mechanisms or direct contracts or agreements (e.g., commodity procurement and management, demographic and health surveys, treatment and prevention of obstetric fistula, policy development) or direct international organization transfers (e.g. UNICEF, UNAIDS, UNFPA) or intra-governmental transfers (e.g. Voice of America, the Centers of Disease Control, State Department for PEPFAR).

- **What should be the project life-cycle be?** Options include:
 - 5 years
 - 10 years
 - 5 year + 2-5 year renewal option
 - 3 year with an option for 2 year renewal

The benefits of each option need to be discussed with the program and contractor officers. A recent trend of USAID is to have shorter life cycles, but conventional wisdom is that for large complicated programs is important to have the longest cycle possible.

- **What should be the optimal funding scenario?** The current funding projections for the USAID health program are not sufficient to expect a major impact at the national or even regional level. Funding for Nigeria's health program is about the same as allocated to Senegal, a much smaller population and a less complex structure. To be effective, the Mission should move aggressively to solicit additional funds for the Nigeria health program. Unquestionably, health is and should continue to be a key element for USAID's goal of "investing in people." Funding levels will ultimately depend on availability of funds as determined by Agency priorities.

Given the unpredictable nature of USAID, the Mission should build in flexibility to the planning and programming process to allow for the "ebbs and flows." There have been USAID agreements/contracts that have high ceilings that will allow expansion, but these should be realistic. In any case, procurement solicitations should not be competed at a level that builds artificial expectations. In addition, ideas should be explored which allow for "accordion type" budgeting—budget that can be adapted to the changing budget levels, and this is usually adjusted at the time of the annual work planning.

Further, given the probability and need of USAID to leverage funding to achieve impact, new and creative options funding options should be investigated, for example:

- Can USAID instruments take money from other donors, from the government or the multi-laterals such as the Global Fund, UNICEF or other multilaterals for implementation?
- Are there effective mechanisms for seamless joint programming between USAID and other donors, foundations, and private sector donors?
- How can the USG or projects accept money from multi-national companies such as was done with the Angola mining companies and USAID/Angola?

- Is there a way to effectively use the USAID loan guarantee authority?

In order to effectively develop the procurement solicitations and to have timely awards, it will be important for the Mission to adhere to the timeline that the health team recently developed during its workshop in December; to conduct important analyses to inform the design and drafting of the scope of work for the procurement(s) as well as the new strategy; and to identify and request the necessary technical assistance to help with the design, analysis and drafting of the new Mission strategic plan and solicitations.

H. MAJOR CONCLUSIONS AND NEXT STEPS

In this review, the team identified lessons learned and areas needing improvement for the current USAID health portfolio. This report suggests, gives options, and provides actions step to update the current strategy and to plan for the future. The team hopes that this report will assist the Mission to refine its current program, to take actions for programming for health in Nigeria, and to conduct analytical thinking for the upcoming visioning exercises.

After this review and with validation of findings by the stakeholders, this team concludes that USAID/Nigeria is on a trajectory to significantly increase the use of MNCH and RH/FP services in *selected* local government areas and communities in *target states* in Northern Nigeria. The technical strategy used now is generally appropriate and the approaches are basically sound for the level of work and scope that is being implemented at this point. However, with the limited funding there is little or no room for expansion. It is not likely that funding for USAID's work for health will increase dramatically beyond the plus up level of FY 2007. The team is concerned that the limited USAID resources will not permit scale up and replication of all of the good and effective activities which are drastically needed by the large population of Nigeria, especially northern Nigeria. This suggests a dramatic change in operating philosophy in how USAID perceives and implements its health program.

For the *future* health program, the Mission might want to consider efficiently using its limited resources for modeling, testing, and refinement of solid approaches appropriate to the Nigerian milieu in the target areas. Then, to have greater impact at the state and national level, USAID might then use its leadership role and influence to garner additional financial resources funds (from other multilateral or other bilateral donors, foundations, multi-national corporations or from the GON/government) for state-level scale up and replication of the proven models. This approach will take significant time to develop and implement and this concept should be used as grist for planning for the new 2009-2014 Mission Strategy.

For the "*here and now*" USAID needs to identify actions recommended in this report which can be done immediately to reinforce the foundation for a new bilateral program and the next strategy. The team suggests that major *immediate* actions include:

- Using the annual planning process, update the current health strategy and develop a master implementation plan that clearly defines the coordinated actions of each implementing partner - bilateral and field supported.
- Determine and formalize the basic service package, identify those areas that can be easily integrated, and get consensus from the implementing agencies on what they can do within their current program to contribute to immediate program implementation.
- Conduct necessary analyses that will strengthen the current program and provide direction for the future strategic plan. These might include assessments of:
 - the current and potential human resources available for the health sector;

- the various health management and support systems (training, supervision, commodity management, management information and recording keeping, policy development and advocacy, and how they might be improved;
 - non-governmental, community and faith based organizations, and how they might best be used to effectively deliver health care.
 - the commodity logistic systems and how it might be improved in getting materials and supplies to the “last mile” and to the service delivery points.
- Develop an inventory of potential sources that can be tapped to marshal technical and financial resources for the Nigerian Health Program.
 - Intensify and formalize coordination mechanisms with the government, with the donors, with the implementing partners, and with Washington.

While this report does make recommendations and action suggestions for mid-course modifications, the Mission and the health team indeed can take pride in its management and the accomplishments of the complex and challenging health program in Nigeria.